STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 From 05/07/2024 to 05/10/2024, Surveyor conducted a complaint investigation and standard survey at Garrow Villa, a CBRF in Brillion. Twelve deficiencies were identified. The complaint was unsubstantiated. Census: 16	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 interview and record review the provider did not ensure 2 of 2 caregivers reviewed were screened for clinically apparent communicable disease including tuberculosis within 90 days before the start of employment. Caregiver D was not screened for communicable disease and Caregiver E was not screened until greater than 60 days after his/her employment began.	N 220		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 220	Continued From page 1 Findings include: On 05/07/2024 at approximately 11:00 a.m., Surveyor reviewed employee records provided by Assistant Administrator B. Records documented the following: - Caregiver D was hired on 01/30/2024. Caregiver D's record did not include a communicable disease screen. - Caregiver E was hired on 02/01/2024. Caregiver E's record included a communicable disease screen dated 04/24/2024, greater than 60 days after his/her date of hire. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Caregiver D and Caregiver E did not have communicable disease screening completed within 90 days prior to starting to provide care to residents. Administrator A stated s/he and Assistant Administrator B recently took over operations of the facility and were still catching up on things.	N 220		
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	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 277	Continued From page 2 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 caregivers reviewed that required continuing education received at least 15 hours per calendar year. Caregiver C did not receive any continuing education in 2023. Findings include: On 05/07/2024 at approximately 11:00 a.m., Surveyor reviewed employee records provided by Assistant Administrator B. Records indicated Caregiver C was hired on 02/22/2021. Caregiver C's record included 16.5 hours of continuing education in 2022, but no documentation of continuing education in 2023. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Caregiver C's record did not include continuing education for 2023. Administrator A replied, "Yeah. I have no clue." Administrator A stated s/he and Assistant Administrator B recently took over operations of the facility and were still catching up on things.	N 277		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2).	N 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 301	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had an admission agreement completed before or at the time of admission. Resident 2 did not have an admission agreement completed. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 10/09/2023. Resident 2 was his/her own decision maker. Resident 2's admission agreement was entirely blank. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Resident 2's admission agreement was not signed. Administrator A replied, "We had no idea." Administrator A explained that neither s/he, nor Assistant Administrator B were in their current roles at the time of Resident 2's admission.	N 301		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 302	Continued From page 4 for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 clients reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before or 7 days after admission. Resident 1 did not have a communicable disease screen, including tuberculosis test, completed. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/20/2022. Resident 1's record did not include a communicable disease screen with a tuberculosis test. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Resident 1 did not have a communicable disease screen, including tuberculosis test, on file. Administrator A stated neither s/he, nor Assistant Administrator B were in their roles at the time of Resident 1's admission and s/he had no further documentation to provide.	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 352	Continued From page 5 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 1 of 3 residents reviewed received his/her medication as prescribed. Resident 1 did not recieve his/her Humalog 100/ml as prescribed. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/20/2022 with a physician order for Humalog 100/ml (Start Date: 04/08/2024) Inject 10 units 3 times daily plus sliding scale with meals <120=0 units, 121-150=2 units, 151-200=4 units, 201-250=6 units, 251-300=8 units, 301-350=10 units, 351-400=12 units, 401-450=14 units, >451=Call physician. Surveyor reviewed Resident 1's Medication Administration Record (MAR), dated 04/08/2024 to 04/30/2024, and identified the following administrations did not follow the physician order: - 04/09/2024 7:42 a.m. Blood Sugar 273, 13 units administered. *Per physician order, 18 units should have been administered. - 04/09/2024 11:24 a.m.: Blood Sugar 361, 17 units administered. *Per physician order, 22 units should have been	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 352	Continued From page 6 administered. - 04/11/2024 11:23 a.m.: Blood Sugar 377, 18 units administered. *Per physician order, 22 units should have been administered. - 04/12/2024 7:43 a.m.: Blood Sugar 208, 14 units administered. *Per physician order, 16 units should have been administered. - 04/22/2024 4:06 p.m.: Blood Sugar 279, 16 units administered. *Per physician order, 18 units should have been administered. - 04/25/2024 4:09 p.m.: Blood Sugar 361, 16 units administered. *Per physician order, 18 units should have been administered. - 04/29/2024 7:41 a.m.: Blood Sugar 258, 22 units administered. *Per physician order, 18 units should have been administered. - 04/29/2024 4:04 p.m.: Blood Sugar 329, 18 units administered. *Per physician order, 20 units should have been administered. