STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD ASSISTED LIVING GREEN HOUSI	6370 N GREEN BAY AVE GLENDALE, WI 53209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 06/18/2024, with information gathered through 06/28/2024, Surveyors conducted a standard survey, two verification visits for SOD WR6G11 dated 04/25/2023 and SOD XD4Y16 dated 01/03/2023 and a complaint investigation. Twenty-one deficiencies were identified. Complaint substantiated. Eight of the 21 violations are repeat violations, see Statement of Deficiency: XD4Y11, dated 04/18/2018, XD4Y12, dated 12/28/2018, XD4Y13, dated 06/28/2019, XD4Y14, dated 01/29/2021, XD4Y15, dated 11/17/2021, XD4Y16 dated 01/03/2023. Results for SOD WR6G11 dated 04/25/2023 under SOD XD4Y17 results. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 11	{N 000}		
{N 165}	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not submit a written	{N 165}		

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

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{N 165}	Continued From page 1	{N 165}		

report to the department within 3 working days after an incident or accident resulting in serious injury requiring emergency room treatment for 1 of 1 resident (Resident 17) reviewed.

This is a repeat deficiency. See statement of Deficiency (SOD) XD4Y16, dated 01/03/2023.

Findings include:

The facility is licensed as a 12 bed class CNA (non-ambulatory) facility to provided services for the developmentally disabled, advanced aged, emotionally disabled/mental illness, irreversible dementia/Alzheimer's and physically disabled.

On 06/18/2024 at approximately 9:25 AM, Surveyors reviewed Resident 17's Falls/Incident Reports and identified the following:

Resident 17's Fall/Incident report on 05/25/2024 at 8:00 PM stated the following:
-"Type of incident: Alleged fall, found on floor"
-"Location of Incident: Own apartment."
-"What did resident tell you about what happened: [S/he] was trying to catch [him/herself] and fell."
-"Describe what you saw/heard: During change, I turned my back to throw away trash and when I turned around [s/he] was on the floor. I heard [him/her] scream then fall."
-"Were there witnesses: No."
-"Were there injuries: Yes. Scare [sic] on head, small scar on elbow."

On 06/18/2024 at approximately 10:00 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated Resident 17 went to the Emergency Department that night but returned home in the early morning hours. Director of Operations F stated there was no

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{N 165}	Continued From page 2 documentation about Resident 17 returning and what treatment s/he had at the Emergency Department. Director of Operations F stated Operations Manager Q stated Resident 17 returned back to facility with a bandage over his/her head. On 06/18/2024 at approximately 10:30 AM, Surveyors requested Resident 17's after visit summary (AVS) from the Emergency Department. Director of Operations F stated s/he could not locate it in Resident 17's record. Director of Operations F stated s/he would have to contact the Emergency Department to get a copy of the AVS. On 06/18/2024 at approximately 4:00 PM, Surveyor reviewed the provider's self-report history. The department did not receive a self-report for Resident 17's fall on 05/25/2024, resulting in an emergency room visit and sutures to his/her forehead. On 06/25/2024 at 2:39 PM, Director of Operations F sent Surveyor the after visit summary for Resident 17. Director of Operations F stated the following: "I just know [sic] obtained the AVS for the 5/25 ED visit at Froedtert. [Resident 17] was provided with sutures so [s/he] was in fact treated in the hospital, and I understand because [s/he] received that treatment it would have required reporting to the Department per the codes."	{N 165}		
{N 214}	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited	{N 214}		

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{N 214}	Continued From page 3	{N 214}		

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 observation, record review and interview, Administrator D did not supervise the daily operation of the Community-Based Residential Facility (CBRF) related to resident care and services. The administrator did not provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety were protected and promoted.

This is a repeat deficiency. See statement of Deficiency (SOD) XD4Y16, dated 01/03/2023.

Findings include:

The facility is licensed as a 12 bed class CNA (non-ambulatory) facility to provided services for the developmentally disabled, advanced aged, emotionally disabled/mental illness, irreversible dementia/Alzheimer's and physically disabled.

