STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015119	A. BUILDING: _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HAVEN	400 MARTIN DR FREDONIA, WI 53021

(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 11/01/2023 to 11/03/2023, Surveyor conducted a complaint investigation and standard survey at Forest Haven, a CBRF in Fredonia. Five deficiencies were identified. The complaint was unsubstantiated. Census: 21	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 caregivers reviewed had a communicable disease screen, using centers for disease control and prevention standards, completed within 90 days before the start of employment. Caregiver E and Caregiver F were not tested for tuberculosis within 90 days before the start of employment.	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: On 11/01/2023 at approximately 10:00 a.m., Surveyor reviewed the hiring records of Caregiver E and Caregiver F. Surveyor identified the following concerns: - Caregiver E, hired 06/05/2023, was tested for tuberculosis on 08/11/2014, greater than 90 days from his/her date of hire. - Caregiver F, hired 07/08/022, was tested for tuberculosis on 01/27/2022, greater than 90 days from his/her date of hire. On 11/01/2023 at approximately 11:10 a.m., Surveyor interviewed Administrator A and Wellness Coordinator B. Surveyor shared concern that neither Caregiver E, nor Caregiver F were tested for tuberculosis within 90 days of hire. Administrator A reviewed records and confirmed Surveyor's concern. Administrator A stated s/he thought the tuberculosis tests were "good for longer than 90 days" as long as there was a corresponding screen, which was completed for both employees.	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		

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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 2 of 2 caregivers reviewed received at least 15 hours of continuing education as required. Caregiver C did not receive 15 hours of continuing education in 2021 or 2022. Caregiver D did not receive 15 hours of continuing education in 2022. Findings include: On 11/01/2023 at approximately 10:00 a.m., Surveyor reviewed the records of 2 employees that required continuing education in 2021 and 2022. Surveyor identified the following concerns: - Caregiver C, hired 01/04/2018, received 14 hours of continuing education in 2021 and 0 hours of continuing education in 2022. - Caregiver D, hired 02/05/2019, received 15+ hours of continuing education in 2021 and 0 hours of continuing education in 2022. On 11/01/2023 at approximately 11:10 a.m., Surveyor interviewed Administrator A and Wellness Coordinator B. Surveyor shared concern that 2 of 2 caregivers reviewed had not received required continuing education. Administrator A acknowledged the caregivers had not received 15 hours of continuing education each year and stated both caregivers worked "as needed." Administrator A confirmed both caregivers had worked for the facility in 2023. Wellness Coordinator B stated Caregiver D worked for a hospice agency and may have had	N 277		

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N 277	Continued From page 3 continuing education with that agency. The provider was given until 11/02/2023 to provide follow up documentation. No documentation was received.	N 277		
N 389	83.35(3)(d) Service plans updated annually or on changes 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 2 of 3 residents had their individual service plan (ISP) updated when there was a change in the residents' condition. Resident 2's ISP did not include his/her need for a carbohydrate consistent diet and discontinued blood sugar monitoring. Resident 3's ISP did not include his/her change in diet and transfer status. Findings include: On 11/01/2023 at approximately 10:00 a.m., Surveyor reviewed resident records and identified	N 389		

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N 389	Continued From page 4 the following concerns: Example 1 - Resident 2: Resident 2 was admitted to the provider's facility on 08/03/2023 with diagnoses of diabetes and dysphagia. Resident 2's ISP, dated 09/12/2023, documented s/he required a general diet and blood sugar monitoring 2 times daily. Resident 2's record included an order on admission stating Resident 2 required a consistent carbohydrate diet. The record included a physician order, dated 09/03/2023, that changed blood sugar checks from 2 times daily to 1 time daily in the morning. Surveyor interviewed Administrator A and Wellness Coordinator B regarding Resident 2's care. Administrator A confirmed Resident 2's blood sugar monitoring had not been required 2 times daily since shortly after admission. Administrator A confirmed Resident 2 required a carbohydrate consistent diet and stated all their meals are low sugar. Administrator A acknowledged Resident 2's ISP needed to be updated with current blood sugar monitoring protocol and diet. Example 2 - Resident 3 Resident 3 was admitted to the provider's facility on 01/24/2023 with diagnosis of dementia. Resident 3's ISP, dated 04/11/2023, indicated s/he was independent with transfers and mobility and that s/he required a regular diet and thin liquids. Resident 3's record indicated s/he was enrolled on service with hospice on 04/19/2023. Hospice records indicated Resident 3 required 1 assist for transfers on 05/09/2023 and 1-2 assist for transfers thereafter. The record included a physician order, dated 06/26/2023, for a	N 389		

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N 389	Continued From page 5 mechanical soft diet. Resident 3 discharged on 07/22/2023. On 11/01/2023 at approximately 1:00 p.m., Surveyor interviewed Administrator A and Wellness Coordinator B regarding Resident 3's care. Administrator A confirmed the provider's staff used the facility's ISP, not the hospice ISP. Administrator A confirmed Resident 3 had a change in his/her diet and transfer status, but the ISP was not updated.	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 2 of 3 residents reviewed were evaluated, using the department's form, to determine their capability to evacuate the facility. Resident 1 and Resident 2 were not evaluated for their ability to evacuate the facility. Findings include:	N 393		

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N 393	Continued From page 6 On 11/01/2023 at approximately 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: - Resident 1 was admitted to the provider's facility on 12/28/2022. Resident 1's record included a blank evacuation assessment. - Resident 2 was admitted to the provider's facility on 08/03/2023. Resident 2's record included a blank evacuation assessment. On 11/01/2023 at approximately 11:30 a.m., Surveyor interviewed Administrator A. Surveyor shared that Resident 1 and Resident 2's records included a blank evacuation assessment and asked Administrator A if an evacuation assessment was completed within 3 days of admission. Administrator A replied, "No. That was overlooked."	N 393		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were stored in a secure area. Toxic substances were unsecured in the laundry room and furnace room. Findings include: On 11/01/2023 at approximately 12:30 p.m., Surveyor toured the provider's facility with	N 499		

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N 499	Continued From page 7 Wellness Coordinator B. Surveyor observed the laundry room, which stored laundry detergent, was unlocked and accessible. Surveyor observed the furnace room, which stored the housekeeping cart that contained cleaning agents, was accessible to residents. Surveyor asked Wellness Coordinator B if the laundry room and furnace room were usually kept locked. Wellness Coordinator B replied, "No." On 11/01/2023 at approximately 1:00 p.m., Surveyor interviewed Administrator A and Wellness Coordinator B. Surveyor shared concern that toxic substances were accessible to residents. Wellness Coordinator B stated s/he would begin locking the laundry room once s/he obtained a key. Administrator A stated they would have a lock installed on the furnace room.	N 499		