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 _____	R-C 04/25/2024

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 04/17/2024, Surveyor conducted a complaint investigation and verification visit at Noreen Family Home. Data was collected through 04/25/2024. Four of 5 complaints were substantiated. Twelve violations were identified. Two of the 12 violations were repeat deficiencies. See Statement of Deficiencies (SOD) VFCD12, dated 11/22/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall	N 158		

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

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N 158	Continued From page 1 maintain documentation of any investigation. This Rule is not met as evidenced by: Based on interview and record review, the provider did not maintain documentation of an alleged incident of misappropriation or conduct an appropriate investigation when $84.00 went missing from Resident 2's funds in March 2024. The provider did not report the situation to the Department. Findings include: The Department received a complaint related to misappropriation of resident property. On 04/17/2024 at 10:40 AM, Surveyor interviewed Administrator A. Administrator A shared that Resident 2's funds were missing $84.00 in March 2024. Administrator A said s/he "investigated" all staff. Surveyor asked how s/he documented these investigations, and Administrator A replied, "I really didn't." Administrator A stated, "I tried to narrow it down, but I couldn't... I replaced the funds." Administrator A said multiple times during the conversation that the only staff that knew where the key was hidden was Caregiver D. Surveyor reviewed Resident 2's record. There was no evidence that Resident 2 was missing $84.00, that the funds were replaced, or that the provider investigated or reported the situation. Cross reference: N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 158		

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N 170	Continued From page 2	N 170		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 2's legal representative was notified when Resident 2's funds were missing. An audit of resident funds in March 2024 found Resident 2's funds were missing $84.00. Findings include: The Department received a complaint related to misappropriation of resident property. On 04/17/2024 at 10:40 AM, Surveyor interviewed Administrator A. Administrator A stated s/he and House Manager (HM) C took 2 residents on a vacation to Las Vegas. While they were gone, s/he left the key to the resident funds in a container on a shelf in the living room. Administrator A stated only 1 staff member knew where the key was hidden but anyone in the home could access the key. When Administrator A returned, s/he and Caregiver D audited resident funds and found Resident 2's account was missing $84.00. Administrator A said s/he "investigated" all staff. Administrator A stated, "I tried to narrow it down but I couldn't... I replaced the funds."	N 170		

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N 170	Continued From page 3 Surveyor reviewed Resident 2's record. There was no evidence that Resident 2 was missing $84.00, that the funds were replaced, or that the provider reported the situation. At 10:57 AM, Surveyor asked Administrator A if s/he notified Resident 2's guardian, Guardian E, about the missing funds. Administrator A stated, "I did not let [Resident 2's] guardian know... I just replaced it." Cross reference: N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 170		
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 interview, record review, and observation, the licensee did not follow all laws governing the program and operation. This is a repeat deficiency. See Statement of Deficiency (SOD) VFCD12, dated 11/22/2023. Findings include: On 01/24/2024, the Department issued a notice and order letter with SOD VFCD12 that read: "1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall ensure each resident admitted or retained has an ambulatory or cognitive status that is consistent with the license classification	N 196		

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N 196	Continued From page 4 under s. DHS 83.04(2). WITHIN 14 DAYS of receipt of this notice, the licensee shall hold an individual care conference for [Resident 2], with their legal representative and case manager (if any), for the purpose of developing a plan of correction to resolve the deficiency related to the requirements specified by Wis. Admin. Code § DHS 83.27(2)(a), as identified in Statement of Deficiency VFCD12. The licensee will obtain a statement of agreement with the plan, dated, and signed by all persons involved in developing the plan. A copy of the statement of agreement will be made available to department representatives upon request. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 3 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for [Resident 2] with a copy of Statement of Deficiency VFCD12 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request." Between February and April 2024, the Department received 5 complaints related to resident care, resident rights, and the environment. Between 04/17/2024 and 04/25/2024, Surveyor investigated the 5 complaints and completed a verification visit to determine if the previous	N 196		

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N 196	Continued From page 5	N 196		

deficiencies had been corrected. Four of the 5 complaints were substantiated and 2 of the 4 deficiencies identified in the previous survey (SOD VFCD12) were not corrected. The following is a list of the concerns identified during the survey. Items with an asterisk (*) are the issues that were cited in SOD VFCD12:
- The provider did not investigate, document, or report an allegation of misappropriation of resident funds.
- Resident funds were not safeguarded from misappropriation.
- The administrator did not supervise the facility in a way that ensured his/her child's behavior did not adversely affect residents.
- Residents were given involuntary discharge notices that did not include all required content.
- Residents did not receive medication as ordered.
- Resident funds in excess of $200 were not placed in an interest-bearing account.
- Residents were not thoroughly assessed prior to admission or upon changes in condition.
- A record of medication administration was not accurately maintained.
- Rooms were not free of unpleasant odor.
- Exterior areas were not maintained and free of hazard.*