On 06/18/2024, Surveyors reviewed Department records and identified the following:

On 05/08/2023, the Department issued a Notice and Order letter with Statement of Deficiency (SOD) XD4Y16 dated 01/03/2023. The letter stated:

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{N 214}	Continued From page 4 Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Parkwood Assisted Living Green House: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall monitor the physical and mental health of residents and make arrangements for services unless otherwise arranged for by the resident. The licensee will develop (or review/revise) written procedures and provide staff training for all managers and resident care staff to address: Assessment and Service Plan: -All required written resident assessments will be retained in resident records, in accordance with Wis. Admin. Code § DHS 83.35(1)(d). -All staff responsible for assisting in resident assessment will be trained on assessment procedures. -The timely development, completion and revision of individualized services plans. The ISP review process shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or legal representative shall sign the ISP acknowledging their involvement in, understanding of and agreement with the ISP. -All staff responsible for providing services to residents will review the resident's individualized service plan and will provide services in accordance with the plan. All managers and resident care staff will receive in-service training regarding the procedure required by Order #1. Documentation of training will be maintained in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content."	{N 214}		

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{N 214}	Continued From page 5 On 06/18/2024 at 8:45 AM, Surveyor requested resident assessments and care plans per special orders from Director of Operations F. Director of Operations F stated if Surveyors did not see the documentation in the resident record, then the presumption would be it was not completed. Surveyors could not locate admission agreements, service plans, pre-admission assessments and resident evacuation assessments for all resident files reviewed. On 06/18/2024 with information gathered through 06/28/2024, Surveyors conducted a verification visit and a complaint investigation at Parkwood Assisted Living Green House resulting in 21 violations. Eight of the 21 violations are repeat violations, see Statement of Deficiency: XD4Y11, dated 04/18/2018, XD4Y12, dated 12/28/2018, XD4Y13, dated 06/28/2019, XD4Y14, dated 01/29/2021, XD4Y15, dated 11/17/2021, XD4Y16 dated 01/03/2023. 83.12(4)(c) Reporting Incidents with Serious Injury (repeat) 83.15(3)(a) Administrator Shall Supervise Daily Operation (repeat) 83.20(2)(a)-(d) Department-Approved Training Courses 83.25 Continuing Education 83.28(3) Provide Admission Agreement As Required 83.28(5) Temporary Service Plan 83.28(6) Resident Rights, Grievance Procedure, Rules 83.35(1)(a) Pre-admission and Ongoing Assessments (repeat) 83.35(3)(b) Service Plan Development: Parties Involved (repeat) 83.35(4) Resident Satisfaction Evaluation	{N 214}		

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{N 214}	Continued From page 6 83.35(5)(a) Initial Evaluation of Evacuation Limitations 83.37(2)(d) Documentation of Medication Administration (repeat) 83.37(3)(c)Medication Storage: Locked Cabinet 83.38(1)(c) Leisure Time Activities 83.38(1)(g) Health Monitoring 83.38(1)(h) Medication Administration (repeat) 83.39(3) Hand Washing 83.41(1)(c) Dishwashing 83.41(3)(b) Food Safety (repeat) 83.45(3) Toxic Substances (repeat) 83.48(3)(a) Fire Detection System Inspected On 06/18/2024 at approximately 9:30 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated s/he would be working to fix all of these issues since s/he had recently bought the facility from Administrator D. Director of Operations F stated s/he is hoping things will be able to get fixed sooner since s/he is now in charge of the facility since purchasing. Director of Operations F stated s/he is aware of DHS 83 and will need to be in substantial compliance before an official change of ownership can happen.	{N 214}		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material.	N 239		

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N 239	Continued From page 7 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 staff interview, the provider did not ensure 1 of 3 employees (Caregiver EE) reviewed received Department approved training courses within 90 days after starting employment and/or assuming job duties. Caregiver EE did not have training in fire safety. Findings include: On 06/18/2024 at approximately 11:00 AM, Surveyors reviewed Caregiver EE's employee records. Caregiver EE was hired on 06/02/2023. The record for Caregiver EE, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 06/18/2024 at approximately 11:15 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated s/he thought	N 239		

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N 239	Continued From page 8 Caregiver EE had completed all the Department approved courses but could not find evidence in his/her record. On 06/18/2024 at 11:15 AM, Surveyors verified Caregiver EE was not on the Community-Based Care and Treatment training registry for fire safety.	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 received at least 15 hours per calendar year of continuing education in calendar year 2023. Caregiver DD did not have any evidence of continuing education in 2023. This is a repeat deficiency. See statement of Deficiency (SOD) XD4Y16, dated 01/03/2023. Findings include:	{N 277}		

