STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110210	A. BUILDING: _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WRIGHT HOME	637 N WRIGHT RD JANESVILLE, WI 53546

(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 12/11/2023, Surveyor conducted a standard survey at Wright Home. Fifteen deficiencies were identified. Census: 8	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 record review and interview, the provider did not report a serious injury resulting in emergency room treatment to the Department within 3 working days. Resident 2 sustained 2 falls on 10/12/2023 and 10/31/2023 that resulted in him/her receiving staples. Findings include: On 12/11/2023, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted on 02/15/2022 with diagnoses including schizoaffective disorder, obsessive compulsive disorder, and anxiety. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2's hospital discharge summary dated 10/12/2023 documented:	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		

"Reason for visit: Fall, Head Laceration
Diagnoses: Injury of head, initial encounter, Laceration of scalp, fall.
Follow up with hospital and trauma center in 1 week (around 10/19/2023)
Why: For suture removal."

Resident 2's incident report dated 10/31/2023 documented:
"[Resident 2] was in room trying to put coat on, lost balance and fell backwards, staff was in the kitchen on my way to [him/her]. Called 911 to help [him/her]. Picked up by ambulance. Location of injury-head. What is the injury?-Busted head open in back."
A review of Resident 2's hospital discharge summary dated 10/31/2023 documented:
" ...presented to emergency department (ED) at 1430 with head laceration with extensive bleeding following a witnessed fall at [his/her] group home of thirty years. ...Head lac hematoma "arterial level bleed." Bleeding controlled in ED with extensive management. Staples placed ....Up to 1 L bleed from scalp lesion. Recent ED visit was October 12 for fall with head laceration as well."

On 12/11/2023, Surveyor reviewed Department records, which indicated no self-reports were submitted regarding Resident 2's laceration/staples on 10/12/2023 and 10/31/2023.

On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated s/he did not submit a self-report for Resident 2's falls with injury. Administrator B stated s/he was unaware this was a requirement. Administrator B stated s/he will review reporting requirements for the future.

Cross Reference:

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N 165	Continued From page 2 N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 165		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not prohibit the existence of a condition which may create substantial risk to the welfare of residents. The provider's fire detection system had not been operational for at least a month without attempts to be repaired. Findings include: On 12/11/2023 at 9:00 AM, Surveyor entered the facility to conduct a standard survey. Surveyor observed Resident 2 sitting in a wheelchair at the dining room table. Surveyor reviewed the provider's program statement which documented: "The facility is a class A-(Semi-Ambulatory) and will accommodate eight residents. Admissions Policy: ....At least one staff person is on duty at all times. The provider can admit ambulatory and semi-ambulatory people who are capable of taking independent action for their own safety in an emergency situation. Our residents must be able to evacuate the facility within 2 minutes	N 205		

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N 205	Continued From page 3	N 205		

without any help or prompting."

On 12/11/2023 at 9:05 AM, Surveyor interviewed Licensee A. Licensee A stated Resident 2 just started using a wheelchair this past Friday due to being weak and unsteady with his/her walker. Licensee A stated the provider consulted with Resident 2's hospice team and they recommended the wheelchair for the time being. Licensee A acknowledged the provider is not supposed to have any admissions who operate a wheelchair per their license. Licensee A stated the provider was hopeful Resident 2 would rebound and start using his/her walker in the short term.

On 12/11/2023 at 9:32 AM, Surveyor toured the provider's environment including 8 resident bedrooms. During the survey, the Surveyor noticed each smoke detector and heat detector was not illuminated indicating it was not functional. Surveyor observed the provider's fire annunciator on the first floor just outside the kitchen. The annunciator was off and not functioning.

On 12/11/2023 at 9:40 AM, Surveyor interviewed Licensee A and asked about the provider's fire detection system. Licensee A stated the fire detection system had not been working for at least the last month. Licensee A stated if the fire detection system is plugged in, it will read an error message and also will trigger the alarm until unplugged. Surveyor asked Licensee A if s/he had called their fire safety contractor to address the issue. Licensee A stated "no", we wanted to try some other things before going that route.

On 12/11/2023 at 10:21 AM, Surveyor interviewed Administrator B regarding the provider's fire

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N 205	Continued From page 4	N 205		

detection system. Administrator B confirmed the fire detection system had not been working for at least a month. Administrator B stated the provider had their fire inspection completed in early November 2023 and told the inspector s/he would have their fire detection system inspected immediately. Surveyor asked if an updated 2023 fire detection inspection was completed. Administrator B stated "no, we wanted to try a few additional things, before going that route." Administrator B stated his/her husband/wife was the maintenance person for the facility and s/he was going to try to figure out the problem. Administrator B took the Surveyor downstairs to the basement to the see the provider's fire panel. Surveyor observed a fire panel that was not plugged in or functioning. Administrator B demonstrated plugging in the fire detection system and right away an alarm was triggered throughout the home. Administrator B stated the provider is having money issues and does not know how it would come up with the funds to repair the system.