On 04/17/2024 at 10:28 AM, Surveyor interviewed Administrator A. Administrator A stated they did not hold a care conference with Resident 2's team to determine a plan of correction per the special order #1. Administrator A stated s/he emailed Resident 2's team on 01/29/2024, letting them know Resident 2 could not remain living at the facility. Administrator A said s/he did not send Resident 2's guardian or managed care organization a copy of the notice and order letter or SOD VFCD12 per special

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N 196	Continued From page 6 order #2. At 11:00 AM, Surveyor interviewed Licensee B. Licensee B stated s/he thought they took care of the situation by issuing a discharge notice to Resident 2's team after they received SOD VFCD12. Licensee B stated they did not hold a care conference or send Resident 2's guardian and case manager a copy of the notice and order letter or SOD. Cross references: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse Neglect N0170 DHS 83.12(5)(b) Notification: Abuse And Neglect Allegations N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0370 DHS 83.34(3) More Than $200 Personal Funds From Resident N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0489 DHS 83.44(2)(a) Rooms Clean And Free From Odors N0492 DHS 83.45(1)(a) Exterior Areas	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily	N 214		

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N 214	Continued From page 7	N 214		

operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.

This Rule is not met as evidenced by:
Based on interview, the administrator did not supervise the facility to ensure residents received proper treatment and their rights were respected. Administrator A's child's (Child J) disruptive behavior caused resident distress. Child J used Resident 4's electric razor to shave a patch of Resident 4's hair without Resident 4's permission.

Findings include:

The provider is licensed to care for 8 elderly and/or developmentally disabled adults. The facility had a staff living quarters where the administrator resided.

The Department received complaints related to Child J's behavior toward residents.

On 04/17/2024 at 10:07 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he got along well with the staff and other residents. Resident 3 stated the best thing about the facility was the TV. Resident 3 stated a child lived at the facility and s/he was at school now. Surveyor asked if s/he got along with the child. Resident 3 shook his/her head no and made a noise of disgust. Resident 3 stated Child J "yells all the

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N 214	Continued From page 8	N 214		

time" and takes the TV remote.

At 10:17 AM, Surveyor interviewed Resident 4. Resident 4 stated Child J "bothers me once and awhile." Resident 4 stated Child J will play with Resident 4's TV remote in Resident 4's room. Resident 4 stated Child J liked to hang out in Resident 4's room. Resident 4 stated it was ok with him/her most of the time but one time, about 1 month ago, Child J was in Resident 4's room and started playing with Resident 4's electric razor. Resident 4 stated Child J cut Resident 4's hair without Resident 4's permission and attempted to shave Resident 4's eyebrows. Resident 4 stated s/he needed to block Child J so s/he did not cut off his/her eyebrows. Resident 4 stated s/he was not happy about it.

At 11:50 AM, Surveyor interviewed Administrator A. Administrator A stated Child J was 5 years old. Administrator A stated Child J could not walk through the door without Resident 3 yelling at him/her. Administrator A stated Resident 3 liked his/her environment quiet and calm so having a child in the home upset him/her. Administrator A stated Child J liked to hang out in resident rooms but s/he was not allowed in Resident 4's room anymore because Child J shaved a patch of hair from Resident 4's head and then used Resident 4's razor to shave his/her own head. Administrator A stated, "[Resident 4] told me. [S/he] was upset." Administrator A stated s/he was not aware of any other concerns about Child J's behavior toward residents. Administrator A stated Child J was never present in the facility without Administrator A.

On 04/22/2024 at approximately 10:15 AM, Surveyor interviewed Caregiver G. Caregiver G stated Child J was "very hyper" and Child J was