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{N 277}	Continued From page 9 On 06/18/2024, at approximately 10:00 AM, Surveyors reviewed Caregiver DD's record. Caregiver DD was hired on 12/11/2022. Surveyors did not see evidence of Caregiver DD's continuing education for calendar year 2023. On 06/18/2024 at approximately 10:30 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated Caregiver DD only had a few hours of medication training with the nurse but no other continuing education so they missed it for him/her.	{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). This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide an admission agreement for 4 of 4 residents reviewed (Resident 16, Resident 17, Resident 18 and Resident 19). Findings include: On 06/18/2024 at approximately 10:30 AM, Surveyors requested to review Resident 16's, Resident 17's, Resident 18's and Resident 19's record. Surveyors identified the following: -Resident 16 was admitted on 11/16/2015 and his/her record did not contain evidence of an admission agreement.	N 301		

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N 301	Continued From page 10 -Resident 17 was admitted on 03/02/2023 and his/her record did not contain evidence of an admission agreement. -Resident 18 was admitted on 06/17/2021 and his/her record did not contain evidence of an admission agreement. -Resident 19 was admitted on 02/29/2024 and his/her record did not contain evidence of an admission agreement. On 06/18/2024 at approximately 11:00 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated s/he looked in all 4 residents' records and could not locate an admission agreement for all 4 residents. Director of Operations F stated if it was completed, it would have been in their records.	N 301		
N 304	83.28(5) Temporary service plan. Temporary service plan. Upon admission, the CBRF shall develop a temporary service plan as required under s. DHS 83.35(2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop a temporary service plan for 1 of 1 resident (Resident 19) reviewed. Findings include: On 06/18/2024 at approximately 10:00 AM, Surveyors requested to review Resident 19's record. Resident 19 was admitted on 02/29/2024 and his/her record did not contain evidence of a temporary service plan.	N 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 304	Continued From page 11 On 06/18/2024 at approximately 10:30 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated Resident 19 was admitted on 02/29/2024 and had two falls the same day and went out to the hospital and never came back because s/he was a 1:1 and they could not accommodate his/her needs. Director of Operations F stated they had not developed his/her temporary care plan and did not complete one after s/he left the facility. Director of Operations F acknowledged s/he was familiar with the regulations and a temporary care plan should have been implemented upon admission.	N 304		
N 305	83.28(6) Resident rights, grievance procedure, rules Resident rights, grievance procedure, and house rules. Before or at the time of admission, the CBRF shall provide and explain resident rights, the house rules of the CBRF as required under s. DHS 83.32 (2), and the grievance procedure, including written information regarding the names, addresses and telephone numbers of all resident advocacy groups serving the client groups in the facility, including the long term care ombudsman program and the protection and advocacy services of Disability Rights Wisconsin, Inc. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide resident rights, grievance procedures and house rules before or upon admission for 4 of 4 residents reviewed (Resident 16, Resident 17, Resident 18 and Resident 19).	N 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 305	Continued From page 12 Findings include: On 06/18/2024 at approximately 10:30 AM, Surveyors requested to review Resident 16's, Resident 17's, Resident 18's and Resident 19's record. Surveyors identified the following: -Resident 16 was admitted on 11/16/2015 and his/her record did not contain evidence of Resident 16 being provided with resident rights, grievance procedures and house rules before or upon admission. -Resident 17 was admitted on 03/02/2023 and his/her record did not contain evidence of Resident 17 being provided with resident rights, grievance procedures and house rules before or upon admission. -Resident 18 was admitted on 06/17/2021 and his/her record did not contain evidence of Resident 18 being provided with resident rights, grievance procedures and house rules before or upon admission. -Resident 19 was admitted on 02/29/2024 and his/her record did not contain evidence of Resident 19 being provided with resident rights, grievance procedures and house rules before or upon admission.. On 06/18/2024 at approximately 11:00 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated s/he looked in all 4 residents' records and could not locate evidence of residents being provided with resident rights, grievance procedures and house rules before or upon admission for all 4 residents. Director of Operations F stated if it was completed, it would have been in their records.	N 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 381}	Continued From page 13	{N 381}		
{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. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not conduct assessments upon admission for 1 of 1 resident reviewed (Resident 19). This requirement is being cited for the fourth time. This is a repeat deficiency from Statement of Deficiency (SOD) XD4Y12, dated 12/28/2018, SOD XD4Y13, dated 06/28/2019 and SOD XD4Y16, dated 01/03/2023. Findings include: On 06/18/2024 at approximately 10:30 AM, Surveyors requested to review Resident 19's record. Surveyors identified the following: -Resident 19 was admitted on 02/29/2024 and his/her record did not contain evidence of a pre-admission assessment.	{N 381}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD ASSISTED LIVING GREEN HOUSI	6370 N GREEN BAY AVE GLENDALE, WI 53209

