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	0019949	A. BUILDING: _____ B. WING _____	10/02/2024

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N 000	Initial Comments On 10/01/2024, with information obtained through 10/02/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a probationary licensing survey at Larson House, a community-based residential facility (CBRF) located in Columbus, WI. As a result of the survey, 4 deficiencies were identified. Census: 36	N 000		
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 observation, record review, and interview, the provider did not ensure that the individual service plans (ISPs) of 3 of 3 residents reviewed were updated with changes in their needs, abilities, and condition. Resident 3, who utilized continuous oxygen,	N 389		

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

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ambulated at times with a wheelchair, voluntarily participated in a smoking schedule, and demonstrated behaviors such as cigarette seeking, yelling at staff, behavioral incontinence, and complaining of difficulties breathing (reportedly thought to be in part related to attention-seeking), did not have these behaviors and needs identified in his/her ISP.

Resident 4, whose diabetes management was complicated by known consistent and frequent refusals of his/her insulin, did not have these behaviors identified in his/her ISP.

Resident 5's most recent ISP indicated the need for his/her bowel movements to be documented, which was not a current need as identified by staff report.

Findings include:

Example 1 - Resident 3's behaviors, wheelchair use, smoking schedule, oxygen use

On 10/01/2024, at approximately 3:35 p.m., Surveyor interviewed Caregiver E regarding Resident 3's needs. Caregiver E reported that Resident 3 was known to yell at staff, especially if staff weren't quick enough in anticipating his/her needs. Caregiver E reported that there was initially a struggle with Resident 3's cigarette schedule but s/he had recently agreed to a supervised smoking schedule where staff supervised him/her smoking 6 times per day. Caregiver E showed Surveyor the smoking schedule, located on the wall near the patio exit door. The posted document was titled, "Resident supervised smoking schedule" and listed times of 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 6:00 p.m., and 8:00 p.m. Caregiver E reported that

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Resident 3 used to use a 4-wheeled walker for ambulation but has been recently using a manual wheelchair at all times that s/he could propel him/herself in. Caregiver E reported s/he had heard other staff discuss known behaviors of Resident 3 to attempt to pick up others' cigarette butts off the ground or out of ashtrays to continue smoking them, but had not seen it him/herself. Caregiver E reported that Resident 3 was also known to demonstrate behavioral incontinence, characterized by having incontinent episodes when staff did not give in to his/her requests. Caregiver E reported that an example of this was how, on occasion, Resident 3 would pee on the floor if staff refused to give a cigarette due to it not being his/her scheduled time to receive one. Caregiver E reported that some of these behaviors, such as the behavioral incontinence and attempting to use others' cigarette butts, had improved recently.

While interviewing Caregiver E, Surveyor observed Resident 3 outside smoking while seated in his/her manual wheelchair. When finished with his/her cigarette, s/he propelled him/herself back inside and down the hallway.

At approximately 3:45 p.m., Surveyor interviewed Caregiver F. Caregiver F reported that Resident 3 "used to" demonstrate more cigarette-seeking behaviors, such as seeking cigarette butts from the ground, when s/he first admitted to the provider but the behaviors had improved since implementation of him/her participating in the supervised smoking schedule.

On 10/01/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/14/2024 with diagnoses including nicotine dependence, unspecified urinary incontinence,

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and chronic obstructive pulmonary disease. Resident 3 was documented as being his/her own legal decision maker. Surveyor reviewed Resident 3's observation notes from 06/14/2024 - 10/01/2024. An observation entry on 06/14/2024, at 3:45 p.m., documented, "Resident is on 2 liters of oxygen at all times..." Other observation notes detailed the following 21 occurrences of behaviors related to Resident 3 complaining of difficulties breathing:

- 06/14/2024 (5:30 p.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] [oxygen (O2)] Saturation levels are in the high 90's."

- 06/15/2024 (1:00 p.m.): (Same exact entry as above)

- 06/15/2024 (7:45 p.m.): "Resident standing in [his/her] doorway screaming 'I cant [sic] breathe'. When staff go in to resident room resident has oxygen on and O2 saturation levels are in the high 90"s [sic]."

- 06/17/2024 (12:45 p.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] O2 Saturation levels are in the high 90's. [As needed (PRN)] Nebulizer offered to resident. Resident refused PRN Nebulizer treatment."