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N 214	Continued From page 9 "too much for [Resident 4] and [Resident 3]." On 04/22/2024 at 10:35 AM, Surveyor interviewed Caregiver H. Caregiver H stated s/he primarily worked weekend evenings. Caregiver H stated Child J was a problem and Administrator A left Child J at the facility with staff and residents while s/he went out. Caregiver H voiced frustration at having to babysit Child J while trying to care for residents. Caregiver H stated, "[Child J] hit me really hard yesterday because I wouldn't get [him/her] something." Caregiver H said Child J jumped on furniture, rode his/her bike through the house, took resident snacks, and left his/her belongings lying around, which Caregiver H felt was a trip hazard for residents. Caregiver H stated Resident 3, Resident 4, and Resident 5 got frustrated with Child J because they wanted to be left alone. Caregiver H stated staff did not feel comfortable discussing their concerns with Administrator A or Licensee B because they were afraid of retaliation from Administrator A. On 04/22/2024 at 12:30 PM, Surveyor interviewed Caregiver I. Caregiver I stated, "[Child J] is wild. [S/he] runs around the house and is disruptive... they [residents] get angry with [him/her]... [s/he] doesn't listen to anyone." Caregiver I stated s/he witnessed Child J tug on residents' arms in the past. Caregiver I stated Child J went into resident rooms freely, and Resident 3 kept his/her door locked because s/he did not want Child J in his/her room. Caregiver I stated it was about 1 or 2 months ago when s/he found Child J in Resident 4's room shaving his/her own head. Caregiver I stated Child J's hair was on the floor of Resident 4's room and s/he was playing with Resident 4's razor. Caregiver I stated Administrator A was in the living room at the time.	N 214		

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N 214	Continued From page 10 On 04/23/2024 at 3:00 PM, Surveyor interviewed Nurse K. Nurse K voiced concerns about Child J's behavior. Nurse K stated s/he observed Child J riding his/her bike throughout the house, ramming it into walls. Nurse K stated during one of his/her visits, s/he observed Child J forcefully take the remote out of a resident's hand and change the channel. The resident was watching TV at the time. Nurse K stated s/he approached Child J a little while later and reminded him/her that Administrator A told Child J s/he needed to take turns with the TV and Child J told Nurse K s/he could do whatever s/he wanted. Nurse K stated s/he observed a resident return home and place money on Administrator A's desk in the living room. Child J went to the desk and put the money in his/her pocket. Nurse K said another resident with a walker went up to Child J and told him/her to put the money back because it was not his/hers. Nurse K said s/he watched Child J get upset and shove the resident's walker. On 04/25/2024 at 10:55 AM, Surveyor interviewed House Manager (HM) C. HM C stated, "It's not a good situation for them [Administrator A and Child J] to live here for many reasons." HM C described Child J as "a very hyperactive child." HM C said Resident 3 and Resident 4 did not have patience for him/her but at times s/he observed them enjoying Child J's company. HM C felt Child J's interactions with residents were more positive than negative. HM C stated Child J was at the facility without Administrator A often. On 04/25/2024 at 8:30 AM, Surveyor discussed concerns identified during the survey, including concerns that Child J's behavior was negatively	N 214		

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N 214	Continued From page 11 affecting residents. Administrator A stated s/he spoke with Resident 4's family about Child J shaving Resident 4's hair. Administrator A insisted Resident 4's family found the situation funny. Administrator A said Resident 4 was not upset at all when Child J shaved his/her head but this was different from what Administrator A stated to Surveyor on 04/17/2024.	N 214		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats.	N 328		

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N 328	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide involuntary discharge notices to 2 of 2 residents (Resident 1 and Resident 2) that included the following requirements: a statement indicating the resident's legal representative may ask for Department review, the contact information for the regional office's director, or the contact information for the regional office ombudsman program. Findings include: The provider is licensed to care for 8 semi-ambulatory adults in the client groups advanced aged and developmentally disabled. On 04/17/2024, Surveyor reviewed 2 involuntary discharge notices issued in 2024. Resident 1 was admitted to the facility on 12/22/2023. Administrator A sent Resident 1's care team an email on 01/29/2024 that read, in part, "Noreen Family Home is giving a 30 day termination notice for [Resident 1]. [S/he] is no longer a candidate for this facility due to requiring more assistance with [his/her] physical and mental health... [S/he recently hurt [his/her] ankle... which is requiring [him/her] to use a wheelchair. We are only a semi-ambulatory facility which means anyone in a wheelchair can't be her [sic] per DHS." Resident 2 was admitted on 07/05/2023. Administrator A sent Resident 2's care team an email on 01/29/2024 that read, in part, "Noreen Family Home is giving a 30 day termination notice for [Resident 2]... Since [s/he] is in a wheelchair and was unaware when we accepted [him/her],	N 328		

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(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 328	Continued From page 13 our facility is only a semi-ambulatory facility which means anyone in a wheelchair can't be her [sic] per DHS." On 04/17/2024 at 1:30 PM, Surveyor interviewed Administrator A and Licensee B. Both stated they were unaware of the involuntary discharge requirement to include a statement indicating the resident's legal representative may ask for Department review, the contact information for the regional office's director, and the contact information for the regional office ombudsman program.	N 328		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure residents were free from misappropriation. Eighty-four dollars went missing from Resident 2's funds in March 2024. The provider did not revise their system to ensure resident funds were safeguarded after the incident. Findings include:	N 348		