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{N 381}	Continued From page 14 On 06/18/2024 at approximately 11:00 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated s/he looked in Resident 19's record and could not locate a pre-admission assessment. Director of Operations F stated if it was completed, it would have been in their record.	{N 381}		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not involve 3 of 3 residents reviewed (Resident 16, Resident 17 and Resident 18) and the resident's legal representative, as appropriate, in developing the individual service plan (ISP) and did not have the plan signed acknowledging their involvement in,	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

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N 387	Continued From page 15 understanding of, and agreement with the plan. This is a repeat deficiency and being cited for the fourth time. See statement of Deficiency (SOD) XD4Y14, dated 01/29/2021, SOD XD4Y15 dated 11/17/2021 and SOD WR6G11 dated 04/25/2023. Findings include: On 06/18/2024 at approximately 10:30 AM, Surveyors requested to review Resident 16, Resident 17's and Resident 18's record. Surveyors identified the following: -Resident 16 was admitted on 11/16/2015. Resident 16 had a guardian, and his/her record did not have an ISP signed by Resident 16's guardian. The current signed ISP in Resident 16 was dated 11/10/2020 and was signed by a former Licensed Practical Nurse (LPN). -Resident 17 was admitted on 03/02/2023 and was his/her own person. Resident 17's record did not contain evidence of a signed ISP by Resident 17. -Resident 18 was admitted on 06/17/2021 and was his/her own person. Resident 18's record did not contain evidence of a signed ISP by Resident 18. On 06/18/2024 at approximately 11:00 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated s/he looked in Resident 16's, Resident 17's and Resident 18's records and could not locate an ISP that was signed for all 3 residents. Director of Operations F stated if it was completed, it would have been in their records.	N 387		

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	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

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N 392	Continued From page 16	N 392		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide 3 of 3 residents reviewed (Resident 16, Resident 17 and Resident 18) and/or their legal representatives, an opportunity to complete an evaluation of the resident's level of satisfaction within the community-based residential facility (CBRF) services. Findings include: The facility is licensed as a class CNA (non-ambulatory) facility for 12 residents with programs in advanced age, emotionally disturbed/mental illness, developmentally disabled, physically disabled, and irreversible dementia/Alzheimer's. On 06/18/2024 at approximately 10:30 AM, Surveyors requested to review Resident 16's, Resident 17's and Resident 18's records. Surveyors identified the following: -Resident 16 was admitted on 11/16/2015 and had a legal guardian. Resident 16's record did not contain evidence of an annual satisfaction survey provided for calendar years 2022 and 2023. -Resident 17 was admitted on 03/02/2023 and	N 392		

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N 392	Continued From page 17 was his/her own person. Resident 17's record did not contain evidence of an annual satisfaction survey provided for calendar year 2024. -Resident 18 was admitted on 06/17/2021 and was his/her own person. Resident 18's record did not contain evidence of an annual satisfaction survey provided for calendar years 2022, 2023 and to date in 2024. On 06/18/2024 at approximately 10:45 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated if Surveyors did not see evidence the satisfaction surveys were provided in the records, then the surveys were not sent out to Resident 16's, Resident 17 and/or Resident 18's legal guardians. Director of Operations F stated the facility's electronic medical record system was able to conduct these and s/he was working on getting them into the system but has not done it yet.	N 392		
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.	N 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

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N 393	Continued From page 18	N 393		

This Rule is not met as evidenced by:
Based on record review and staff interview, the provider did not evaluate 3 of 3 residents reviewed (Resident 16, Resident 17 and Resident 18), within 3 days of the resident's admission.

Findings include:

The facility is licensed as a class CNA (non-ambulatory) facility for 12 residents with programs in advanced age, emotionally disturbed/mental illness, developmentally disabled, physically disabled, and irreversible dementia/Alzheimer's.