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed the above dates when Resident 1 did not receive his/her insulin as prescribed with Administrator A and Assistant Administrator B. Assistant Administrator B stated it appeared caregivers were still following Resident 1's previous sliding scale orders. Administrator A stated they had a staff meeting scheduled for 05/08/2024 and s/he would follow up with caregivers.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 389	Continued From page 7 Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 individual service plans (ISP) reviewed was updated to include his/her behaviors and interventions. Resident 2's ISP did not include his/her behaviors and interventions related to behaviors. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 10/09/2023. Resident 2's progress notes, dated 12/01/2023 to 05/07/2024, documented the following behaviors: - 12/11/2023: Resident attempted to get another resident to come to bed with him/her. - 12/18/2023: Refused to leave another resident's room and started to take his/her pants off. - 12/23/2023: Told staff to shut up. Went into other residents rooms and would yell or threaten	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 389	Continued From page 8	N 389		

staff when redirected. Pushed staff when being redirected.
- 12/27/2023: Wandered the facility and attempted to get into the medication room.
- 12/30/2023: Resident charged the front door and ran outside of the building. Resident ran around the building and then went inside. Once inside resident was opening all doors, including resident rooms, trying to find an exit. Resident charged staff. Staff called law enforcement. Resident was taking to the hospital for a psychiatric evaluation.
- 01/05/2024: Wandered into multiple resident rooms.
- 01/06/2024: Resident entered another resident's room without consent. Resident then got into a verbal altercation with this resident.
- 02/12/2024: Refused to get washed up or clothes changed.
- 02/23/2024: Refused to change his/her clothing.
- 03/01/2024: Resident reported seeing and was talking to a family member who was not physically present at the facility.
- 03/02/2024: Flooded his/her kitchenette. Very agitated. Pushed another person and wandered into resident rooms.
- 03/04/2024: Refused to wear depend.
- 03/25/2024: Resident refused to be changed and became aggressive.
- 03/31/2024: Resident was yelling profanities toward staff and other residents. Resident charged at staff.
- 04/07/2024: Resident was trying to run out the front door and talking about cults.
- 05/02/2024: Resident was found with no briefs on and has been found this way several nights over the past 2 weeks.

Resident 2's ISP, dated 02/20/2024, stated Resident 2 could become combative or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 389	Continued From page 9 aggressive. Resident 2's ISP did not include wandering, verbal aggression, or elopement behaviors. Resident 2's ISP did not include interventions for the combative or aggressive behaviors identified in the ISP. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Resident 2's ISP did not include all behaviors or interventions for behaviors. Administrator A shared that they have several interventions, including playing music, serving a favorite food or particular staff coming to the facility. Administrator A stated they would be sure to have the behaviors and interventions included in the ISP.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 1 resident reviewed was evaluated for their mental and physical	N 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 393	Continued From page 10 capability to respond to a fire alarm within 3 days of his/her admission. Resident 2 had not been evaluated for his/her ability to respond to a fire alarm. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 10/09/2023. Resident 2's record did not include an evacuation assessment. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Resident 2's record did not include an evacuation assessment. Administrator A took note of Surveyor's observation. Assistant Administrator B stated they would follow up and ensure each resident's assessment was updated.	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 2 residents reviewed were evaluated for their mental and physical capability to respond to a fire alarm at least annually or when there was a change in resident's mental or physical capability to respond to a fire alarm. Resident 1 had not been evaluated for his/her ability to respond to a fire alarm in greater	N 394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 394	Continued From page 11 than 1 year. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/20/2022. Resident 1's evacuation assessment was dated 09/22/2022. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Resident 1's evacuation assessment had not been updated since 2022. Administrator A took note of Surveyor's observation. Assistant Administrator B stated they would follow up and ensure each resident's assessment was updated.	