Surveyor reviewed the provider's annual fire detection system inspection dated 11/14/2022 which documented the provider had 20 smoke detectors, 8 heat detectors, and 6 pull stations throughout the facility.

On 12/11/2023 at 11:00 AM, Surveyor interviewed Licensee A about staffing for each shift. Licensee A stated the provider staff's each shift with 1 caregiver. Licensee A stated staff on the 3rd shift are allowed to sleep if all of their duties are completed. Licensee A stated s/he worked last night and s/he slept from 2:30 AM-5:30 AM. Licensee A stated each staff member is different depending on how fast they complete their work, and will lay in a recliner chair in the living room.

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N 205	Continued From page 5 Licensee A stated no residents during the 3rd shift required supervision, behaviors, or unstable health conditions that required close monitoring. Surveyor asked about Resident 2, since s/he was on hospice. Licensee A stated the provider had been operating like this for years. Surveyor asked since the fire detection system was not working, are staff still sleeping on the 3rd shift. Licensee A stated "yes", but staff position themselves in the living room, which they can hear any concerns from both ends of the house. Cross Reference: N0535 DHS 83.48(1)(b) Smoke And Heat Detectors Per Nfpa 72 N0538 DHS 83.48(3)(a) Fire Detections Systems Inspected Annually	N 205		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by:	N 219		

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N 219	Continued From page 6 Based on record review and interview, the provider did not ensure complete background checks were conducted upon hired for 2 of 2 employees reviewed. The complete background check is to include the background information disclosure form (BID), the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS). Findings include: On 12/11/2023, Surveyor reviewed employee records and identified the following: -Caregiver D was hired on 12/04/2022 and his/her record included a DOJ and IBIS letter dated 02/07/2023 (over 2 months after hire). -Caregiver E was hired in May 2023 and his/her record did included a DOJ and IBIS letter dated 12/12/2023 (day after survey). On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated s/he is in charge of conducting background checks for employees. Administrator B stated s/he does not think s/he ran background checks for Caregiver D and Caregiver E in a timely manner but wanted to check at the office. Administrator B stated due to the ongoing staffing challenges somethings are being missed. Surveyor and Administrator B agreed if background checks for Caregiver D and Caregiver E existed, they would need to be submitted no later than 12/12/2023 at 12:00 PM.	N 219		

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N 219	Continued From page 7 As of 12/12/2023, no background checks were submitted that were completed upon hire for Caregiver D and Caregiver E.	N 219		
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 2 of 2 employees (Caregiver D and Caregiver E) was screened for clinically apparent communicable disease including tuberculosis (TB). Findings include: On 12/11/2023, Surveyor reviewed employee records and identified the following: Caregiver D had a hire date of 12/04/2022.	N 220		

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N 220	Continued From page 8 Caregiver D's record did not contain documentation to show Caregiver D was screened for clinically apparent communicable disease including TB within 90 days of starting employment. Caregiver E had a hire date of May 2023. Caregiver E's record did not contain documentation to show Caregiver E was screened for clinically apparent communicable disease including TB within 90 days of starting employment. On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated s/he is in charge of conducting TB tests and communicable disease screens for employees. Administrator B stated s/he does not think s/he completed TB tests on staff, but wanted to check at the office. Administrator B stated due to the ongoing staffing challenges somethings are being missed. Surveyor and Administrator B agreed TB tests and communicable disease screens for Caregiver D and Caregiver E existed, they would need to be submitted no later than 12/12/2023 at 12:00 PM. As of 12/12/2023, no TB tests or communicable disease screens were submitted for Caregiver D and Caregiver E.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and	N 230		

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N 230	Continued From page 9 misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees obtained training which shall include the following: job responsibilities; prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; CBRF policies and procedures; recognizing and responding to resident changes of condition. Findings include: On 12/11/2023, Surveyor reviewed employee records and identified the following: The record for Caregiver D, hired 12/04/2022, did not contain evidence of any of the above orientation training topics. The record for Caregiver E, hired May 2023, did not contain evidence of any of the above orientation training topics. On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated s/he is in charge of training new staff.	N 230		

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N 230	Continued From page 10 Administrator B stated s/he does not think orientation training was documented. Administrator B stated due to the ongoing staffing challenges something's are being missed. Surveyor and Administrator B agreed if orientation training existed for Caregiver D and Caregiver E, documentation would need to be submitted no later than 12/12/2023 at 12:00 PM. As of 12/12/2023, no orientation training was submitted for Caregiver D and Caregiver E. Cross Reference: N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0243 DHS 83.21(1)-(3) All Employee Training	N 230		
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	N 239		

