STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	R-C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

(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 06/22/2023, Surveyor conducted a verification visit and complaint investigation at Sunset Ridge Assisted Living. Three deficiencies were identified; 1 was a repeat deficiency and 10 previous deficiencies from statement of deficiency (SOD) Y15311, dated 01/12/2023 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 15	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 4's legal representative and physician were notified when Resident 4's suprapubic catheter was dislodged. Findings include: On 06/22/2023, Surveyor conducted a verification	N 169		

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

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N 169	Continued From page 1 visit and complaint investigation in regards to resident care. Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 07/12/2021 with a catheter in place. Resident 4's record included 2 incident reports that document: 11/17/2023 at 8:00 p.m., "RA was helping resident to bed and noticed area around cath was very green/yellow with discharge present. RA removed gauze to clear area, cath tube was stuck to tube and tube fell out of place. Resident refused RA to call on call nursing and advised RA to 'just poke it back in'. There was urine output present in tubing. Tube put back into hole, urine output present. Corrective Plan of Action: RA is aware to not put cath back in and re-teach cath care going forward and to notify nurse staff going forward." 11/18/2023 at 7:30 a.m., "Staff went to get Resident up and out of bed and went to change cath bag and noticed no urine was in it. The urine was all in [his/her] brief and all on [his/her] bed. [Power of attorney] POA took Resident to Emergency Room." Surveyor reviewed a hospital discharge summary, dated 11/18/2023, documenting that Resident 4 was seen in the emergency department for suprapubic catheter dislodgement and treatment of a urinary tract infection. At 3:37 p.m., Surveyor interviewed Caregiver C, who documented the incident report on 11/18/2023. Caregiver C stated that there was no issues with Resident 4's catheter when s/he left his/her shift and when s/he came to work the next morning and saw that the catheter was not in	N 169		

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N 169	Continued From page 2 place, s/he notified Resident 4's activated POA and the POA took Resident 4 to the emergency room. At approximately 4:15 p.m., Surveyor reviewed the above concerns with Administrator A. Administrator A acknowledged the concern and stated s/he is aware the POA should have been notified.	N 169		
{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. 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.	{N 239}		

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{N 239}	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees reviewed obtained all department approved training as required. Caregiver C and G did not have training in fire safety within 90 days after starting employment. Caregiver G did not have training in first aid and choking within 90 days after starting employment. Repeat violation from statement of deficiency (SOD) Y15311, dated 01/12/2023. Findings include: On 06/22/2023, Surveyor conducted a review of 3 employees to verify compliance with department approved training requirements. Surveyor requested training records from Administrator A for Caregiver C and Caregiver G, who were both working during the time of the survey. Fire Safety The record for Caregiver C, hired 09/09/2020, and the record for Caregiver G, hired 02/14/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 06/22/2023, at 2:17 p.m., Surveyor interviewed Caregiver C and asked if s/he had received training in fire safety. Caregiver C stated no, that s/he has been reminding Administrator A. At approximately 2:32 p.m., Surveyor interviewed Administrator A. Administrator A confirmed that Caregiver C has still not completed or met an exemption for fire safety training and that s/he just has not gotten it done. At 3:05 p.m., Surveyor interviewed Caregiver G and asked if	{N 239}		

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{N 239}	Continued From page 4 s/he had received training in fire safety. Caregiver G stated s/he has not. First aid and Choking The record for Caregiver G, hired 02/14/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 06/22/2023, at 3:05 p.m., Surveyor interviewed Caregiver G and asked if s/he had received training in first aid and choking. Caregiver G stated s/he has not, that s/he has only completed standard precautions. On 06/22/2023, Surveyor verified Caregiver C and was not on the Community-Based Care and Treatment training registry for fire safety and that Caregiver G was not on the Community-Based Care and Treatment training registry for fire safety or first aid and choking.	{N 239}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 4 received prompt and adequate treatment when his/her suprapubic catheter was dislodged. Findings include:	N 353		

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N 353	Continued From page 5 On 06/22/2023, Surveyor conducted a verification visit and complaint investigation in regards to resident care. Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 07/12/2021 with a catheter in place. Resident 4's record included 2 incident reports that document: 11/17/2022 at 8:00 p.m., "RA was helping resident to bed and noticed area around cath was very green/yellow with discharge present. RA removed gauze to clear area, cath tube was stuck to tube and tube fell out of place. Resident refused RA to call on call nursing and advised RA to 'just poke it back in'. There was urine output present in tubing. Tube put back into hole, urine output present. Corrective Plan of Action: RA is aware to not put cath back in and re-teach cath care going forward and to notify nurse staff going forward." 11/18/2022 at 7:30 a.m., "Staff went to get Resident up and out of bed and went to change cath bag and noticed no urine was in it. The urine was all in [his/her] brief and all on [his/her] bed. [Power of attorney] POA took Resident to Emergency Room." Surveyor reviewed a hospital discharge summary, dated 11/18/2022, documenting that Resident 4 was seen in the emergency department for suprapubic catheter dislodgement and treatment of a urinary tract infection. At 3:35 p.m., Surveyor reviewed the incident reports with Marketing H. Marketing H stated that Resident 4's POA was not activated so the provider could not sent him/her out against his/her wishes.	N 353		

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N 353	Continued From page 6 At 3:37 p.m., Surveyor interviewed Caregiver C, who documented the incident report on 11/18/2022. Caregiver C stated that when s/he came to work the next morning and saw that the catheter was not in place and s/he knew Resident 4 had an activated POA so Caregiver C notified Resident 4's activated POA and the POA took Resident 4 to the emergency room. Caregiver C provided Surveyor and Marketing H with Resident 4's POA paperwork that confirmed that Resident 4's POA became activated on 10/14/2022. Marketing H stated that the POA should have been notified and the nurse should have been called. At approximately 4:15 p.m., Surveyor reviewed the above concerns with Administrator A. Administrator A acknowledged the concern and stated s/he is aware of the issue of Resident 4 not receiving treatment until the following day after his/her catheter showed signs of infection and became dislodged.	N 353		