STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 10/13/2023 through 10/25/2023, Surveyor conducted a complaint investigation and standard survey at Terova Senior Living of Mequon. Eight deficiencies were identified. The complaint was unsubstantiated. Census: 32	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 1 of 2 employees (Housekeeper D) was screened for clinically apparent communicable disease including tuberculosis (TB).	N 220		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 1 Findings include: On 10/13/2023, Surveyor reviewed employee records and identified the following: Housekeeper D had a hire date of 06/09/2023. Housekeeper D's record did not contain documentation to show Housekeeper D was screened for clinically apparent communicable disease including TB within 90 days of starting employment. On 10/19/2023 at 3:02 PM, Surveyor interviewed Administrator A. Administrator A noted after the survey began on 10/13/2023 Housekeeper D was administered a TB test because his/her record was missing one. Administrator A did not comment why Housekeeper D's TB test was missing. Administrator A acknowledged employee TB tests need to be completed at time of hire.	N 220		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the	N 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 223	Continued From page 2 provider did not maintain documentation of training for 2 of 2 employees reviewed. The records for Caregiver B and Caregiver C did not contain documentation of completed caregiver background checks and training in orientation, all employee, task specific, and continuing education. Findings include: On 10/19/2023, Surveyor reviewed employee records and identified the following: The record for Caregiver B, hired 03/17/2023, did not contain evidence of a completed caregiver background check and training in orientation, all employee, and task specific. The record for Caregiver C, hired 10/01/2020, did not contain evidence of a completed caregiver background check and training orientation, all employee, task specific, and continuing education for 2021 & 2022. On 10/13/2023 at 9:00 AM, Surveyor interviewed Business Office Manager G. Business Office Manager G stated Management Team H took over in May 2023 and Licensee I took all previous staff files with them. Business Office Manager G stated the previous provider had him/her box all employee records and would not let anyone make any copies. On 10/13/2023 at 3:00 PM, Surveyor interviewed Administrator A. Administrator A confirmed on 05/17/2023, Management Team H took over and is operating under Licensee I's license. Administrator A stated the change of ownership is still under review by the Department.	N 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 223	Continued From page 3 Administrator A stated when Licensee I's team left, they did not leave any staff records and, "we had staff fill out new applications and training documentation." Administrator A stated his/her team had reached out to Licensee I to obtain records without success. On 10/19/2023 at 3:02 PM, Surveyor interviewed Administrator A. Surveyor attempted to reach out to Licensee I without success. Surveyor noted any documentation or evidence in the above employee record topics would need to be submitted no later than 10/25/2023 at 12:00 PM. Administrator A stated s/he would have his/her team continue to follow up with Licensee I. On 10/25/2023 at 12:24 PM, Resident Services Coordinator L provided additional employee records. Surveyor reviewed orientation, all employee, and task specific training documentation dated 05/18/2023 for Caregiver B and Caregiver C. Surveyor reviewed complete background checks dated 10/17/2023 (4 days after survey) for Caregiver B and Caregiver C. Surveyor reviewed continuing education training documentation from 2021 that noted Caregiver C completed approximately 2 hours.	N 223		
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	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 239	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 employees obtained all department approved training as required. Housekeeper D did not have training in fire safety within 90 days after starting employment. Housekeeper D did not have training in standard precautions before performing duties that may expose him/her to bodily fluids. Findings include: On 10/13/2023, Surveyor reviewed employee records and identified the following: The record for Housekeeper D, hired 06/09/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety or standard	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 239	Continued From page 5 precautions. On 10/19/2023, Surveyor verified Housekeeper D was not on the Community-Based Care and Treatment training registry for fire safety or standard precautions. On 10/19/2023 at 3:02 PM, Surveyor interviewed Administrator A. Administrator A confirmed the provider did not have evidence Housekeeper D completed or met an exemption for fire safety training and standard precautions. Administrator A did not comment to why Housekeeper D did not complete department approved training as required. Surveyor noted Housekeeper D was hired after Management Team H took over.	N 239		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by:	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 302	Continued From page 6 Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 11 and Resident 15) were screened for clinically apparent communicable disease, including tuberculosis (TB) by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days or 7 days after admission. Findings include: On 10/13/2023, Surveyor reviewed resident records and identified the following: Resident 11 was admitted on 08/03/2023. The documents provided to Surveyor from Resident 11's record did not contain the results of a TB test and a statement showing Resident 11 was free of communicable disease. Resident 15 was admitted on 06/19/2023. The documents provided to Surveyor from Resident 15's record did not contain the results of a TB test and a statement showing Resident 15 was free of communicable disease. On 10/19/2023 at 3:02 PM, Surveyor interviewed Administrator A. Administrator A stated all resident record documentation was submitted by Wellness Director F. No further comment was provided.	N 302		
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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 7	N 389		

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, interview, and record review, the individual service plan (ISP) was not updated for 1 of 2 residents reviewed (Resident 11) when there was a change in resident needs and abilities.