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N 348	Continued From page 14 The Department received a complaint related to misappropriation of resident property. On 04/17/2024 at 10:40 AM, Surveyor interviewed Administrator A. Administrator A stated s/he and House Manager (HM) C took 2 residents on a vacation to Las Vegas. While they were gone, s/he left the key to the resident funds in a container on a shelf in the living room. Administrator A stated only 1 staff member (Caregiver D) knew where the key was hidden, but anyone in the home could access the key. When Administrator A returned, s/he audited resident funds and found Resident 2's account was missing $84.00. Administrator A stated, "I tried to narrow it down, but I couldn't... I replaced the funds." Administrator A stated s/he took another trip after Las Vegas. Surveyor asked what Administrator A did with the key to resident funds during that trip. Administrator A said s/he placed it in the same location. Administrator A stated s/he audited funds when s/he returned, and no funds were missing from any resident accounts. Surveyor asked what Administrator A planned to do in the future when s/he was out of town. Administrator A stated next time s/he left s/he would provide the key directly to HM C rather than place it on the shelf where anyone could access it. Surveyor reviewed Resident 2's record, including financial ledgers and progress notes. There was no evidence that Resident 2 was missing $84.00, that the funds were replaced, or that the provider investigated the situation. Cross references:	N 348		

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N 348	Continued From page 15 N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse Neglect N0170 DHS 83.12(5)(b) Notification: Abuse And Neglect Allegations	N 348		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received his/her medication as ordered by his/her physician. Resident 1's prescribed trazodone was not ordered timely, causing Resident 1 to run out of the medication in January and March 2024. Findings include: The Department received a complaint related to medication administration. On 03/28/2024, the Department received images of a medication blister card with a pharmacy label indicating the medication in the blister packs was trazodone 100mg tablet, take one tablet by mouth at bedtime at 8PM, prescribed to Resident 1. The label read, "*REORDER WHEN DOWN TO 7 DAY SUPPLY*." A second separate pharmacy sticker was attached to the card that read, "FACILITY MUST REORDER." The images showed 2 of the blisters (blisters #14 and #15)	N 352		

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had been taped up. The contents in blister #15 were visible; there were 2 round tablets in it. Staff documented on the card that the first tablet was removed from the card on 02/23/2024. Assuming Resident 1 received the medication daily and the provider removed the medications from the blisters progressively, blister #14 would have been designated for 03/09/2024 and blister #15 would have been designated for 03/10/2024.

On 04/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 12/22/2023 and discharged on 03/11/2024.

Surveyor reviewed Resident 1's medication administration record (MAR) and found staff were not accurately recording Resident 1's medication administration. Resident 1's progress notes mentioned medication refusals and ordered medication holds but did not show evidence of refusals that corresponded with these progress notes.

Resident 1 was prescribed trazodone 100mg, take 1 tablet by mouth at bedtime.

Resident 1's January trazodone MAR was blank for dates 01/19/2024, 01/20/2024, 01/21/2024, and 01/22/2024. Staff documented in notes that Resident 1 did not get trazodone on 01/20/2024 or 01/21/2024 because it was not in the facility. There was no additional documentation evidencing if Resident 1 did or did not receive trazodone on 01/19/2024 or 01/22/2024.

Resident 1's 03/09/2024 trazodone MAR had circled staff initials. There was no note on the MAR or in Resident 1's progress notes that explained why Caregiver H's initials were circled on this date.

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N 352	Continued From page 17 According to the staff schedule provided by Administrator A, Caregiver H worked on 03/09/2024 and 03/10/2024. On 04/22/2024 at 10:35 AM, and 04/25/2024 at 10:28 AM, Surveyor interviewed Caregiver H. Caregiver H stated s/he typically only worked on weekends. S/he stated s/he reported to work for his/her second shift of the weekend (03/10/2024) and Administrator A asked Caregiver H why s/he did not give Resident 1 his/her trazodone the evening before (03/09/2024). Caregiver H stated s/he administered Resident 1 his/her medication that was in the medication cabinet. Administrator A stated Resident 1's trazodone was on Administrator A's desk, not in the cabinet. Caregiver H stated s/he looked at the card and noticed the medication looked different. Caregiver H stated Resident 1's trazodone was normally 1 large tablet and the medication in the card on Administrator A's desk had 2 small tablets in it. Caregiver H said, "I said, 'Those aren't [Resident 1's] pills,' and [Administrator A] said, 'I put mine in there because [his/hers] were gone.'" On 04/22/2024 at 12:30 PM, Surveyor interviewed Caregiver I. Caregiver I said Resident 1's trazodone ran out right before Administrator A and House Manager (HM) B went to Las Vegas. Caregiver I stated s/he administered Resident 1 the last trazodone tablet, then placed the empty medication card on Administrator A's desk to signal the need to reorder. Caregiver I stated when s/he came in the next day, s/he observed Resident 1's trazodone medication card with repackaged tablets that were different than Resident 1's typical trazodone medication. Caregiver I said Resident 1 did not receive trazodone for at least 2 days.	N 352		