On 06/18/2024 at approximately 10:30 AM, Surveyors requested to review Resident 16, Resident 17 and Resident 18's records. Surveyors identified the following:

-Resident 16 was admitted on 11/16/2015 and his/her record did not contain evidence of an initial evacuation assessment.
-Resident 17 was admitted on 03/02/2023 and his/her record did not contain evidence of an initial evacuation assessment.
-Resident 18 was admitted on 06/17/2021 and his/her record did not contain evidence of an initial evacuation assessment.

On 06/18/2024 at approximately 10:45 am, Surveyors interviewed Director of Operations F. Director of Operations F stated if Surveyors did not see the assessment in the records, then the assessments were not completed. Director of Operations F stated the facility's electronic medical record system was able to conduct these and s/he was working on getting them into the system but has not done it yet.

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	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 415}	Continued From page 19	{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 staff interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 2 of 2 residents reviewed (Resident 20 and 21). This is a repeat deficiency. See statement of Deficiency (SOD) XD4Y16, dated 01/03/2023. Findings include: On 06/18/2024 at 9:26 AM, Surveyors reviewed Resident 20 and Resident 21's June 2024 MAR. EXAMPLE 1 Resident 20 was admitted to the facility on 04/25/2024 and needed assistance with	{N 415}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 415}	Continued From page 20 medication administration from staff. Resident 20's MAR had a total of 4 blank entries for administering his/her medications from 06/12/2024-06/18/2024. Resident 20's MAR stated that Resident 20 was on the following medications: -"Atorvastatin 80 mg (milligrams) tablet, one tablet by mouth everyday at bedtime for HLD (hyperlipidemia) -Eliquis 5mg tabs, take 1 tablet by mouth 2 times a day for DVT prevention (deep vein thrombosis) -Losartan Potassium 25 mg, take 1 tablet by mouth every day for HTN (hypertension) -Melatonin 3 mg tablet, take 1 tablet by mouth every day at bedtime." Resident 20's MAR had missing entries on the following dates: Atorvastatin 80 mg tablet on 06/16/2024 at 8:00 PM (1 entry), Eliquis 5mg tabs at 4:00 PM on 06/13/2024 and 06/14/2024 (2 entries), and Melatonin 3 mg tablet at 8:00 PM on 06/16/2024 (1 entry). EXAMPLE 2 Resident 21 was admitted to the facility on 06/04/2024 and needed assistance with medication administration from staff. Resident 21's MAR had a total of 16 blank entries for administering his/her medications from 06/04/2024-07/03/2024. Resident 21's MAR states that Resident 21 is on the following medications: -"Amlodipine Besylate 10 mg, take 1 tablet by mouth every morning for hypertension -Hydrochlorothiazide 12.5 mg, take 1 tablet by mouth every morning for HTN	{N 415}		

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	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

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{N 415}	Continued From page 21 -Hydroxychloroquine 200 mg, take 1 tablet by mouth every morning for RA (rheumatoid arthritis) -Losartan 50 mg tablet, take 1 tablet by mouth every morning for HTN -Pantoprazole Sodium 20 mg, take 1 tablet by mouth every morning before breakfast -Stimulant Laxative Plus tablet, take 1 tablet by mouth 2 times a day for constipation -Vitamin D3 50 mcg (micrograms) tablet, take 1 tablet by mouth every morning for supplement" Resident 21's MAR had missing entries on the following dates: Amlodipine Besylate 10 mg on 06/04/2024 and 06/05/2024 at 8:00 AM (2 entries), Hydrochlorothiazide 12.5 mg on 06/04/2024 and 06/05/2024 at 8:00 AM (2 entries), Hydroxychloroquine 200 mg on 06/04/2024 and 06/05/2024 at 8:00 AM (2 entries), Losartan 50 mg tablet on 06/04/2024 and 06/05/2024 at 8:00 AM (2 entries), Pantoprazole Sodium 20 mg on 06/04/2024 and 06/05/2024 at 8:00 AM (2 entries), Stimulant Laxative Plus tablet on 06/04/2024 and 06/05/2024 at 8:00 AM and 4:00 PM (4 entries) and Vitamin D3 50 mcg tablet on 06/04/2024 and 06/05/2024 at 8:00 AM (2 entries). On 06/18/2024 at 9:45 AM, Surveyors interviewed Director of Operations F about missing entries on Resident 20's and 21's June 2024 MAR. Director of Operations F stated staff should have been documenting on the MAR and have been re-educated recently on how to do this.	{N 415}		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD ASSISTED LIVING GREEN HOUSI	6370 N GREEN BAY AVE GLENDALE, WI 53209