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N 239	Continued From page 11 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 2 of 2 employees reviewed obtained all department approved training as required. Caregiver D did not have training in standard precautions or fire safety within 90 days after starting employment. Caregiver E did not have training in fire aid and choking within 90 days after starting employment. Findings include: On 12/11/2023, Surveyor reviewed Caregiver D's and Caregiver E's record to verify compliance with department approved training requirements. Surveyor requested training records from Administrator B. Standard Precautions The record for Caregiver D, hired 12/04/2022, did not contain evidence of training or evidence of meeting an exemption for standard precautions. Fire Safety The record for Caregiver D, hired 12/04/2022, did not contain evidence of training or evidence of meeting an exemption for fire safety.	N 239		

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N 239	Continued From page 12 On 12/11/2023, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for standard precautions or fire safety. First Aid and Choking The record for Caregiver E, hired May 2023, did not contain evidence of training or evidence of meeting an exemption for First Aid and Choking. On 12/11/2023, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for first aid and choking. On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated due to ongoing staffing challenges, staff are not completing their CBRF training requirements within 90 days. Administrator B stated s/he would work on getting Caregiver D and Caregiver E signed up for the classes they required. Cross Reference: N0230 DHS 83.19 Orientation N0243 DHS 83.21(1)-(3) All Employee Training	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61	N 243		

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N 243	Continued From page 13 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 2 employees	N 243		

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N 243	Continued From page 14 reviewed completed training in all employee training. Caregiver D and Caregiver E did not have documentation for completion of training in resident rights, client groups or challenging behaviors. Findings include: On 12/11/2023, Surveyor conducted a review of 2 employees to verify compliance with all employee training requirements. Surveyor requested training records from Administrator B. Resident Rights: The record for Caregiver D, hired 12/04/2022, did not contain evidence of training or evidence of meeting an exemption for resident rights. The record for Caregiver E, hired May 2023, did not contain evidence of training or evidence of meeting an exemption for resident rights. Client Group: The record for Caregiver D, hired 12/04/2022, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver E, hired May 2023, did not contain evidence of training or evidence of meeting an exemption for client group training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors: The record for Caregiver D, hired 12/04/2022 did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.	N 243		

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N 243	Continued From page 15 The record for Caregiver E, hired May 2023, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated s/he is in charge of training new staff. Administrator B stated s/he does not think all employee training was completed, but s/he wanted to check at the office where records are kept. Administrator B stated due to the ongoing staffing challenges something's are being missed. Surveyor and Administrator B agreed if all employee training existed for Caregiver D and Caregiver E, documentation would need to be submitted no later than 12/12/2023 at 12:00 PM. Cross Reference: N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses	N 243		
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.	N 381		

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N 381	Continued From page 16	N 381		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure an assessment of Resident 2's physical and mental condition was completed when there was a change in needs.

Resident 2 was not re-assessed when s/he experienced repeated falls with injury.

Finding include:

On 12/11/2023, Surveyor reviewed Resident 2's record and identified the following:

Resident 2 was admitted on 02/15/2022 with diagnoses including Schizoaffective disorder, obsessive compulsive disorder, and anxiety. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf.

Resident 2's individual service plan (ISP) dated 03/14/2023 did not document Resident 2 as a fall risk or include any interventions to mitigate this risk.

Resident 2's hospital discharge summary dated 10/12/2023 documented:
"Reason for visit: Fall, Head Laceration
Diagnoses: Injury of head, initial encounter, Laceration of scalp, fall.
Follow up with hospital and trauma center in 1 week (around 10/19/2023)
Why: For suture removal."

Resident 2's incident report dated 10/22/2023 documented:
"[S/he] was trying to get up out [his/her] chair and fell and hit [his/her] head. It was no injuries.

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Paramedics was called to pick [him/her] up. [S/he] was okay. Location of injury-head. What is the injury?-No injury."

Resident 2's incident report dated 10/31/2023 documented:
"[Resident 2] was in room trying to put coat on, lost balance and fell backwards, staff was in the kitchen on my way to [him/her]. Called 911 to help [him/her]. Picked up by ambulance. Location of injury-head. What is the injury?-Busted head open in back."
A review of Resident 2's hospital discharge summary dated 10/31/2023 documented:
" ...presented to emergency department (ED) at 1430 with head laceration with extensive bleeding following a witnessed fall at [his/her] group home of thirty years. ...Head lac hematoma "arterial level bleed." Bleeding controlled in ED with extensive management. Staples placed ....Up to 1 L bleed from scalp lesion. Recent ED visit was October 12 for fall with head laceration as well."