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N 352	Continued From page 18 On 04/25/2024 at 10:55 AM, Surveyor interviewed HM B. HM B stated s/he and Administrator A were in Las Vegas from 03/11/2024 through 03/14/2024. On 04/22/2024 at approximately 10:15 AM, and on 04/25/2024 at 10:05 AM, Surveyor interviewed Caregiver G. Caregiver G stated s/he observed Resident 1's medication card to be taped up with tablets that were different from what was packaged by the pharmacy. Caregiver G said the medication card originally had 1 large tablet in each blister and there were 2 smaller tablets in the taped blisters. Caregiver G stated s/he heard the medication that was repackaged in the blisters was Administrator A's personal trazodone medication. Caregiver G stated staff did not feel comfortable administering the repackaged medication to Resident 1, and Caregiver G destroyed the repackaged medication on 03/10/2024. Caregiver G stated staff did not administer the medication that was repackaged in the blister cards, and Resident 1 was not administered trazodone from the date s/he ran out through discharge. On 04/24/2024, Surveyor reviewed the facility medication destruction logs which indicated Caregiver G destroyed 4 50mg tablets of trazodone on 03/10/2024. The reason for destruction was "other." On 04/25/2024 at 8:30 AM, Surveyor interviewed Administrator A and Licensee B. Surveyor asked for clarification on the missing documentation on Resident 1's January MAR. Administrator A stated Resident 1's trazodone was not timely ordered, so s/he did not receive it on 01/19/2024 through 01/22/2024. Administrator A explained Resident	N 352		

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N 352	Continued From page 19 1's trazodone needed to be reordered manually; it did not come in on the regular pharmacy delivery. Administrator A stated staff did not let Administrator A know when the medication was low so s/he did not order it right away. Surveyor asked if Resident 1's trazodone ran out any other time during his/her placement. Administrator A stated, "I don't think so." Surveyor discussed the information received during the survey indicated Resident 1's trazodone ran out in March before Administrator A went to Las Vegas. Administrator A denied knowledge of this. Surveyor stated s/he received an image of Resident 1's medication card repackaged with tablets that did not match the description on the pharmacy label, and asked if Administrator A knew anything about this situation. Administrator A denied knowing anything about Resident 1's trazodone card being repackaged with different medication and stated no staff had brought this to his/her attention. Cross Reference: N0415 DHS 83.37(2)(d) Documentation Of Medication Administration	N 352		
N 370	83.34(3) More than $200 personal funds from resident Funds in excess of $200. A CBRF receiving more than $200 of personal funds from a resident shall deposit funds in excess of $200 in an interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident funds in excess	N 370		

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N 370	Continued From page 20 of $200 were placed in an interest-bearing account. Findings include: On 04/17/2024 at 10:55 AM, Surveyor reviewed resident funds with Administrator A. Resident 4's account had $240.15. Administrator A stated it was the provider's policy to keep resident funds at or below $200. Administrator A stated the provider received $350.00 monthly to put in Resident 4's account. Surveyor asked if they placed Resident 4's money into an interest-bearing account. Administrator A stated they did not, but they tell Resident 4 to spend his/her money quickly. Surveyor reviewed Resident 4's financial ledger for the past year. Resident 4's account balance was over $200 for approximately 2 weeks every month.	N 370		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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N 381	Continued From page 21 This Rule is not met as evidenced by: Based on record review and interview, the provider did not adequately assess Resident 1 prior to admission. Resident 1 was placed at the provider and the provider realized within days Resident 1's needs were more than what they could manage. The provider did not reassess Resident 1. Findings include: On 04/17/2024 at approximately 9:45 AM, Surveyor interviewed Administrator A. Administrator A stated that one resident (Resident 1) discharged in 2024. Administrator A stated Resident 1 "disrupted the whole household ... [s/he] needed way more care than what we could give [him/her]." Administrator A stated s/he realized Resident 1 was not a good fit for the home within days of admission. Administrator A explained that Resident 1 did not seem like s/he needed much care when Administrator A completed the pre-admission assessment. On 04/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 12/22/2023 and discharged on 03/11/2024. Resident 1's record included 1 undated assessment that was titled Pre-Admission Evaluation. At approximately 1:00 PM, Administrator A stated this was the form s/he used to assess Resident 1 prior to admission, and s/he found it online. The 4-page form included 16 functional and social assessment questions with multiple-choice, Likert scale responses that rated need based on 0 - Independent, 1- Supervision, 2 - Moderate Assistance, and 3 - Maximum Assistance. Based on this assessment, Resident 1 needed	N 381		

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supervision in most activities of daily living, Resident 1 did not use a wheelchair, and s/he required behavioral interventions multiple times a week, but not daily.