- 06/17/2024 (7:45 p.m.): "Resident standing in [his/her] doorway screaming 'I cant [sic] breathe'. When staff go in to resident room resident has oxygen on and O2 saturation levels are in the high 90"s [sic]. PRN Nebulizer treatment offered.

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N 389	Continued From page 4 Resident refused PRN Nebulizer treatment." - 06/19/2024 (2:45 p.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] O2 Saturation levels are in the high 90's. PRN Nebulizer offered to resident. Resident refused PRN Nebulizer treatment." - 06/19/2024 (7:00 p.m.): "Resident standing in [his/her] doorway screaming 'I cant [sic] breathe'. When staff go in to resident room resident has oxygen on and O2 saturation levels are in the high 90"s [sic]. PRN Nebulizer treatment offered. Resident refused PRN Nebulizer treatment." - 06/21/2024 (10:45 a.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] O2 Saturation levels are in the high 90's. PRN Nebulizer offered to resident. Resident refused PRN Nebulizer treatment." - 06/21/2024 (7:45 p.m.): "Resident standing in [his/her] doorway screaming 'I cant [sic] breathe'. When staff go in to resident room resident has oxygen on and O2 saturation levels are in the high 90"s [sic]. PRN Nebulizer treatment offered. Resident refused PRN Nebulizer treatment." - 06/23/2024 (1:45 p.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] O2 Saturation levels are in the high 90's." - 06/23/2024 (9:00 p.m.): "Resident standing in	N 389		

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[his/her] doorway screaming 'I cant [sic] breathe'. When staff go in to resident room resident has oxygen on and O2 saturation levels are in the high 90"s [sic]. PRN Nebulizer treatment offered. Resident refused PRN Nebulizer treatment."

- 06/24/204 (5:15 p.m.): "Resident screaming from [his/her] room. Staff went in to assist resident but [s/he] states [s/he] does not need anything. Resident has pressed [his/her] pendant numerous times but again states [s/he] does not need anything. When staff leave resident screams that [s/he] can not breathe. Resident O2 is 98 and oxygen is working properly. Resident asked to be seen in [emergency room] but changed [his/her] mind in less than 2 mins. [Family member] is aware. [Resident 3 family member] states resident has a history of 'yelling out for attention.'"

- 06/26/2024 (1:15 p.m.): "Resident is yelling that [s/he] cant [sic] breathe, O2 is 98%. Resident denies wanting a neb treatment. Oxygen is working and has been checked by writer."

- 06/27/2024 (1:30 p.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] O2 Saturation levels are in the high 90's. PRN Nebulizer treatment offered. Resident refused PRN Nebulizer treatment."

- 06/27/2024 (5:00 p.m.): "Resident standing in [his/her] doorway screaming 'I cant [sic] breathe'. When staff go in to resident room resident has oxygen on and O2 saturation levels are in the high 90"s [sic]. PRN Nebulizer treatment offered to resident. Resident refused PRN Nebulizer treatment."

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N 389	Continued From page 6 - 06/29/2024 (10:50 a.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] O2 Saturation levels are in the high 90's. PRN Nebulizer treatment offered. PRN nebulizer given to resident." - 06/29/2024 (12:15 p.m.): "Resident [complains of] [shortness of breath], [emergency medical services] called..." - 06/29/2024 (9:30 p.m.): "Resident standing in [his/her] doorway screaming 'I cant [sic] breathe'. When staff go in to resident room resident has oxygen on and O2 saturation levels are in the high 90"s [sic]. PRN Nebulizer treatment offered to resident. PRN Nebulizer treatment given." - 06/30/2024 (5:45 a.m.): "Resident seen in [emergency room] for [complaints of] [shortness of breath]. Resident O2 is 98%..." - 07/01/2024 (11:15 a.m.): "...When staff go in to resident room to ask [him/her] how they can help resident [s/he] is stating that [s/he] can not breathe. [S/he] has [his/her] oxygen on and [his/her] O2 Saturation levels are in the high 90's. PRN Nebulizer treatment offered to resident. PRN nebulizer given to resident." - 07/11/2024 (3:15 p.m.): "Late Entry: Yesterday 7/10 resident paged multiple times during writers [sic] shift. The first time resident stated [s/he] couldn't breathe writer went and checked a PRN nebulizer treatment for resident. Resident still had some solution in the reservoir from hours before." Surveyor also observed an observation entry on	N 389		

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08/10/2024, at 6:30 p.m., which documented, "After dinner resident asked writer for a cigarette. Writer was told that resident was already given allotted cigarettes for the day. Resident then shouted down the hall 'no I was not given any.' Writer called on call...Staff [unidentified initials] just told writer that resident is outside digging in the ashtray being rude and demanding cigarettes from other residents as well as staff."

