STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010740	A. BUILDING: _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOREEN FAMILY HOME	2913 INGALLS ROAD MENOMONIE, WI 54751

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 06/12/2023, Surveyor conducted a complaint investigation and abbreviated survey at Noreen Family Home. Data was collected through 06/13/2023. One of 2 complaints was substantiated. Fifteen violations were identified. Census: 6	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review, observation, and interview, the licensee did not ensure the program and operation complied with all laws. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. The facility was licensed in 2004. Between 2004 and 2018, the provider had 6 surveys and a total of 4 violations were issued. The provider had 1 complaint in approximately 16 years, which was substantiated in 2018. The current survey was prompted by 2 complaints related to the provider's resident care and services. The complaints were received by the Department in April and May 2023; one	N 196		

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

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N 196	Continued From page 1	N 196		

complaint was substantiated. The following concerns were identified during the survey:
- New employees were not screened for communicable disease prior to working with residents.
- Caregivers did not receive required training, including new-employee training and continuing education.
- Residents were admitted that were not compatible with the license.
- Resident rights were not promoted or protected.
- A new resident did not have a temporary service plan upon admission.
- Comprehensive service plans were not completed within 30 days from admission.
- Qualified staff were not onsite and awake when residents in need of 24-hour care were present.
- Medications were not securely stored.
- Insulin was not properly labeled to ensure safety/efficacy.
- Emergency evacuation drills were not conducted as required in 2021 or 2022.

On 06/12/2023 at 10:22 AM, Surveyor interviewed House Manager (HM) B and Resident Care Assistant (RCA) A. They explained that Licensee D sold the facility and program to Administrator C. HM B stated Administrator C managed the billing and facility maintenance and HM B managed resident care, employees, and the day-to-day programming. HM B stated Administrator C had no experience managing an assisted living provider and did not know the requirements. HM B said s/he recently started an administrator course and anticipated becoming the administrator when his/her coursework was complete.

At approximately 10:45 AM, HM B called Licensee B to inform him/her of the survey.

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N 196	Continued From page 2 Surveyor interviewed Licensee B who stated s/he was no longer involved with the operation. Licensee D said s/he assumed everything was finalized and that Administrator C had notified the Department of the change in ownership. Licensee B believed Administrator C was the owner and licensee. At 11:25 AM, Surveyor interviewed Administrator C. Administrator C stated s/he purchased the businesses form Licensee D in December 2022 and became the owner and administrator as of 01/01/2023. Administrator C stated s/he had no history of caregiving or managing an assisted living provider, but s/he met the qualifications for an administrator because s/he completed an administrator course in October or November 2022 and had a 4-year degree. Administrator C indicated s/he was working with the Department to change the license. Administrator C stated s/he had not heard back from the Department, so s/he assumed the license was changed and Administrator C was the licensee. Throughout the survey, HM B and Administrator C asked many questions about the regulations related to staff training, resident care, and safety procedures. HM B and Administrator C voiced their appreciation with the technical assistance and resources Surveyor provided. At exit (06/12/2023 at approximately 2:25 PM), HM B stated Licensee D left and neither HM B nor Administrator C knew what they were doing. Administrator C agreed. Cross references: N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease	N 196		

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N 196	Continued From page 3 N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0243 DHS 83.21(1)-(3) All Employee Training N0277 DHS 83.25 Continuing Education N0287 DHS 83.27(2)(a) Admissions Compatible With The License Class N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality N0385 DHS 83.35(2) Temporary Service Plan N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0432 DHS 83.38(1)(h) Medication Administration N0526 DHS 83.47(2)(e) Other Evacuation Drills Z0012 Wis. Stat. ch. 50.065(2)(bm) Out Of State Background Checks	N 196		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

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N 220	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 staff sampled were screened for communicable disease, including tuberculosis (TB), in accordance with the Centers for Disease Control and Prevention (CDC). Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 06/12/2023, Surveyor reviewed staff records. Resident Care Assistant (RCA) A was hired on 06/08/2021. RCA A's record included a 1-step TB skin test, completed over 1 month after hire on 07/12/2021. RCA A's record did not include evidence that s/he was screened for other communicable diseases. RCA B was hired on 11/26/2022. RCA B's record did not include evidence s/he was screened for communicable disease prior to or after hire. RCA E was hired on 10/17/2022. RCA E's record did not include evidence s/he was screened for communicable disease prior to or after hire. At 2:25 PM, Surveyor interviewed Administrator C and House Manager (HM) B. HM B stated new hires would be tested for TB. Surveyor asked if new employees were screened for other communicable diseases. HM B asked if they needed to be and Surveyor provided technical assistance. HM B stated they did not screen for any other communicable diseases upon hire.	N 220		