Resident 1's record included a court summary of Resident 1's situation that led to protective placement, dated 12/14/2023. The document indicated Adult Protective Services became involved in June 2023 following reports of emergency services called to Resident 1's home in response to low oxygen, disorientation, and inability to form sentences. The report read, "It was later determined by APS (adult protective services) that [Resident 1] has end-stage COPD (chronic obstructive pulmonary disease) but was not using [his/her] oxygen concentrator as directed by [his/her] medical doctor ... Upon APS arriving to [Resident 1's] home on June 6, 2023, [Resident 1] was home alone. [S/he] was in [his/her] bed and unable or unwilling to get up, leaving APS only the ability to speak to [him/her] through [his/her] bedroom window ... APS staff spoke with [Resident 1] for a period of time, but were unable to gather useful information from [him/her] (indicating a dangerousness in [him/her] being left unsupervised)."

The report indicated APS contacted Resident 1's spouse, who confirmed Resident 1 had not been using his/her oxygen which had caused increased confusion over the past month. APS contacted Resident 1's child, who was Resident 1's healthcare power of attorney at the time. Resident 1's child became hostile and required police involvement. Family denied concerns presented to them about Resident 1's health and need for 24-hour supervision and blamed Resident 1's managed care organization for getting APS involved. Resident 1's family

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announced in-home service providers were fired immediately. Resident 1's family's ongoing behavior caused hospice to announce termination of services if Resident 1 remained in the home. According to the report, Resident 1 was receiving bathing services twice a week from his/her managed care organization and hospice personal care services 5 times per week. The report read, "[Resident 1] appears to appreciate the care [s/he] received from [his/her] providers; though [s/he] is losing these services at no fault of [his/her] own."

Resident 1's record included a cognitive assessment, dated 12/14/2024 that read, "Patient has difficulty with answering some orientation questions ... patient does not know reasoning for hospitalization or current month/year. In conversation, patient is rather perseverative and often talks in circles about the same topic. [S/he] frequently asks SLP (speech/language pathologist) where [his/her] medications are ... Patient presents with severe cognitive/communication deficits characterized by impaired attention, memory, executive functioning, language, and visual-spatial skills. Patient also exhibits impaired orientation and insight into current situation ... [S/he] performed similarly on cognitive assessment [sic] completed in March of this year."

Resident 1's individual service plan (ISP), dated 01/01/2024, indicated the following:
- Resident 1 required 1 to 1 staff most of the time when s/he was awake.
- Was a fall risk due to weakness and his/her medication.
- Had tremors that caused him/her to spill his/her food.
- Had short-term memory loss and forgot

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receiving care, medication, or food.
- Independent with mobility most of time using a front-wheeled walker, but "has been requiring one assist or wheelchair that is a one assist from staff throughout the day recently due to an injured foot/ankle."
- "Communicates by yelling most of the time for staff and often forgets what [s/he] called them for."

On 01/29/2024, Administrator A sent Resident 1's care team an email indicating Resident 1 was no longer a candidate for the provider due to needing more care than what the provider could offer. The email indicated Administrator A first shared this decision with Resident 1's guardian a week before Resident 1's court date. According to Resident 1's daily progress notes, the court appearance occurred on 01/16/2024.

On 04/22/2024 at 10:35 AM, Surveyor interviewed Caregiver H. Caregiver H stated Resident 1 was challenging. Caregiver H stated Resident 1 was more independent when s/he first arrived at the provider but s/he seemed to watch other residents and adopt their care needs. Caregiver H stated s/he felt Resident 1 did these things in an effort to get staff's attention. Caregiver H said Resident 1 saw staff applying lotion on one of the residents' heels, and soon after Resident 1 began asking for lotion on his/her feet. Caregiver H said Resident 1 would tell staff s/he could not move and demanded them to help him/her get things within his/her reach but staff would pass by Resident 1's room and observe him/her walking around. Caregiver H stated Resident 1 did anything s/he could, to get staff to stay in his/her room, including purposefully spilling drinks on the floor so staff would have to mop. Caregiver H said Resident 1 needed his/her

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wheelchair for all mobility near the end of his/her placement, and Caregiver H felt the device was needed because Caregiver H was on so much medication that s/he was lethargic and unsteady.