Surveyor reviewed Resident 3's medication administration records (MARs) from 09/01/2024 - 10/01/2024, which from 09/13/2024 through 10/01/2024 contained an entry titled, "Behavior Monitoring Each Shift" which staff initialed off on. Entries were occasionally entered in the "notations" section of the MARs, in which staff answered a prompt that read, "Did Resident Have Any Behaviors on Your Shift?" Staff responses to the prompt included the following:

- 09/13/2024 (8:36 p.m.): "Screaming and yelling."

- 09/16/2024 (6:10 a.m.): "yelling at writer for a pain pill writer got [him/her] one as soon as I could."

- 09/17/2024 (9:17 p.m.): "constant incontinence and yelling."

- 09/19/2024 (7:52 p.m.): "would not go to toilet when needing to go instead [s/he] sat in wheelchair and floode [sic] during shiftd [sic] floor 3x."

- 09/20/2024 (12:55 p.m.): "Yelling at staff because they wont [sic] push [him/her] to [his/her] room."

- 09/21/2024 (8:34 p.m.): "constant incontinence,

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yelling, demanding cigarettes."

- 09/22/2024 (8:28 p.m.): "constant incontinence and yelling. Resident also taking cups to [his/her] room and unscrewing the lid and spilling them on the floor."

- 09/23/2024 (5:48 a.m.): "yelling out."

- 09/25/2024 (7:57 p.m.): "Didn't use restroom when needing to go just sat in wheelchair."

- 09/29/2024 (5:45 a.m.): "snuck a cigrette [sic]."

- 09/29/2024 (12:40 p.m.): "Keeping cigarettes in [his/her] room."

Surveyor reviewed Resident 3's ISP, last signed as reviewed on 06/19/2024, which indicated the following:

- Under the "Ambulation and Transferring" heading: "Resident uses a 4 wheeled walker for mobility. Resident needs stand by assistance when walking long distance."

- Under the "Destructive" heading, which was under the "Behavior Patterns" section: "Resident displays no destructive/abuse behaviors towards peers, staff or property." The same section also documented that Resident 3 required behavior monitoring 3x/daily and as needed with the following guidance: "Concerns to be reported to Management."

There were no behavioral concerns identified in Resident 3's ISP, such as his/her cigarette-seeking behaviors, behavioral incontinence, and/or repeated breathing complaint concerns. There was also no

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information regarding his/her oxygen use, wheelchair use (with guidance for wheelchair vs. 4-wheeled walker use), or smoking needs including his/her adherence to a smoking schedule.

At approximately 6:18 p.m., Surveyor interviewed Administrator A and Regional Manager B. Administrator A reported awareness of Resident 3's behaviors and that they seemed to be at least in part motivated by seeking attention. Administrator A reported that Resident 3 had been known to scream all night long with complaints of difficulties breathing, but staff's monitoring of him/her had not identified any objective concerns indicative of problems with his/her oxygen. Administrator A reported that Resident 3's cigarette-seeking behaviors had improved since s/he was put on the supervised smoking program (where Resident 3 was allotted 6 cigarettes daily and staff smoked outside with him/her). Administrator A reported that Resident 3 used the wheelchair as more of a recent mode of ambulation since his/her falls the previous month and that s/he sometimes used his/her wheelchair but sometimes used his/her 4-wheeled walker. Both Administrator A and Regional Manager B acknowledged Surveyor's concern that Resident 3's oxygen use, information about his/her wheelchair use vs. walker use, and behaviors behind the identified need for behavioral monitoring, were not identified in Resident 3's ISP.