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N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 resident care staff sampled received orientation training prior to working with residents. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 05/25/2023, the Department received a complaint related to staff training. On 06/12/2023, Surveyor reviewed staff records. Resident Care Assistant (RCA) E was hired on 10/17/2022. His/her record included new hire paperwork that had not been filled out or signed. The record included no evidence of training. At 1:08 AM, Surveyor interviewed House	N 230		

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N 230	Continued From page 6 Manager (HM) B. HM B stated Licensee D, who sold the business and was no longer involved with the program as of 01/01/2023, hired RCA E. HM B stated s/he would make a note to review all of the new hire documents with RCA E and have him/her complete his/her required trainings. Cross reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 230		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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N 239	Continued From page 7	N 239		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 5 resident care staff sampled completed Department-approved training.

Resident Care Assistant (RCA) G did not complete any Department-approved courses.

RCA F did not complete first aid and choking, fire safety, or medication administration.

Findings include:

The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled.

On 05/25/2023, the Department received a complaint related to staff training.

On 06/12/2023 at 10:15 AM, Surveyor learned from House Manager (HM) B and RCA A that Licensee D sold the property and business to Administrator C and as of 01/01/2023, Licensee D was no longer involved. HM B stated Administrator C had no experience and was responsible for billing and maintenance. HM B said s/he was responsible for staff training as of 01/01/2023.

At approximately 12:30 PM, House Manager (HM) B asked Surveyor if all care staff needed to complete Department-approved courses. Surveyor provided technical assistance and asked how many had not completed Department-approved classes. HM B provided a list which included RCA G and RCA F. HM B

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N 239	Continued From page 8 stated both staff passed medications during their shifts. On 06/12/2023, Surveyor reviewed staff records and the Wisconsin Community-Based Care and Treatment Registry. RCA F was rehired on 04/17/2023. RCA F originally worked at the facility from 01/14/2021 through 01/13/2022. RCA F's record did not include training exemptions or evidence of Department-approved training. The Registry indicated s/he completed 1 Department-approved course (standard precautions on 03/30/2020). RCA G was hired on 11/26/2022. RCA G's record did not include training exemptions or evidence of Department-approved training. His/her name was not found on the Registry, indicating s/he had not completed any Department-approved courses. At 1:15 PM, Surveyor interviewed HM B. HM B stated RCAs were responsible for assisting staff with toileting, transfers, dressing, showers, etc. RCA G was occupationally exposed to residents' bodily fluids each shift, requiring standard precautions prior to working the floor. Cross reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general	N 243		

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N 243	Continued From page 9	N 243		

rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment.

Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment.

Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.

Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

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N 243	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers sampled completed all employee training. Resident Care Assistant (RCA) E did not complete resident rights, client group, or challenging behavior training within 90 days of hire. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 05/25/2023, the Department received a complaint related to staff training. On 06/12/2023 at 10:15 AM, Surveyor learned from House Manager (HM) B and RCA A that Licensee D sold the property and business to Administrator C and as of 01/01/2023, Licensee D was no longer involved. HM B stated Administrator C had no experience and was responsible for billing and maintenance. HM B said s/he was responsible for staff training as of 01/01/2023. Surveyor reviewed staff records. RCA E was hired on 10/17/2022. His/her record did not include evidence of resident rights, client group, or challenging behavior training. At 1:08 AM, Surveyor interviewed HM B. HM B stated Licensee D hired RCA E and would have been responsible for his/her training. HM B stated s/he would make a note to have RCA E complete his/her required trainings. Cross reference:	N 243		

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N 243	Continued From page 11 N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 243		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 staff reviewed completed continuing education in 2022. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 05/25/2023, the Department received a complaint related to staff training. On 06/12/2023, Surveyor reviewed staff records. Resident Care Assistant (RCA) A was hired on 06/08/2021. His/her training record indicated s/he completed 12.25 hours in 2022. No evidence was	N 277		

