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	0012273	A. BUILDING: _____ B. WING _____	C 07/22/2024

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N 000	Initial Comments On 07/12/2024, the Department conducted an abbreviated licensing survey and self-report investigation at Exodus House. Data was collected through 07/22/2024. Eight violations were identified. Census: 5	N 000		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees sampled received a communicable health screen as required. Direct Support Staff (DSS) D was not screened for communicable diseases and was not screened for tuberculosis (TB) according to the Centers for Disease Control and Prevention (CDC) standards. Program Manager (PM) B was not screened for TB according to the CDC standards.	N 220		

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

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N 220	Continued From page 1 Findings include: The Department of Health Services publication, Tuberculosis Screening and Testing: Health Care Personnel (HCP) and Caregivers (including assisted living staff), states: "Perform baseline testing for all HCP and caregivers without documented evidence of prior LTBI [latent tuberculosis] or TB disease... IGRA [blood test] or TST [tuberculin skin test] may be performed; IGRA is preferred... - If testing is positive, obtain chest x-ray and refer HCP or caregiver to provider for additional workup for TB disease. - In the absence of newly identified risks or symptoms, previous documented negative IGRA or TST results (within 12 months) may be used. - If TST is used as the baseline testing, 2-step testing is recommended for HCP and caregivers who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative, and documentation of results is available, a one-step TST may be performed before hire." (Retrieved 01/11/2024 from https://dhs.wisconsin.gov/publications/p02382.pdf) On 07/12/2024, Surveyor reviewed 2 employee records. DSS D was hired on 09/06/2023. DSS D's record did not include evidence s/he was screened for general communicable illness by a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse. DDS D had a 1-step TST completed on 08/28/2023 by a certified medical assistant.	N 220		

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N 220	Continued From page 2 PM B was hired on 11/29/2020. PM B's record included a 1-step TST completed on 08/20/2020. On 07/19/2024 at 1:20 PM, Surveyor interviewed Administrator C. Administrator C stated new employee communicable health screens were managed by a 3rd party. After that 3rd party reviews the results, they would let the provider know if the employee was eligible for hire or not. Administrator C was unsure what was included in the provider's health screening protocol.	N 220		
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 2 of 2 staff sampled, Direct Support Staff (DSS) D and Program Manager (PM) B, completed orientation training. Findings include:	N 230		

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N 230	Continued From page 3 On 07/12/2024, Surveyor reviewed employee records. DSS D was hired on 09/06/2023. PM B was hired on 11/29/2020. Neither employee's training record included evidence of training in the following orientation topics: preventing and reporting abuse, neglect, and misappropriation of resident property, or recognizing and responding to resident changes of condition. On 07/19/2024 at 1:20 PM, Surveyor interviewed Administrator C. Administrator C stated the provider recently revised their training program and hired a training coordinator to establish training guidelines and monitor training progress. Administrator C stated that prior to this change, PM B was responsible for monitoring his/her direct staff's training and Administrator C was responsible for monitoring PM B's training. Administrator C stated PM B did not receive training on abuse/neglect/misappropriation or resident changes in condition. Administrator C stated s/he would review DSS D's training and send evidence of these training if s/he could find it. As of 07/22/2024, Surveyor did not receive additional training documentation for PM B or DSS D.	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	N 239		

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N 239	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 staff sampled completed Department-approved training. Program Manager (PM) B did not complete standard precautions, fire safety, or first aid and choking training. PM B did not complete medication management training prior to assuming medication responsibilities. Direct Support Staff (DSS D) did not complete medication management training prior to assuming medication responsibilities. Findings include: On 07/12/2024, Surveyor reviewed employee	N 239		

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N 239	Continued From page 5 records. PM B was hired on 11/29/2020. PM B's training record and the Wisconsin Training Registry indicated PM B completed 1 Department-approved training, medication management, on 02/29/2024. PM B did not complete training in standard precautions, fire safety, or first aid and choking. DSS D was hired on 09/06/2023. DSS D's record and the Registry indicated DSS D did not complete medication management training. Neither employee record included evidence of training exemptions. On 07/19/2024 at 1:20 PM, Surveyor interviewed Administrator C. Administrator C stated PM B and DSS D did not have training exemptions. Administrator C stated PM B told Administrator C that s/he completed his/her Department-approved training prior to the creation of the Wisconsin Training Registry, but PM B was unable to produce certifications or evidence of these trainings. Administrator C stated s/he asked PM B to redo these trainings. Administrator C confirmed DSS D did not complete medication training. Administrator C stated that all staff monitored and assisted with resident medications. Administrator C said residents directed their own medications but staff maintained control of the medication in a central location and monitored resident medication compliance. Administrator C stated PM B and DSS D were both responsible for resident medication. Administrator C was aware employees with medication responsibilities needed the Department-approved medication	N 239		