Example 2 - Resident 4's consistent insulin refusals

On 10/01/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 08/28/2024 with diagnoses including type 2

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diabetes mellitus with hyperglycemia and schizophrenia. Resident 4 was documented as being his/her own legal decision maker. Resident 4's medical provider orders included scheduled insulin to be administered before breakfast, lunch, and dinner. Each order contained a monitoring parameter directing staff to "Notify [medical doctor] if blood sugar under 80 or above 450 and resident is symptomatic," as well as hold parameters directing for the insulin to be held if his/her blood sugar was below 80. Surveyor reviewed Resident 4's MARs from 09/01/2024 - 10/01/2024 and observed an entry indicating that Resident 4, at least at one point, had a Dexcom G7 Sensor with the direction for the sensor to be changed every 10 days. An "end date" for the sensor, which was also the date that staff last initialed off on having changed the sensor, was 09/09/2024 (about 3 weeks prior to the survey). In reviewing the MARs, Surveyor observed multiple occasions in which Resident 4 refused his/her insulin, despite his/her blood sugar values falling within the parameters for administration, with the following annotations:

- 09/03/2024 (breakfast): "said blood sugar was too low."

- 09/03/2024 (lunch): "said blood sugar to [sic] low."

- 09/06/2024 (dinner): "Residents [sic] blood sugar was 124 and [s/he] told writer [s/he] did not want any insulin."

- 09/08/2024 (dinner): "Resident did not want."

- 09/10/2024 (lunch): "Resident refused to let me inject [his/her] insulin because [his/her] [blood sugar] was 112. Resident was told to speak with

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management about [his/her] order. Resident was told that the order states Inject Subcutaneously : 22 Units Before Lunch" and that it does not say 'hold dose if [blood sugar] is anywhere below 120.'"

- 09/13/2024 (dinner): "Did not want insulin [blood sugar] 144."

- 09/29/2024 (dinner): "Resident said sugars were to [sic] low."

Additional refusals were documented, despite Resident 4's blood sugar values documented being within the parameters for administration, on 09/16/2024 (lunch), 09/18/2024 (breakfast), 09/20/2024 (lunch), 09/24/2024 (lunch), 09/27/2024 (lunch), and 09/30/2024 (breakfast).

Surveyor reviewed Resident 4's observation notes from 08/28/2024 - 10/01/2024 and observed the following entries related to his/her diabetes management:

- 09/03/2024 (3:45 p.m.): "Endocrinology notified that resident has refused [his/her] insulin multiple times since moving in...Resident states [s/he] will not take 22 units 3 times daily per order. Writer also let Endo know that resident has refused Tresiba and Trulicity. Message left with [clinic staff] at clinic."

- 09/06/2024 (5:30 p.m.): "[Medical company] will be shipping residents [sic] Dexcom supplies to facility. Due to ship out on 9-10-24."

- 09/17/2024 (11:30 a.m.): "Endocrinologists notified of resident refusing insulins frequently."

Surveyor reviewed Resident 4's ISP, last

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N 389	Continued From page 12	N 389		

documented as reviewed on 06/28/2024 (later confirmed by Administrator A to have been 09/28/2024). There was no information about Resident 4's diabetes management or the behaviors Resident 4 demonstrated with consistent insulin refusals in his/her ISP.

At approximately 6:18 p.m., Surveyor interviewed Administrator A and Regional Manager B. Administrator A reported that the date was incorrectly recorded on Resident 4's ISP but s/he knew it would have been reviewed after his/her admission. Administrator A reported s/he was not sure if Resident 4 currently used a Dexcom for blood sugar monitoring but would have to look into it. Administrator A reported awareness of Resident 4's consistent insulin refusals and reported it was something that staff were trying to stay in contact with Resident 4's endocrinologist about. Administrator A reported that it was sometimes a struggle with residents' clinicians because staff wanted to maintain regulatory compliance with letting medical providers know about 2 consecutive medication refusals but clinicians sometimes didn't like the frequent updates or would report not wanting to be aware of refusals to that frequency. Administrator A reported that staff were typically able to work out a schedule where when residents frequently and consistently refused medications their clinics would be notified and provided any corresponding vitals (such as blood sugar values for diabetic residents) every so often as agreed upon.