Resident 11's ISP was not updated when s/he had a change in transferring, fall risk status, behaviors, and services provided by outside agencies.

Findings include:

On 10/13/2023, Surveyor reviewed Resident 11's record and identified the following:

Resident 11 was admitted 08/03/2023 with diagnoses including Parkinson's, hallucinations without aggression, and neurogenerative disorder. Resident 11 had an activated healthcare power of attorney that made decisions on his/her behalf.

On 10/13/2023 9:49 AM, Surveyor observed Resident 11's bedroom. Surveyor observed a mattress on the floor next to Resident 11's bed. Resident 11 was observed curled up in bed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 8 s/he appeared confused. Resident 11's ISP dated 07/30/2023 documented: "Fall Risk: Promote safe mobility while being able to maintain independence. Intervention-Wheelchair, assure appropriate footwear, remind to use pendant, staff assistance with ADLs, encourage use of grab bars, shower bench. Transferring: Resident's transferring needs will be accommodated. Staff will offer assistance when physically transferring the resident. Therapy Services: Resident benefits from Therapy Services. Outside Agency to provide Therapy Services." The ISP did not document any concerns with behaviors or skin integrity. Resident 11's progress notes documented: "10/12/2023: [Nurse K] and hospice nurse changed the dressings on the bilateral heels where there is deep tissue injury. The R heel is larger and measures approx. 6x7 cm and has a hard shell of black eschar. L heel is smaller and has very little scabbing, mechanically debrided when dressing removed, and has healthy pink tissue. Resident continues with confusion and hallucinations. [S/he] is bedbound and not interested in getting out of bed. [S/he] is not aware that [s/he] is not able to walk. [S/he] is low bed with floor mat for safety. 10/04/2023: F/u fall 10/2. Has not left [his/her] bed, which is kept low and with a thick floor mat. 10/03/2023: F/u fall from 10/2. Incont of B&B and is a check and change each shift. Up with Hoyer lift when transferring. Alert and oriented at times, but does suffer from confusion and hallucinations. Stays in bed at low to floor setting and has a thick floor mat for safety.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 9 10/02/2023: Fall (unwitnessed) Resident heard yelling from [his/her] room. Found sitting on the floor mat, wearing nothing but a brief, leaning against the low bed. [Resident 11] was assisted in getting dressed and in getting the Hoyer sling under [his/her] body. With 3 staff, [s/he] was lifted off the floor mat and back into the bed ....[S/he/ has hallucinations, where [s/he] sees children and intrusive people that will not leave [his/her] room or come out from under [his/her] bed. 10/01/2023: Deep tissue injury on bilateral heels. Applied heel intended Mepilex dressings to the BLE feet. 09/20/2023: PRN MS04 and Lorazepam utilized at 7:30 for resident ringing pendant, yelling out help, saying there is a "man with a light under that second bed who keeps hitting my legs with a baseball bat." 09/19/2023: On hospice services ....sleeps in low bed with floor mat in place ....Up with Hoyer lift to wheelchair, but prefers to stay in bed. 09/18/2023: Resident found lying on L side on fall mat next to bed. 09/06/2023: ....Also delivered Hoyer lift, which is plugged into outlet charging in the bathroom. 08/31/2023: Resident currently talking loudly to unseen people in [his/her] room. 08/29/2023: Resident assisted into the wheelchair using Hoyer lift. A lot more display of pain offered by [Resident 11] during the rolling from side to side to get the Hoyer sling under [his/her] body. 08/22/2023: DR Visit: [S/he] discussed the hallucinations that [s/he] continues to have. [S/he] noted [Resident 11's] decline and asked that [s/he] meet up next week with [Resident 11's] [spouse] to discuss hospice and activation of the POA-HC] 08/20/2023: Heels are showing signs of pressure injury. L heal has black discoloration. Soft offloading boots donned for protection. Hoyer lift	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 10	N 389		