According to Resident 1's medication administration record (MAR), Resident 1 was prescribed multiple medications throughout his/her placement for pain such as lidocaine 5% patch, diclofenac 1% gel, gabapentin, hydrocodone-acetaminophen, naproxen, and sumatriptan for migraines.

On 04/23/2024 at 3:00 PM, Surveyor interviewed Guardian E. Guardian E stated s/he became involved with Resident 1 shortly before s/he was placed at the provider. Guardian E stated s/he had very little information on Resident 1 when s/he called Administrator A to request placement. Guardian E said, "I'm familiar with Noreen Family Home and I thought it was a perfect fit; looking back, maybe not."

On 04/25/2024 at 8:30 AM, Surveyor interviewed Administrator A and Licensee B about the sources used to assess Resident 1 prior to admission. Administrator A stated Guardian E called to make the referral then went to the hospital to assess Resident 1. Administrator A stated s/he did not have any concerns about Resident 1 at that assessment. Administrator A stated s/he also spoke with Resident 1's managed care organization, which informed him/her that Resident 1 was "pretty independent, but might need some help in the shower." Administrator A stated that after Resident 1 was admitted, Resident 1's family caused a lot of issues. Administrator A stated s/he did not read the court summary or cognitive assessment prior to placement, so s/he was not aware of the family

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(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 381	Continued From page 26 dynamics. Administrator A stated s/he did not know Resident 1 was on hospice until after s/he was admitted to the provider. Surveyor asked if Administrator A assessed each of the areas outlined in 83.35(1)(c). Administrator A reviewed his/her assessment and the requirement and stated s/he did not assess Resident 1 for pain or risks. Surveyor discussed concern that Administrator A's assessment form also did not capture Resident 1's cognitive and behavioral needs or interpersonal relationships. Administrator A agreed and stated s/he would work on creating a new assessment system. Surveyor asked Administrator A if s/he assessed Resident 1 after admission. Administrator A stated s/he did not formally assess Resident 1, but s/he did update his/her ISP. Administrator A stated, "It (the ISP) was totally different from the temporary (service plan)." Administrator A stated s/he updated the ISP based on what staff observed at the provider. Summary: The provider assessed Resident 1 using a functional screening tool that did not capture Resident 1's complex needs. The form did not address Resident 1's pain, cognitive/behavioral needs, interpersonal relationships, or medical needs. The provider did not seek out additional sources of documentation such as assessments performed by Resident 1's hospice program, medical records, or managed care organization information, prior to admitting Resident 1 to the facility. After admission, the provider recognized Resident 1's needs were higher than what they assessed prior to admission but the provider did not complete a new assessment of Resident 1.	N 381		

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	0010740	A. BUILDING: _____ B. WING _____	R-C 04/25/2024

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N 415	Continued From page 27	N 415		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain documentation of Resident 1's medication administration. Findings include: On 04/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 12/22/2023 and discharged on 03/11/2024. Surveyor reviewed Resident 1's medication administration record (MAR) and progress notes and found they did not match. A progress note, dated 01/30/2024 read, "I'm trying to get [him/her] to take [his/her] 8pm meds, since [s/he] did not take them last night, but [s/he's] pretty much refusing to take them ... Since [Resident 1] was not waking up and [Administrator A] and I had concerns, I called hospice ... the nurse recommends we take [his/her] vitals every 4 hrs. Also to stop giving [his/her] lorazepam, hydrocod	N 415		

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N 415	Continued From page 28	N 415		

[sic], and trazodone ... So for now these medications are on hold." Resident 1's MAR showed Resident 1 received all medications as prescribed on 01/29/2024, and the medications that were held on 01/30/2024 were documented as administered but a note on the back of the MAR also read, "All PM meds hold per hospice."

Based on interviews with Caregiver I, Caregiver H, and Caregiver G between 04/22/2024 and 04/25/2024, Resident 1 did not receive his/her trazodone between 03/09/2024 and 03/11/2024 because the medication ran out and was not refilled. Resident 1's March MAR showed trazodone was administered as prescribed on these dates.

On 04/25/2024 at 8:30 AM, Surveyor interviewed Administrator A and Licensee B about the inconsistent documentation. Administrator A reviewed the charting and stated staff failed to document correctly on the MAR. Administrator A stated s/he reviewed his/her expectation for MAR documentation at every staff meeting because it was an ongoing problem. Administrator A said staff were not understanding how to document on the MAR. Administrator A stated the house manager was responsible for monitoring the MAR for accuracy but that was not happening when Resident 1 was at the facility. Administrator A stated, "We were all under stress and in survival mode, so we weren't doing a great job."