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N 419	Continued From page 22 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications administered by the facility were kept locked for 1 of 1 storage area. Findings include: The facility is licensed as a class CNA (non-ambulatory) facility for 12 residents with programs in advanced age, emotionally disturbed/mental illness, developmentally disabled, physically disabled, and irreversible dementia/Alzheimer's. On the day of survey, the census was 11 residents. On 06/18/2024 at 8:40 AM, Surveyors toured the building. Surveyors started in the kitchen where Caregiver DD was because s/he was cleaning a garbage can in the kitchen and serving resident's breakfast. Surveyors observed the medication cart unlocked and unattended from 8:40 AM-9:42 AM. Surveyors observed residents moving freely throughout the facility. On 06/18/2024 at 9:15 AM, Surveyors interviewed Caregiver DD. Caregiver DD stated s/he was the medication passer for the building during the survey. Caregiver DD stated there was one caregiver per shift and that caregiver passed the medications. On 06/18/2024 at 9:42 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated the medication cart should have been locked at all times. At 9:45 AM, Director of Operations F told Caregiver DD the medication cart needed to be locked. Director of Operations F locked the cart for Caregiver DD and Director of Operations F grabbed the medication cart keys	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 419	Continued From page 23 that were hanging in front of the medication cart to Caregiver DD.	N 419		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide a daily activity program to meet the interests and capabilities for 11 of 11 residents. Findings include: On 06/18/2024 at approximately 8:40 AM until 12:45 PM, Surveyors were on-site and did not observe any activities. Surveyors observed residents sitting in the living room in front of the TV during the duration of the survey. On 06/18/2024 at approximately 9:00 AM, Surveyors observed the activity calendar on the wall next to the living room. Per the activity	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 427	Continued From page 24 calendar posted in the facility, there was supposed to be exercise completed at 10:00 AM with the residents. On 06/18/2024 at approximately 12:00 PM, Surveyors interviewed Director of Operations F. Director of Operations F stated there was an activity calendar and staff were the ones to conduct the activities with the residents. Director of Operations F stated s/he would talk to staff about making sure they were completing activities with the residents.	N 427		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 25 changes in the resident ' s health or mental health status 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's (Resident 16's) blood sugar was monitored 2 times daily as ordered. Resident 16's blood sugars were not checked for a total of 15 times from 06/01/2024 to 06/18/2024. Findings include: On 06/18/2024 at approximately 9:19 AM, Surveyors reviewed Resident 16's record. Resident 16 was admitted to the provider's facility on 11/16/2015 with diagnoses including alcohol dependence-in remission, cutaneous abscess of trunk, dementia, and diabetes with diabetic nephropathy. Resident 16's physician orders included an order to test his/her blood sugar 2 times daily for diabetic management (Start Date: 02/25/2021). Surveyors reviewed Resident 16's Medication Administration Record (MAR) and vitals history, dated 06/01/2024 - 08/30/2024, indicated the following occurrences of no blood sugar testing: 06/01/2024 AM and PM, 06/03/2024 AM and PM, 06/05/2024 AM and PM, 06/09/2024-06/12/2024	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

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N 431	Continued From page 26 PM, 06/13/2024 AM and PM, 06/14/2024 AM and PM and 06/15/2024 PM. Resident 16's blood sugars were not checked for a total of 15 times from 06/01/2024 to 06/18/2024. On 06/18/2024 at 9:45 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated staff knew to document the blood sugars and if they were blank, then s/he could assume they were not checked based on the documentation.	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure medication administration was provided to 1 of 1 resident reviewed. The provider did not ensure Resident 18 received all their prescribed medications from 06/03/2024-06/07/2024. This requirement is being cited for the third time. See Statement of Deficiency (SOD) XD4Y14, dated 01/29/2021, and SOD XD4Y15, dated	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015217	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 432	Continued From page 27 11/17/2021. Findings include: On 06/18/2024, Surveyors reviewed Resident 18's record and identified the following: Resident 18 was admitted to the facility on 08/17/2021 and had diagnoses of obesity, schizophrenia, Parkinson disease and adjustment disorder with mixed anxiety and depressed mood. Resident 18 required staff to administer his/her medications. On 06/18/2024 at 10:00 AM Surveyors observed a prescription bottle of medications in the top of the medication cart. The medication was prescribed to Resident 18. The prescription bottle stated the following: "Cephalexin 500 mg (milligrams) caps (capsules), take 1 capsule by mouth 2 times a day for 5 days. Start: 06/03/2024." Surveyors requested to review Resident 18's Medication Administration Record (MAR) for June 2024. Surveyors reviewed Resident 18's June 2024 MAR. Cephalexin 500 mg was not listed on the MAR for staff to document administration. On 06/18/2024 at approximately 10:15 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated s/he was not sure why there was a prescription bottle there and not put in punch cards for the antibiotic. Director of Operations F stated Caregiver DD would know best as s/he worked the day shift and was the one usually passing the medications. On 06/18/2024 at approximately 10:17 AM, Surveyors interviewed Caregiver DD. Caregiver	N 432		