to the bed ....Hallucinations; states that [s/he] is seeing children in [his/her] room. Hoyer lift transferred to bed for check and change of wet brief. Body very stiff, but rolled side to side for staff.
08/13/2023: Resident possible hallucinating-reports seeing "intruders" in [his/her] room but says they are now gone. Wanting [his/her] room fumigated now that they left.
08/12/2023: Later when resident was in bed, [s/he] was heard yelling out "Help me", and when checked on, wanted writer to "get those people out of my bed." Believed there was (sic) 3 people in bed with [him/her]. "My bed is made for only one, not for four." Had difficulty believing writer that there wasn't anybody in but [him/her].
08/10/2023: Hoyer lift to the wheelchair with no issues.
08/09/2023: Documented by [Nurse K]-Resident has fear of falling when transferring. [Resident 11] is also a very hard 2 person transfer. Hoyer lift sling was placed in residents room. The Hoyer lift was how [s/he] was transferred in the last facility [s/he] lived in. This was explained to [him/her] and [s/he] agreed that this would be good.
08/05/2023: Restless at night. Possibility of hallucinating-staff were assisting other residents on [his/her] hallway. Resident had difficulty expressing who or what [s/he] heard.
08/03/2023: [Resident 11] arrived at 11am with family meeting [him/her] at the facility and helping [him/her] with the move in ....Diagnosis: ..abnormalities of gait (2 person transfer with stand pivot sit), hallucinations."

Resident 11's evacuation assessment dated 08/03/2023 documented:
"New move in to Marcus Park. Hard 2 person transfer to wc with stand pivot transfer."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 11 Resident 11's record did not contain an updated ISP when s/he had a change in needs requiring the use of Hoyer lift, the use of a fall mattress, displaying ongoing hallucinations, skin integrity concerns when pressure injuries were discovered on 8/20/2023, and description of roles/responsibilities with hospice/wound care agency. On 10/13/2023 at 9:11 AM, Surveyor interviewed Caregiver B regarding resident care plans. Caregiver B stated s/he can bring up resident care plans on the computer and this is what staff use to care for residents. On 10/19/2023 at 3:02 PM, Surveyor discussed concern of Resident 11's ISP not being updated when s/he had a change in needs with Administrator A. Administrator A stated nursing staff are in charge of updating resident ISPs so s/he would need to follow up. Administrator A did not comment further regarding Resident 11's ISP not being updated when s/he had a change in needs/abilities.	N 389		
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 that employees followed hand washing procedures in accordance with the Centers for Disease Control and Prevention (CDC) standards. Caregiver B was not observed to conduct hand	N 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 441	Continued From page 12	N 441		

hygiene during the morning and lunch medication pass, from approximately 8:54 AM-9:11 AM and 11:24 AM-11:47 AM, which included administering medications to 9 residents.

Findings include:

The provider is licensed to care for 38 residents in the client groups physically disabled, terminally ill, advanced aged and irreversible dementia/Alzheimer's disease.

On 10/13/2023 at 8:54 AM, Surveyor began observing Caregiver B during the morning medication pass. Between 8:54 AM-9:11 AM, Surveyor observed Caregiver B administer medications from the medication cart to 3 residents in the dining room, including Resident 7, Resident 8, and Resident 9. Surveyor observed Caregiver B prepare medications by grabbing medication cups from the stack, pouring water into a small cup, using keys to unlock/lock the medication cart, retrieve medication cards from the cart drawers, and pop medications into medication cups for residents. Between 8:54 AM-9:11 AM, Caregiver B was not observed to conduct hand hygiene.

On 10/13/2023 at 9:11 AM, Surveyor interviewed Caregiver B regarding hand hygiene. Caregiver B noted when s/he was hired training was not provided in hand hygiene. Caregiver B stated the provider's training was short and staff are expected to care for residents.