On 04/25/2024 at 10:55 AM, Surveyor interviewed House Manager (HM) C. HM C stated s/he found out staff were completing the MAR at the start of their shift just to get charting done. HM C said many of the staff did not have prior experience in healthcare so they needed more training. HM C said they all went through their

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N 415	Continued From page 29 required medication training but they needed additional training due to a lack of direct experience. Cross reference: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication	N 415		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was free of odors. Findings include: The Department received a complaint related to odors. On 04/17/2024, Surveyor was on site from 9:40 AM to 1:50 PM and noticed an unpleasant odor that smelled like stale urine. At 10:35, Surveyor interviewed House Manager (HM) C. HM C stated Resident 2 had constant incontinence. HM C stated staff changed and/or toileted Resident 2 every 2 hours and as needed, but sometimes within minutes of putting Resident 2 in his/her wheelchair, s/he would soak through his/her clothing and wheelchair. HM C said Resident 2 was known to leave a trail of urine in the home. HM C stated staff tried to keep up on it, but the house did smell of urine. Administrator A was in the living room at the time	N 489		

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N 489	Continued From page 30	N 489		

Surveyor was speaking with HM C. Administrator A agreed with HM C that the house smelled like urine. S/he stated s/he believed it was soaked into the carpeting. Administrator A said staff had tried to shampoo the carpet, the last time being 2 weeks ago, and they changed Resident 2's bedding multiple times per day. S/he stated s/he talked to Licensee B about replacing the carpeting with hard surfaced floors that could be mopped, but Licensee B did not want to spend the money.

At 11:38 AM, Surveyor interviewed Licensee B. Surveyor asked Licensee B about what they were doing about the odor in the home. Licensee B stated s/he did not notice an odor. Administrator A and Nurse L were in the room at the time of interview and both stated to Licensee B that they noticed an odor. Administrator A reminded Licensee B about Resident 2's incontinence and stated this was why s/he requested the carpet be removed. Licensee B stated s/he would have staff clean the carpets and if that did not work, s/he would hire someone professionally to clean them.

On 04/22/2024 at approximately 10:15 AM, Surveyor interviewed Caregiver G. Caregiver G stated Resident 2 discharged on 04/18/2024 and after they removed Resident 2's belongings and cleaned, the house no longer smelled of urine.

On 04/23/2024 at 3:00 PM, Surveyor interviewed Hospice Nurse (HN) K. HN K stated s/he worked at the facility in January 2024 for a couple of weeks and was called to the facility a couple of times after for as-needed hospice visits. S/he stated the home smelled of urine and s/he found Resident 2 soaked with urine. HN K stated Resident 2's medical team recommended s/he get a catheter due to his/her level of incontinence,

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N 489	Continued From page 31 but Resident 2 refused. HN K stated the provider got better at keeping Resident 2 dry, but the odor remained.	N 489		
{N 492}	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure exterior areas were maintained and free of hazards. The main entrance pathway had multiple trip hazards and uneven steps. The raised concrete patio was sloped toward the ground and did not have railings to prevent falls. This is a repeat deficiency. See Statement of Deficiency (SOD) VFCD12, dated 11/22/2023. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged and developmentally disabled. On 04/17/2024 at 9:40 AM, Surveyor observed the provider's exits which were unchanged from the previous survey. The following issues remained: The main exit led to a raised concrete slab (patio) that was the width of approximately 1/2 of the house. The patio was raised 12 inches from grade and did not have a guardrail. There was a noticeable slope in the patio from the main entrance/exit door to the edge of the patio. This slope created a hazard for any wheeled assistive device. The patio had a short retaining wall	{N 492}		

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{N 492}	Continued From page 32 around the perimeter that was flush with the surface of the patio. Some of the top blocks were missing from the retaining wall, creating a hole (trip hazard) at the edge of the concrete patio. There were steps leading off the concrete patio to a cobblestone paver pathway. The steps were uneven heights and the stone pathway had areas of missing or cracked stones. Both issues created trip hazards. At approximately 9:45 AM, Surveyor interviewed Administrator A. Administrator A stated Licensee B would not address the exterior concerns because s/he did not want to spend the money. At 11:00 AM, Surveyor asked Licensee B if there was a reason why the exterior areas were not addressed. Licensee B looked confused and asked Surveyor to show him/her what s/he was referring to. Licensee B and Surveyor went outside and discussed each concern. Licensee B stated s/he would have the area addressed.	{N 492}		