Example 3 - Resident 5's bowel movement monitoring

On 10/01/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 11/01/2021. Resident 5's prescriptions

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	0019949	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARSON HOUSE	550 RIVER ROAD COLUMBUS, WI 53925

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N 389	Continued From page 13 included PRN polyethylene glycol with directions for administration of a certain amount if no bowel movement was experienced in 2 days and a PRN suppository to be administered once daily for constipation. Resident 5's ISP, signed as last reviewed on 11/21/2023, directed under the "Toileting" heading: "Staff to monitor and document bowel movements. If resident does not have a bowel movement for a total of 6 shifts, notify nursing administration and institute facility bowel program. Staff are to use PRN medications as prescribed by physician." At approximately 6:18 p.m., Surveyor interviewed Administrator A and Regional Manager B. Surveyor requested Resident 5's bowel movement monitoring documentation from 09/01/2024 to 10/01/2024. Administrator A reported that staff were not documenting Resident 5's bowel movements and this was not something that was typically documented on for residents. Administrator A reported that Resident 5 was his/her own legal decision maker and able to make his/her needs known, so s/he was known to reliably report to staff when s/he was experiencing constipation warranting any use of related PRN medication. Administrator A acknowledged Surveyor's concern that since daily bowel movement monitoring documenting did not seem to be a current service/need that Resident 5 demonstrated that it should not be in his/her ISP.	N 389		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas	N 481		

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N 481	Continued From page 14 shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that aspects of the living environment were clean. Findings include: Throughout the day on 10/01/2024, Surveyor toured the environment and observed the following: - At approximately 10:05 a.m., the fan mounted in the hallway between the areas labeled for "Larson House 1" and "Larson House 2" was running with clumped bits of dust stuck to several portions of the grill/guard (Photo 1). - At approximately 10:07 a.m., the oven within the Larson House 2 area kitchenette was observed with small bits of food debris and burnt liquid spots along the bottom area below the oven racks. The inner oven door contained stained areas with burnt areas of food debris (Photo 2). - At approximately 10:13 a.m., the carpet throughout the length of the hallway through the Larson House 2 area, from resident apartment areas all the way up to the Larson House 1 area, contained several various-sized, scattered stained areas (Photos 3, 4, 5, 6, 7, and 8), one of which being an approximate 2' x 6' area. - At approximately 3:48 p.m., the exit door near the apartments located in the Larson House 2 area was observed with several black stains	N 481		

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N 481	Continued From page 15 across the width of it's lower half (Photo 9). At approximately 6:18 p.m., Surveyor interviewed Administrator A and Regional Manager B regarding the areas of concern. Both reported that the areas would be addressed. Administrator A reported that s/he had spoken with staff before about maintaining cleanliness of the fans. Administrator A and Regional Manager B reported that quotes were actively being sought from outside vendors and new carpet was being picked out for replacement flooring of the Larson House 2 area.	N 481		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 of 4 total clothing dryers which required venting consisted of rigid material tubing. Findings include: On 10/01/2024, at approximately 10:18 a.m., Surveyor toured the environment with House Manager C and Maintenance Staff D and observed the laundry area on the lower level laundry room of the facility, located in the area labeled by staff as "Larson House 2." One of the	N 488		

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N 488	Continued From page 16 2 dryers located in that laundry room was observed to have flexible dryer vent tubing. While observing the dryer vent tubing, Surveyor discussed the concern with House Manager C and Maintenance Staff D. Both acknowledged Surveyor's concern and Maintenance Staff D reported s/he would work on changing out the tubing. At approximately 6:18 p.m., Surveyor interviewed Administrator A and Regional Manager B. Both acknowledged Surveyor's concern. Administrator A reported that the dryer was newer and the appliance company that installed it must have installed the flexible dryer vent tubing. Administrator A reported s/he would have the dryer vent tubing addressed.	N 488		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 of 3 resident rooms observed, which had furnaces located within their individual apartments, had doors that did not	N 640		

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N 640	Continued From page 17 allow for automatic or self closing. Findings include: On 10/01/2024, at approximately 10:20 a.m., Surveyor toured laundry and furnace areas with Maintenance Staff D. Maintenance Staff D reported that in the lower level of the facility (identified by staff as "Larson House 2"), the individual resident apartments each had rooms which contained furnaces. At approximately 10:35 a.m., Surveyor toured a sample of 3 resident apartments/rooms in the Larson House 2 area of the CBRF with Regional Manager B and House Manager C. Within each of the apartments/rooms observed, Surveyor observed an enclosed furnace room. Two of the 3 sampled furnace doors, those located in the rooms for Resident 1 and Resident 2, did not fully close upon being released from an open position. At approximately 6:18 p.m., Surveyor discussed the above concern with Administrator A and Regional Manager B. Both reported that they would check all the doors of residents who had apartments with enclosed furnace rooms and ensure they self-closed.	N 640		