On 10/13/2023 at 11:24 AM, Surveyor began observing Caregiver B during the lunch medication pass. Between 11:24 AM-11:47 AM, Surveyor observed Caregiver B administer medications from the medication cart to 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 441	Continued From page 13 residents in the dining room, including Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6. Surveyor observed Caregiver B prepare medications by grabbing medication cups from the stack, pouring water into a small cup, using keys to retrieve medication cards from the cart drawers, and pop medications into medication cups for residents. Surveyor observed Caregiver B administer Resident 5's eye drops without any gloves on. At 11:36 AM, Surveyor observed Caregiver B donning gloves to prepare to test Resident 6's blood sugar. After doffing the gloves, Caregiver B moved to clean up his/her medication cart and assist residents with lunch. Between 11:24 AM-11:47 AM, Caregiver B was not observed to conduct hand hygiene. Throughout the observation period, Caregiver B left the medication cart unlocked and left the computer screen on top of the medication cart open, displaying resident information while visitors walked past. On 10/19/2023 at 3:02 PM, Surveyor interviewed Administrator A. Administrator A acknowledged the concern and stated the provider conducted in-services on hand hygiene and will continue until all staff are retrained. Cross Reference: N0481 DHS 83.43(1) Environment, Safe, Clean, And Comfortable	N 441		
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,	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 452	Continued From page 14 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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary conditions for the prevention of food borne illnesses. Findings include: On 10/13/2023 at 9:35 AM, Surveyor toured the facility and observed the following: Marcus Park: In the kitchenette off the backside of the dining room, Surveyor observed in cabinets- 1 gallon container of peanut butter (approximately ¼ full) was unsealed and 1 (64 oz) glass jar of opened concord grape jelly (approximately ¾ full) noted "refrigerate after opening," In the kitchen near the front of unit, a refrigerator contained 4 small containers of strawberry shortcake dessert unsealed and undated.	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 452	Continued From page 15 Memory Care: In the kitchenette cabinets, Surveyor observed an opened bag of Chex cereal was not sealed or dated. Enhanced Care: In the refrigerator, Surveyor observed a left-over container of what appeared to be chili and a hot dog. The container was undated. Inside the door of the refrigerator, observed 1 (46 oz) box container of orange juice (approximately ¼ full) undated. On 10/19/2023 at 3:02 PM, Surveyor interviewed Administrator A. Administrator A acknowledged food items in the refrigerator and dry food storage needed to be sealed and/or dated. Administrator A stated s/he would retrain staff.	N 452		
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 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 the environment was safe, clean, and comfortable. Findings include:	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 481	Continued From page 16 On 10/13/2023 at 9:35 AM, Surveyor toured the environment, which included 2 units (Marcus Park and Memory Care) in the same facility and observed the following: Example 1-Environment: Marcus Park: In the kitchenette off the backside of the dining room, Surveyor observed a bowl of salsa spilled on the countertop and dried salsa splattered down the cupboards to the floor. Inside a cupboard was a garbage bin with waste items inside and no liner. Inside another cupboard, Surveyor observed a garbage bin without a liner. -Resident 1's bedroom contained 2 plastic bags of soiled briefs laying on the floor. Resident 1's toilet bowl was covered in urine and bowel movement (BM). -At 9:45 AM, Surveyor observed a collected urine specimen sitting on Resident 10's dresser. At 11:14 AM, Surveyor observed the same urine specimen still sitting on Resident 10's dresser. -Observed near exit door 18, a garbage bin with waste items inside and no liner. -Resident 8's bedroom contained 2 garbage bins with waste items inside and no liners. -Resident 6's bedroom contained 1 garbage bin with waste items inside and no liner. -Resident 12's bedroom contained 2 garbage bins with waste items inside and no liners. The drywall around the toilet was discolored and chipped.	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 481	Continued From page 17 In the small kitchen near the front of the unit, Surveyor observed food crumbs and garbage scattered across the floor. The sink had a layer of dirt and hard water crusted in a circular area near the drain. Memory Care: Outside of Resident 13's bedroom, Surveyor observed 1 laundry bin with soiled clothing and 1 garbage bin without a liner. No caregivers were observed completing laundry tasks. At 10:16 AM, while touring the medication cart, Surveyor observed 2 over the counter medications (stool softener and melatonin) without a label, but with the notation "2411." Director of Wellness F stated those are Resident 14's medications and his/her spouse is a resident of the RCAC, so s/he brings those medications to Resident 14. Director of Wellness F stated s/he would provide reeducation to Resident 14's spouse. Example 2: Safety On 10/13/2023 at 10:09 AM, Surveyor toured the memory care unit and observed 1 of 2 medication carts unlocked. Caregiver E was feeding a resident during the observation. Caregiver E confirmed s/he was the medication passer for the unit. Surveyor asked how long the medication cart had been unlocked for. Caregiver E stated s/he did not know the cart was unlocked. On 10/13/2023 at 11:24 AM, Surveyor began observing Caregiver B during the lunch medication pass of Marcus Park. Between 11:24 AM-11:47 AM, Caregiver B was not observed to	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 481	Continued From page 18 conduct hand hygiene. Throughout the observation period, Caregiver B left the medication cart unlocked and left the computer screen on top of the medication cart open, displaying resident information while visitors walked past. On 10/19/2023 at 3:02 PM, Surveyor interviewed Administrator A. Surveyor noted observing inside garbage bins without liners, used medication cups, soiled briefs, personal care items and above mentioned findings. Administrator A acknowledged staff should be using liners inside garbage bins. Administrator A confirmed staff leaving the medication cart unlocked when not in use was against their policy. Administrator A stated ongoing retraining had taken place. Cross Reference: N0441 DHS 83.39(3) Hand Washing	N 481		