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N 277	Continued From page 12 found suggesting s/he completed training in fire safety. At 2:25 PM, Surveyor interviewed House Manager (HM) B. HM B said they required caregivers to complete 15 hours of training annually. HM B stated all training was completed via read and sign documents provided by the Assisted Living Education Academy (ALEA). Surveyor discussed concern that RCA A did not complete 15 hours in 2022 and requested any additional survey materials be sent to Surveyor via email on 06/13/2023. As of 06/14/2023, Surveyor did not receive additional training documentation.	N 277		
N 287	83.27(2)(a) Admissions compatible with the license class A CBRF may not admit or retain any of the following persons: A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04(2). This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider admitted a non-ambulatory resident (Resident 1) that was not compatible with the provider's semi-ambulatory license. Findings include: The provider has a C semi-ambulatory (CS) license to care for 8 residents in the client groups advanced aged and developmentally disabled. A CS license means residents may be ambulatory	N 287		

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N 287	Continued From page 13 or semi-ambulatory, but one or more may not be physically or mentally capable of responding to a fire alarm by exiting the building without assistance. "Semi-ambulatory" means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane, or a walker, according to DHS 83.02(51). DHS 83.02(34) states "non-ambulatory" means a person who is unable to walk but who may be mobile with the help of a wheelchair or other mobility devices. On 06/12/2023 at 10:15 AM, Surveyor entered the facility and observed Resident 1 in a wheelchair. At approximately 10:25 AM, Surveyor interviewed House Manager (HM) B. HM B stated Resident 1 required transfer assistance and ambulated via wheelchair. HM B stated Resident 1 used to be able to walk with a walker but s/he had not done this since prior to admission. HM B confirmed Resident 1's main form of ambulation since admission was a wheelchair. Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/31/2023. His/her record did not include a temporary or comprehensive individual service plan. A care plan from his/her prior placement, dated 01/05/2023, read, "The resident has limited physical mobility." The care plan indicated s/he was a 1-assist with transfers and ambulation with a 2-wheeled walker or wheelchair. During the survey, Surveyor observed caregivers propel Resident 1 throughout the facility.	N 287		

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N 287	Continued From page 14 Cross references: N0385 DHS 83.35(2) Temporary Service Plan N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan	N 287		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and record review, the provider did not ensure Resident 1's right to confidentiality of health and personal information were respected. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled.	N 346		

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	0010740	A. BUILDING: _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOREEN FAMILY HOME	2913 INGALLS ROAD MENOMONIE, WI 54751

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N 346	Continued From page 15 On 05/25/2023, the Department received a complaint related to resident rights. On 06/12/2023 at 12:07 PM, Surveyor observed Resident Care Assistant (RCA) A check Resident 1's blood glucose and administer insulin. Resident 1 was seated at a table in the dining area with 4 other residents. RCA A announced loudly enough for Surveyor to hear from across the room that Resident 1's blood glucose was 260 and then stated, "Ok, [Resident 1]. I need to poke your stomach." RCA A pulled up Resident 1's shirt so that his/her entire stomach was visible. The 2 residents seated at Resident 1's table stopped eating and watched RCA A administer Resident 1's insulin. At 1:20 PM, Surveyor observed a sheet of paper posted in the living room that read, "[Resident 1's] Toileting Schedule." The document listed each time staff were supposed to toilet Resident 1. Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/31/2023 with diagnoses that included dementia, chronic pulmonary embolism, muscle weakness, and diabetes.	N 346		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the	N 385		

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N 385	Continued From page 16 provider did not ensure Resident 1 had a temporary service plan upon admission. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 06/12/2023 at 1:15 PM, House Manager (HM) B handed Surveyor Resident 1's record and stated s/he had not had time to create a care plan for Resident 1 yet. Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/31/2023. His/her record did not include a temporary service plan. At 2:25 PM, Surveyor interviewed HM B. HM B said that when Resident 1 was admitted, s/he would have communicated Resident 1's needs to the staff verbally or through the staff communication log.	N 385		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is	N 386		