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N 239	Continued From page 6 management course, and the provider had been working to get staff trained since the beginning of 2024. Administrator C stated the provider recently revised their training program and hired a training coordinator to monitor training progress. Prior to this change PM B was responsible for monitoring his/her direct staff's training and Administrator C was responsible for monitoring PM B's training.	N 239		
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 sampled, Program Manager (PM) B, completed continuing education training. Findings include: On 07/12/2024, Surveyor reviewed PM B's training record. PM B was hired on 11/29/2020.	N 277		

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N 277	Continued From page 7 PM B completed over 15 hours of training in 2022 but the training did not include the following required topics: standard precautions, medication management, or abuse and neglect. PM B completed over 15 hours of training in 2023 but missed the following topics: standard precautions, medication management, resident rights, abuse and neglect, and fire safety/first aid. On 07/19/2024 at 1:20 PM, Surveyor interviewed Administrator C. Administrator C stated the provider recently revised their training program and hired a training coordinator to establish training guidelines and monitor training progress. Administrator C stated that prior to this change, Administrator C was responsible for monitoring PM B's training. Surveyor asked if PM B completed the missing training topics listed above in 2022 and 2023. Administrator C responded, "Probably not ... I sent [his/her] full training transcript." Administrator C explained PM B had not completed trainings other than what was included on his/her training transcript.	N 277		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage	N 404		

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N 404	Continued From page 8 systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a physician, pharmacist, or registered nurse conducted an onsite review of the provider's medication administration and storage systems in 2022 or 2023. Findings include: The provider is licensed to care for 12 residents in the client groups alcohol/drug dependent and correctional clients. On 07/12/2024, Surveyor interviewed Direct Support Staff (DSS) A. DSS A stated residents managed their own medications but staff stored all resident medications in a central location and monitored resident medication compliance. DSS A stated s/he retrieved medications from storage if a resident requested their prescribed medication, and staff recorded medication administration in a medication administration record. On 07/12/2024 and 07/15/2024, Surveyor requested the provider's annual medication review for 2022 and 2023.	N 404		

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N 404	Continued From page 9 On 07/15/2024 at 3:27 PM, Surveyor received an email from Administrator C that read, "We have not been able to find a pharmacy to do reviews at Exodus so there will not be any logs to review."	N 404		
N 503	83.46(1)(b) Portable space heaters prohibited. The use of portable space heaters is prohibited except for Underwriters Laboratories listed electric heating equipment that is listed for permanent attachment to the wall. Portable space heaters shall have an automatic thermostatic control and shall be physically attached to a wall. This Rule is not met as evidenced by: Based on observation and interview, the provider did not prohibit the use of portable space heaters. Findings include: On 07/12/2024 at approximately 12:15 PM, during a tour of the facility with Direct Support Staff (DSS) A, Surveyor observed a portable space heater in the provider's group room. The space heater was plugged in and producing heat. DSS A unplugged the heater and stated s/he was unaware it was there. On 07/19/2024 at 1:20 PM, Surveyor interviewed Administrator C. Administrator C stated the provider did not allow portable space heaters, and s/he was unsure how long it had been in the facility. Administrator C stated s/he was at the facility about 1 time per month, but s/he was changing his/her schedule to be at the facility weekly.	N 503		

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N 507	Continued From page 10	N 507		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were stored at least 3 feet away from any furnace or water heater. Findings include: On 07/12/2024 at 12:24 PM, during a tour of the facility with Direct Support Staff (DSS) A, Surveyor observed multiple large black garbage bags stored within 3 feet from the provider's furnace. DSS A stated the garbage bags contained past residents' belongings.	N 507		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to:	Y3235		

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Y3235	Continued From page 11	Y3235		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure residents had privacy. The provider had cameras located throughout the facility that violated residents' rights to private treatment and living arrangements.

Findings:

The provider is licensed to care for 12 residents in the client groups alcohol/drug dependent and correctional clients.

On 07/12/2024 at 11:40 AM, Surveyor entered the facility. Resident 1 was relaxing in a desk chair in the lobby living room. Surveyor chatted with Resident 1 briefly before beginning the survey with Direct Support Staff (DSS) A.

At approximately noon, Surveyor toured the facility with DSS A. Surveyor observed cameras in the following areas inside the home:

1) The lobby living room
2) Group room
3) Kitchen area, pointed at the pantry
4) Kitchen area, pointed at the main living room with TV
5) Upstairs hallway leading to resident bedrooms
6) Downstairs hallway leading to resident bedrooms

At approximately 12:45 PM, Surveyor interviewed DSS A. DSS A stated s/he did not know anything about the cameras or the history of when they were put in but s/he did know the camera feed was visible on a monitor in the office. Surveyor

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Y3235	Continued From page 12 observed the monitor which showed feed from 8 cameras; 3 of which were outside. Surveyor could see full view of the lobby living room and a partial view of the resident dining area. On 07/19/2024 at 1:20 PM, Surveyor interviewed Administrator C. Administrator C stated the provider upgraded their camera system in the last 4 months. Administrator C stated some of the cameras were "dummy" cameras but all of the live cameras saved recorded feed for a limited time. Administrator C was unsure how many live cameras were on the property. Administrator C stated Program Manager B had access to view the camera footage.	Y3235		