N 394		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 407	Continued From page 12 that received a scheduled psychotropic medication had the use of the psychotropic medication reassessed at least quarterly for the desired responses and possible side effects by a pharmacist, practitioner or registered nurse. Resident 1's Venlafaxine was not reassessed quarterly. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/20/2022 with a physician order for Venlafaxine 75 mg daily. Resident 1's record did not include scheduled psychotropic reviews. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Resident 1 did not have quarterly reassessments for the use of his/her Venlafaxine. Administrator A confirmed s/he did not have any scheduled psychotropic reviews to provide Surveyor. Assistant Administrator B stated s/he would contact the facility nurse to have the reviews taken care of.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 408	Continued From page 13 of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed that was prescribed a PRN psychotropic medication had the rationale for use and detailed description of the behaviors which indicated the use of the administration in the individual service plan (ISP), that the use of the PRN psychotropic medication was monitored at least monthly and that the resident's record included documentation of the rational for use, description of the behaviors that required administration of the PRN psychotropic medication and the effectiveness for each administration of the PRN psychotropic medication. Resident 2's Lorazepam .5 mg every 6 hours PRN was not included in his/her ISP, was not monitored monthly and did not have documentation in the record regarding the administration. Findings include: On 05/07/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 10/09/2023 with a physician order for Lorazepam .5 mg every 6 hours PRN (Start Date:	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 408	Continued From page 14 01/05/2024). Surveyor identified the following concerns: - Resident 2's ISP, dated 02/20/2024, did not include the rational for use of the Lorazepam PRN or a detailed description of behaviors that would indicate the administration of the Lorazepam. - Resident 2's record did not include monthly assessments of the Lorazepam PRN. - Resident 2's Medication Administration Record (MAR), dated 04/01/2024 to 04/30/2024, indicated the Lorazepam PRN was administered 6 times. The record did not include a description of the behaviors that indicated the administration of his/her Lorazepam for 6 of 6 administrations and did not document the effectiveness of the Lorazepam PRN for 5 of 6 administrations. On 05/07/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator A and Assistant Administrator B that Resident 2's Lorazepam PRN use was not documented in his/her ISP, not monitored monthly and that the record did not document the behaviors that indicated the administration of the Lorazepam PRN or effectiveness. Administrator A stated s/he and Assistant Administrator B recently took over operations of the facility and were still catching up on things. Both Administrator A and Assistant Administrator B stated they would address the concerns.	N 408		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time.	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 525	Continued From page 15 Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire evacuations were conducted at least quarterly and that at least one fire evacuation drill was held annually that simulated the conditions during usual sleeping hours. The provider conducted 1 fire drill in 2023 and had not conducted any fire drills in 2024. Findings include: On 05/07/2024 at approximately 10:00 a.m., Surveyor reviewed environmental records. Environmental records from 01/01/2023 to 05/07/2024 included documentation of 1 fire drill completed on 11/17/2023 at 11:35 a.m. On 05/07/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator A and Assistant Administrator B. Surveyor asked if the provider had conducted any additional drills in 2023 or 2024. Administrator A stated neither s/he nor Assistant Administrator A were in their roles in	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410344	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 S PKWY DR BRILLION, WI 54110

(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 525	Continued From page 16 2023 so s/he had no additional documentation to provide. Administrator A stated they had not conducted fire drills in 2024, but made note to do so.	N 525		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other evacuations drills, such as tornado, flooding or other emergency or disaster, were conducted at least semi-annually. The provider had not conducted any other evacuation drills in 2023 or 2024. Findings include: On 05/07/2024 at approximately 10:00 a.m., Surveyor reviewed environmental records. Environmental records from 01/01/2023 to 05/07/2024 did not include documentation of any other evacuation drills. On 05/07/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator A and Assistant Administrator B. Surveyor asked if the provider had conducted any evacuation drills, other than fire drills, in 2023 and 2024. Administrator A stated neither s/he nor Assistant Administrator A were in their roles in 2023 so s/he had no evacuation drills to provide. Administrator A stated they had not conducted any drills in 2024, but made note to do so.	N 526		