STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015405	A. BUILDING: _____ B. WING _____	C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CFAA INC	1308 S NORWOOD AVE GREEN BAY, WI 54304

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N 000	Initial Comments A complaint investigation and a standard survey were conducted at CFAA Inc on 03/24/2025 with information gathered through 03/26/2025. As a result of this survey 3 deficiencies were identified and the complaint was substantiated. Census: 19	N 000		
N 167	83.12(4)(e) Reporting fire on the premises. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: A fire occurs on the premises of the CBRF. This Rule is not met as evidenced by: Based on record review and staff interview the provider did not send 1 of 1 written reports of a fire that occurred at the CBRF on 08/20/2024 to the State Agency within 3 working days. Findings include: On 03/24/2025, Surveyor reviewed resident records during a complaint investigation and survey at this facility. Resident 1's record showed multiple incidents of Resident 1 smoking in room and having oxygen on at times. A progress note on 08/20/2024 showed Resident 1 in room with oxygen on and started a fire on his/her blanket. The progress report indicated the following: On 08/20/2024 at 10:10 PM, Resident 1 pulled cord for help and came yelling at top of stairs. Staff went to Resident 1's room. Resident 1 had been smoking with oxygen on and staff discovered Resident 1 had started a fire and used blankets to put it out. Resident 1 also burned facial hair and	N 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 167	Continued From page 1 hands. Writer immediately called 911 and grabbed the extinguisher. Resident 1 was upset at the call for emergency assistance. Fire Department arrived and confirmed the fire was out. Resident 1 refused to be checked. All information was given to the Fire Department who left before management arrived. Management discovered the carpet was burned along with a blanket. Resident 1's oxygen tubing had been melted. 0n 03/24/2025 at approximately 1:00 PM, Director - A and Administrator - B confirmed there was no significant injury to Resident 1 during this incident. On 03/24/2025, Surveyor found no report from the provider to the State Agency about this fire on 08/20/2024. There was no self-report provided to Surveyor from the provider about this incident and no statement from provider indicating a report was submitted as required.	N 167		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs.	N 426		

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N 426	Continued From page 2 This Rule is not met as evidenced by: Based on record review and staff interviews the provider did not ensure adequate supervision to meet the needs of 1 (Resident 1) of 1 resident in the facility. Resident 1 had a history of obtaining drugs in the community, smoking in his/her room with oxygen, and of having suicidal thoughts. On 08/20/2024, Resident 1 caused a fire by smoking in his/her room with oxygen on, which resulted in minor burns to self. Findings include: On 03/24/2025 through 03/26/2025, Surveyor reviewed concerns regarding Resident 1's supervision while at this facility. Resident 1 was admitted to the facility on 05/18/2023 with diagnoses of Chronic Hypoxemia failure, DM, enchephalopathy, drug abuse, seizures, history of suicidal thoughts. Resident 1 made own decisions. Progress notes showed Resident 1 was verbally abusive to staff and other residents, refused to follow rules by smoking in room while having oxygen in room, smoked marijuana in room and went into the community to obtain drugs. Resident 1 was able to independently go about the community. Notes showed APS had been involved with Resident 1 since placement. On 01/22/2024, Resident 1 was issued a 30 day notice due to the danger to self and others from smoking in the building while using oxygen, verbally abusing other residents, and drug use. Managed care organization case managers and the provider attempted to find alternative placement but Resident 1 was not accepted at other facilities because of dangerous behaviors.	N 426		

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On 04/04/2024, APS petitioned for guardianship and protective placement for Resident 1 due to continued non-compliance, putting self and others at risk. The petition mentioned Resident 1 had multiple Traumatic Brain Injuries, hypoxia secondary to strangling self, and meth and marijuana use. Police were involved several times but said they could not prove drug use.

Progress notes for Resident 1, reviewed by Surveyor on 03/24/2025, showed on 06/18/2024, Resident 1 called EMS twice at 6:25 AM and at 6:45 PM to request to be taken to the hospital. Resident 1 was immediately discharged and brought back to the facility both times with no new orders or interventions and Resident 1 acting as if nothing had occurred.

On 06/20/2024, police were called by resident saying s/he was suicidal. Police did a wellness and mental health check. Crisis Center was called as the police indicated they could not remove Resident 1 because of protective placement. Notes indicated Resident 1 then settled down. There was no indication the provider increased supervision interventions at this time.

On 07/23/2024, Resident 1 called 911 non-emergent because "no one cares". After an hour and a half, Resident 1 quit calling, took meds and was attended to per the charting note. There was no indication the provider increased supervision interventions at this time.

On 07/30/2024, Resident 1's room smelled of marijuana smoke. There was no indication police were notified or room was checked for drugs.

On 07/31/2024, Resident 1 was having difficulty

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breathing, even with oxygen on.

On 08/05/2024, a Silver Alert was called when Resident 1 walked away from facility. Resident 1 returned by self later that day. There was no evidence the provider increased supervision following this incident.