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N 386	Continued From page 17 responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 had comprehensive individual service plan (ISP) within 30 days after admission. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 06/12/2023 at 1:15 PM, House Manager (HM) B handed Surveyor Resident 1's record and stated s/he had not had time to create a care plan for Resident 1 yet. Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/31/2023. His/her record did not include an ISP.	N 386		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of	N 397		

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N 397	Continued From page 18 supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a qualified resident care staff was on site, on duty, and awake when residents requiring 24-hour care were present in April (24 days), May (29 days), and June (11 days) 2023. Findings include: On 06/12/2023 at 11:00 AM, Surveyor interviewed Resident Care Assistant (RCA) A. RCA A indicated staff were scheduled Monday through Friday as follows: 7:00 AM to 3:00 PM, 2:00 PM to 10:00 PM, and 10:00 PM to 8:00 AM. On weekends, first shift changed to 8:00 AM to 4:00 PM but the rest of the schedule remained the same. RCA A said one staff was scheduled per shift and the noc (overnight) shift (10:00 PM to 8:00 AM) was a sleep shift. House Manager (HM) B generally worked alongside staff Monday through Friday from 8:00 AM to 4:00 PM. Surveyor reviewed staff records and found the following staff did not complete initial training requirements:	N 397		

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N 397	Continued From page 19 - RCA E, hired 10/17/2022 - missing orientation and all-employee training - RCA G, hired 11/26/2022 - missing Department-approved training - RCA F, hired 04/17/2023 - missing Department-approved training Surveyor reviewed staff schedules for April, May and June 2023. The schedules indicated the above staff worked alone at the facility 24 of 30 days in April, 29 of 31 days in May, and 11 of 11 days reviewed in June. Surveyor reviewed resident records. RESIDENT 1 Resident 1 was admitted to the facility on 01/31/2023 with diagnoses that included dementia, chronic pulmonary embolism (COPD), muscle weakness, and diabetes. Resident 1's record did not include a temporary or comprehensive individual service plan (ISP). A care plan from his/her prior placement, dated 01/05/2023, indicated s/he had impaired safety awareness and required 1-assist with transfers, ambulation, dressing, bathing, and personal hygiene. RESIDENT 2 Resident 2 was admitted to the facility on 02/06/2023. Resident 2's ISP, dated 06/07/2023, indicated Resident 2 was a fall risk and required verbal prompts/reminders to complete tasks and safety awareness. The ISP read, "[Resident 2] is on a schedule for when [s/he] smokes cigarettes and staff must be with [him/her] at all times when [s/he] goes outside to smoke. [S/he] does have short term memory loss due to a TBI [traumatic	N 397		

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N 397	Continued From page 20	N 397		

brain injury] and will repeat the same stuff over and over again and not remember that [s/he] had a cigarette ... [S/he] independently walks with a 4-prong walking cane. On occasion staff will walk next to [him/her] if [s/he] is wobbly to prevent a fall from happening."

Resident 2's ISP also indicated s/he had a physician-prescribed fluid restriction and staff needed to remind him/her and monitor his/her intake. According to a hospital discharge summary from 02/20/2023, Resident 2 was not able to monitor his/her fluid intake independently. The report indicated s/he was originally placed on a fluid restriction during a hospitalization on 02/14/2023. S/he had 4 falls after returning to the facility. The report read, "[S/he] already has a fluid restriction in place at [his/her] assisted living following [his/her] previous hospitalization which is reportedly being followed. This makes it most likely that [s/he] is drinking more water during [his/her] workday. [His/her] workplace water intake will need to be monitored to avoid another episode of hyponatremia. The recommendation is to avoid plain water at all times in addition to a 2L restriction of other fluids per day."

At 2:25 PM, Surveyor interviewed HM B and Administrator C. Surveyor asked if any residents required 24-hour care and supervision. HM B identified Resident 1 and Resident 2 as needing this level of care. Surveyor voiced concern about staff training and staff sleeping during noc shift. HM B stated Licensee D, who was no longer involved in the program as of 01/01/2023, allowed noc shift to be a sleep shift.