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N 432	Continued From page 28 DD stated s/he remembered Resident 18 being seen and having an infection but did not remember when the medication came in. Caregiver DD stated s/he did not give the Cephalexin if it was not on the MAR. On 06/18/2024 at approximately 11:00 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated based on the pills being in there and Caregiver DD not knowing about it and it not being on the MAR, it most likely was not given to Resident 18.	N 432		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all employees followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards for 1 of 1 caregiver. Caregiver DD did not wash or sanitize hands while completing tasks in the kitchen and serving food to the residents. Findings include: In October 2002, the CDC published the "Guideline for Hand Hygiene in Healthcare Settings." This guideline sets the standard for caregivers regarding glove use and hand washing to prevent the spread of infections. The CDC has recommended that caregivers wash their hands before having direct contact with residents, after contact with a resident's intact skin, after contact with body fluids or excretions, if moving from a	N 441		

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N 441	Continued From page 29 contaminated-body site to a clean-body site during cares, after contact with inanimate objects and after removing gloves." (Source: CDC website, Guideline for Hand Hygiene in Healthcare Settings; 17-18, October 25th, 2002, https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf (retrieval date: June 16, 2024).) On 06/18/2024 at 8:40 AM to 9:30 AM, Surveyors observed Caregiver DD in the kitchen with soapy water in the sink. Caregiver DD had a dirty garbage lid on the counter of the kitchen and was washing it with a wash cloth. After s/he finished washing the lid, s/he placed the lid back on the garbage can. Caregiver DD then went to the kitchen and grabbed silverware and started placing them on the tables in the dining room. While Caregiver DD was placing silverware on the tables, a resident came out to the table to eat breakfast. Caregiver DD then went to the kitchen and grabbed a plate and dished up breakfast for the resident. Caregiver DD did not wash or sanitize hands in between any of the tasks. On 06/18/2024 at 9:45 AM, Surveyors interviewed Director of Operations F. Director of Operations F acknowledged staff were supposed to perform hand hygiene between residents and other tasks. Director of Operations F stated s/he would talk to Caregiver DD about hand hygiene.	N 441		
N 447	83.41(1)(c) Dishwashing Dishwashing. 1. Whether washed by hand or mechanical means, all equipment and utensils shall be cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Residential dishwashers may be used in kitchens serving 20 or fewer residents. Kitchens serving	N 447		

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N 447	Continued From page 30	N 447		

21 or more residents shall have a commercial type dishwasher for washing and sanitizing equipment and utensils in accordance with standard practices described in the Wisconsin food code. 2. A 3-compartment sink for washing, rinsing and sanitizing utensils, with drain boards at each end is required for all large facilities with a central kitchen. Washing, rinsing and sanitizing procedures shall be in accordance with standard practices described in the Wisconsin food code. In addition, a single compartment sink or overhead spray wash located adjacent to the soiled drain board is required for pre-washing.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure dishes, equipment and utensils washed by hand were cleaned using separate steps for pre-washing, washing, rinsing, and sanitizing.

Findings include:

On 06/18/2024 at approximately 8:40 AM, Surveyors observed Caregiver DD wash dishes by hand in the kitchen sink. The facility had a working dishwasher, but Caregiver DD stated s/he washed the dishes from breakfast by hand. There were 2 separate sink compartments. Surveyors observed utensils, plates, and drinking cups on the counter on a drying towel.