On 08/19/2024, Resident 1 called Brown County and said s/he wanted to commit suicide. Notes said to "keep eye on [Resident 1]." There was no evidence of increased supervision despite this being the second call since 06/20/2024 threatening suicide and a past history of strangling self.

On 08/20/2024, Resident 1 smoked in his/her room with oxygen on. Resident 1 started a fire in his/her blanket and used blankets to put it out. Resident 1 burned facial hair and called 911. The Fire Department came. The fire was already out. Resident 1 wouldn't let self be medically checked.

There was no evidence the provider put extra supervision in place despite these incidents until 08/21/2024. There was no direction to staff how to deal with these behaviors such as when to call The Crisis Center, when to have more supervision, or what do do when Resident 1 threatened suicide.

Resident 1's ISP did not address the need for increased supervision until 08/21/2024 after setting self and room on fire by smoking in room with oxygen on despite multiple documentations of Resident 1 smoking in room, at times with oxygen on prior to 08/21/2024.

Resident 1's ISP did not address the need for increased supervision due to a history of suicidal

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thoughts and actions and what staff should do if voicing them despite Resident 1 calling police on 06/20/2024 and 08/19/2024 saying s/he was suicidal and having a past history of strangling self.

Resident 1's ISP did not address the need for increased supervision despite having a history of illicit drug use and what staff should do if suspected of having drugs on return from the community.

There was no evidence of an increase in supervision or frequency of monitoring for any of these behaviors addressed in Resident 1's ISP until 08/21/2024 when the provider put a Safety Policy in place.

In an interview with DIR (Director) - A and ADM (Administrator) - B on 03/24/2025 at approximately 1:00 PM, Surveyor asked what was in place to supervise Resident 1 knowing s/he still had lighters after starting a fire in his/her room and burning self on 08/20/2024. Both indicated they were mindful to check Resident 1 but s/he would become belligerent and refuse to go outside to smoke. DIR - A indicated if Resident 1 had suicidal thoughts they were generally in daytime hours and just wanting attention. If they were concerning, the provider would call the Crisis Center. The ISP provided to Surveyor by ADM-B on 3/24/2025 at 1:00 PM, indicated Resident 1 had "No Behavior Problems" listed.

On 03/24/2025 at 1:10 PM, ADM - B indicated they would look for an updated ISP. On 03/25/2025 at approximately 11:06 AM ADM - B sent Surveyor an updated ISP dated 05/19/2024. This ISP indicated Resident 1 had behaviors of

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swearing/agitation and drug use. It indicated Resident 1 will swear at staff when agitated, has a previous substance abuse problem, and does drugs on premises and on occasion away from facility. There were no directives for increased staff supervision or what to do about these behaviors. The ISP said Resident 1 used oxygen and staff should monitor for smoking material after every outing resident goes on. Resident 1 had smoking materials on self when starting a fire in his/her room on 08/20/2024.

On 03/24/2025 at 1:20 PM, ADM - B told Surveyor they initiated a Safety Policy on 08/21/2024 and provided a copy to Surveyor. This policy indicated it was in response to the incident on 08/20/2024 with Resident 1. Staff directives were as follows:

1 - Remind Resident 1 to notify us when leaving and returning to the building
2. Ask Resident 1 to show his pockets for any smoking material.
3. Continue to monitor Resident 1 every 2 hours throughout their shift.
4. Report any abnormal behaviors or other changes to management and document in chart.
5. Remind Resident 1 that smoking is only allowed in designated area and times.

The provider did not ensure adequate supervision to meet the needs of Resident 1 for obtaining drugs in the community, smoking in room with oxygen on causing a fire and burns to self, and a plan for increased supervision when having suicidal thoughts.

Resident 1 was discharged from the facility on 10/01/2024 to another facility.

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N 617	Continued From page 7	N 617		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and staff interview the provider did not ensure that water temperatures at fixtures used by residents were 115 degrees F (Fahrenheit) or lower. Temperatures tested at sinks in 4 of 4 shower rooms ranged from 124.8 degrees F to 133.5 degrees F. Findings include: This facility is licensed at a Class CNA (Nonambulatory) building . A Class CNA CBRF serves residents who are ambulatory, semi-ambulatory or non-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. This facility serves residents who are advanced aged, physically disabled, and who have irreversible dementia or Alzheimer's disease. On 03/24/2025 from 9:30 to 10:00 AM, Surveyor observed hot water temperatures at sinks in 4 of 4 resident shower rooms with DIR (Director) - A.	N 617		

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N 617	Continued From page 8 Water temperatures at the sinks in the upstairs shower rooms were 126.1 degrees F in the north shower room and 133.5 degrees F in the south shower room. The temperature in the south shower room lowered to 126.8 degrees F after several minutes but then stopped. On 03/24/2025, water temperatures at the sinks in the downstairs shower rooms were 125.6 degrees F in the north shower room and 131.7 degrees F in the south shower room on the first floor. The temperature in the south shower room lowered to 124.8 after several minutes but then stopped. DIR - A confirmed these temperatures and said all 4 shower rooms were used by the residents. Publication DHS/DQA P-01942 dated 08/2017 states, "...Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury ..."	N 617		