Cross references:
N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws

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N 397	Continued From page 21 N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0243 DHS 83.21(1)-(3) All Employee Training	N 397		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 6 of 6 residents' medications were securely stored. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 05/25/2023, the Department received a complaint related to the provider's medication storage. On 06/12/2023 at 10:15 AM, Surveyor entered the facility and observed the medication cabinet to be unlocked and keys hanging on the wall next to it. At 11:09, Surveyor asked House Manager (HM) B if s/he could observe the provider's medication storage. HM B removed the keys from the wall to unlock the medication cabinet but found the padlock to be disengaged/open. Surveyor asked HM B when staff were last in the cabinet. HM B asked Resident Care Assistant (RCA) A who stated s/he was last in the medication cabinet at	N 419		

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N 419	Continued From page 22 around 9:00 AM. HM B hung the keys back up on the wall hook next to the medication cabinet.	N 419		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medication services were provided to meet resident needs when the provider did not label Resident 1's insulin pens after they were opened. Findings include: On 05/25/2023, the Department received a complaint related to medication services. On 06/12/2023 at 12:15 PM, Surveyor observed the provider's medication storage. Surveyor observed Resident 1's medication supply to include 2 opened insulin pens: Basaglar 100unit/mL KwikPen and Novolog Mix 70-30 flexpen. The pharmacy label on the Basaglar pen indicated it was filled on 03/30/2023 and the Novolog on 05/12/2023. Neither pen was	N 432		

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N 432	Continued From page 23 date-marked for when it was opened. Surveyor asked Resident Care Assistant (RCA) A, the medication passer for the day, if they documented when the pens were opened. RCA A stated they did not. According to Harvard Health, "All insulins must be stored with care to ensure that they remain safe and effective. Improper storage could result in the breakdown of insulin, affecting its ability to control ... your blood sugar level effectively and predictably. Once you open a new vial (meaning once you stick a needle in the vial) or pen, use a Sharpie to note the date you opened it right on the packaging. This will help you remember when to stop using it." (Source: Harvard Health Blog, Safe and Effective Use of Insulin Requires Proper Storage, 12/04/2018, https://www.health.harvard.edu/blog/safe-and-effective-use-of-insulin-requires-proper-storage-2018120415486, retrieved 06/12/2023). According to Drugs.com, opened Basaglar KwikPens should be stored at room temperature and used within 28 days and opened Novolog Mix 70-30 should be stored at room temperature and used within 14 days. (Sources: https://www.drugs.com/mtm/basaglar-kwikpen.html and https://www.drugs.com/mtm/novolog-mix-70-30.html, retrieved 06/12/2023).	N 432		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually.	N 526		

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N 526	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least 2 emergency evacuation drills, other than fire, were conducted in 2021 and 2022. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 06/12/2023, Surveyor reviewed the provider's emergency evacuation drill documentation for 2021 and 2022. The provider conducted 2 "other" drills over these years; a severe weather drill on 06/11/2021 and 12/15/2022. At 2:25 PM, Surveyor interviewed HM B and Administrator C. HM B stated s/he strived to do evacuation drills every 3 months and the drill documentation Surveyor reviewed was all s/he had. HM B stated Licensee D, who was no longer involved in the program as of 01/01/2023, may have additional evacuation drill documentation. At 2:56 PM, Surveyor interviewed Licensee D. Licensee D stated s/he requested staff complete emergency drills monthly and file them in the binder Surveyor reviewed. Licensee D stated s/he did not have additional drill documentation and s/he could not explain why staff did not complete drills per his/her request.	N 526		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS	Z 012		

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Z 012	Continued From page 25 If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an out-of-state criminal record check was completed for 1 of 1 staff sampled. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled.	Z 012		

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Z 012	Continued From page 26 On 06/12/2023, Surveyor reviewed staff records. Resident Care Assistant (RCA) A was hired on 06/08/2021. His/her background information disclosure form (BID), dated 06/09/2021, indicated s/he resided in Oklahoma within the previous 3 years. His/her file did not include evidence that the provider made a good faith effort to obtain a criminal history report from Oklahoma. At 2:25 PM, Surveyor interviewed HM B and Administrator C. HM B stated Licensee D completed RCA A's caregiver background check. At 2:56 PM, Surveyor interviewed Licensee D. Licensee D stated that if RCA A's file did not include an out-of-state criminal record check, s/he did not do it.	Z 012		