On 06/18/2024, at approximately 9:30 AM, Surveyor interviewed Caregiver DD. Caregiver DD stated s/he washed the dishes in soapy water, rinsed and then placed the dishes in a rack to air dry. Surveyor asked if Caregiver DD used any sanitizer. Caregiver DD stated s/he was

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N 447	Continued From page 31 familiar with the separate steps for pre-washing, washing, rinsing and sanitizing but s/he did not use the sanitizer this time. Caregiver DD showed Surveyors where the black bin with sanitizer was. The black bin with the sanitizer solution was kept on top of the fridge and had dust caked in the bin and sanitizer solution. On 06/18/2024, at approximately 10:30 AM, Surveyors interviewed Director of Operations F. Director of Operations F stated staff should have been using the dishwasher to clean the dishes and if they can not, they knew they should have been using the sanitizer if they were hand washing dishes.	N 447		
{N 452}	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	{N 452}		

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{N 452}	Continued From page 32 This Rule is not met as evidenced by: Based on observation and interview, the provider did not store food in a sanitary manner. Surveyors found multiple food items that were not labeled and dated in the refrigerator to avoid contamination. This had the potential to affect 11 of 11 residents residing in the facility. This requirement is being cited for a third time. See Statement of Deficiency (SOD) XD4Y14, dated 01/29/2021 and SOD XD4Y16, dated 01/03/2023. Findings include: On 06/18/2024, at approximately 9:15 AM, Surveyors toured the environment. Surveyors observed multiple food items in the refrigerator that were not labeled or not sealed properly. Observations of opened items in the refrigerator: -opened chunky mixed fruit can with a napkin over it with no date -opened vanilla yogurt tub (32 ounces) with no date -opened lunch meat bag with no date -opened hot dogs in the freezer with no date -opened bag of lettuce salad with no date According to the Wisconsin Food Code, the Federal Department of Agriculture's Food Code, and ServSafe standards date marking is necessary to indicate when food must be consumed or discarded. These standards indicate refrigerated, read to eat (RTE), potentially hazardous food (PHF), and time/temperature controlled for safety (TCS) foods that are removed from manufacturer packaging and/or prepared for consumption must	{N 452}		

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{N 452}	Continued From page 33 be date marked and discarded within 7 days. Refrigerated, RTE, PHF, and TCS foods prepared and packaged in a food processing plant shall also be date-marked when opened in the facility (date not to exceed 7 days). (Servsafe Coursebook, 7th Ed., 2017, p. 5-23) On 06/18/2024, at approximately 10:30 AM, Surveyors interviewed Director of Operations (DOO) F. DOO F stated the food in the refrigerator should have been properly sealed and dated at all times.	{N 452}		
{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 that cleaning compounds, polishes, insecticides and toxic substances were labeled and stored in a secure area. Bottled cleaning compounds and toxic substances were observed in an unsecured cabinet, under the kitchen sink. This requirement is being cited for a third time. See Statement of Deficiency (SOD) XD4Y14, dated 01/29/2021 and SOD XD4Y16, dated 01/03/2023. Findings include: The facility is licensed as a 12-bed class CNA serving individuals who may be developmentally	{N 499}		

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{N 499}	Continued From page 34 disabled, advanced aged, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, public funding and physically disabled. On 06/18/2024, at approximately 8:50 AM, Surveyors observed unlocked cabinet below kitchen sink. The unsecured cabinet door contained two containers of Clorox wipes, all-purpose cleaner with bleach, Comet spray cleaner and dishwasher soap. Surveyors observed resident's freely moving around during the survey. On 06/18/2024, at approximately 9:15 AM, Surveyors interviewed Director of Operations (DOO) F regarding the unsecured toxic substances. DOO F stated the maintenance person was supposed to fix it and the cabinets should have beeen able to lock since the substances were kept under there.	{N 499}		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the fire detection system was inspected for 1 of 1 calendar year (2023). Findings include:	N 538		

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N 538	Continued From page 35 On 06/18/2024, Surveyor reviewed facility safety records. There was no fire detection system inspection for calendar year 2023. On 06/18/2024 at approximately 9:00 AM, Surveyor requested from Director of Operations F the annual fire detection system inspection for calendar year 2023. Director of Operations F stated s/he did not have it completed for calendar year 2023. Director of Operations F stated s/he knew they were out of compliance for that. Director of Operations F reported s/he was the one who would schedule it and they were trying to schedule them to come in soon and complete an inspection. CROSS REFERENCE N0393 DHS 83.35(5)(a) Initial Evaluation of Evacuation Assessment	N 538		