Resident 2's progress notes documented:
"11/28/2023: [S/he] almost fell to walker in [his/her] room by leaning to the right, but staff was able to steady [him/her]."

Resident 2's progress notes did not include a fall assessment.

On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated the provider did not complete an assessment after Resident 2 continued to experience falls with injury. Administrator B stated Resident 2 was admitted to hospice services on 11/07/2023, and since then has not had any falls with injury. Surveyor asked if any interventions were put in place after Resident 2's falls in

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N 381	Continued From page 18 October 2023. Administrator B stated "no, we did not know we had too." Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury	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 interview the provider did not ensure all Individual Service Plans (ISP) had been signed by the responsible parties. One of 2 residents reviewed did not contain the required signatures. Findings include:	N 387		

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N 387	Continued From page 19 On 12/11/2023, Surveyor reviewed resident records and identified the following: Resident 3 was admitted on 12/27/2023 with diagnoses including Schizophrenia, delusional disorder, personality disorder, and Parkinson's. Resident 3 had a guardian that made decisions on his/her behalf. Resident 3's record contained an ISP dated 01/26/2023. The ISP did not include a signature from Resident 3's guardian. On 12/11/2023 at 1:15 PM, Surveyor interviewed License A and Administrator B. Administrator B acknowledged Resident 3's ISP was missing the required signatures. Administrator B stated Resident 3's guardian had been changing lately since his/her guardian of many years retired. Administrator B stated the only reason they were updated about the changes were from Resident 3's managed care organization.	N 387		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action.	N 404		

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N 404	Continued From page 20 When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on interview and record review, the provider did not arrange on an annual basis, for a physician, pharmacist, or registered nurse to conduct an on-site review of the CBRF's medication administration and medication storage systems for 2022 and 2023. Findings include: On 12/11/2023, Surveyor conducted a standard survey and asked Administrator B for the annual reviews of the medication administration and storage reviews for 2022 and 2023. The provider did not have evidence of the medication administration and storage review for 2022 and 2023. On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B stated the provider did not complete annual medication storage and medication storage system reviews for 2022 and 2023. Administrator B stated s/he was unaware of this requirement.	N 404		
N 423	83.37(3)(g) Medication storage: controlled substances. Controlled substances. The CBRF shall provide	N 423		

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N 423	Continued From page 21 separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 1's Morphine was in a separately locked area within the locked medications area for storage of scheduled II drugs. Findings include: On 12/11/2023 at 9:59 AM, Surveyor toured the provider's medication cabinet. Surveyor observed Resident 1's medications, which included a medication pill bottle with 10 tablets of Morphine Sulfate 15mg with a dispensed date of 10/30/2023. Licensee A stated Resident 1 was on hospice and s/he knows Morphine is a controlled substance and should have been secured in a separately locked area within the medication cabinet. Licensee A stated s/he just had gone through the medication cabinet the day before and must had missed Resident 1's Morphine. On 12/11/2023 at 1:15 PM, Surveyor interviewed Licensee A and Administrator B regarding the above concern. Licensee A and Administrator B acknowledged the concern and stated they will ensure all schedule II drugs are stored in a separately locked area within the medication cabinet going forward.	N 423		

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N 427	Continued From page 22	N 427		
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, record review and interview, the provider did not ensure leisure activities appropriate to resident needs. There were no activities were observed on day of survey. Findings include: On 12/11/2023 at 9:00 AM-1:15 PM, Surveyor did not observe any activities being offered to residents. Surveyor observed residents in their room or watching TV in the living room. Surveyor observed an activity calendar dated June 2022. On 12/11/2023 at 9:30 AM, Surveyor interviewed Resident 3. Resident 3 stated they use to offer activities such as bingo and cards, but "they have not offered activities in a long time." Resident 3	N 427		

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N 427	Continued From page 23 stated residents usually spend time in their rooms or can watch TV in the living room. On 12/11/2023 at 11:00 AM, Surveyor interviewed Licensee A regarding activities. Licensee A stated the provider used to offer activities when staffing was better, but has gotten away from offering activities on a daily basis. Licensee A acknowledged residents should be offered activities daily. Licensee A stated the current activity calendar from June 2022 was around the time the provider stop offering activities daily. Licensee A reiterated staffing issues as the concern.	N 427		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observations and interview, the provider did not have planned or posted menus readily available to the residents. Findings include: On 12/11/2023 at 9:59 AM, Surveyor toured the kitchen and dining room. Surveyor did not observe a menu posted or menu readily available to residents. On 12/11/2023 at 1:30 PM, Surveyor observed	N 450		

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N 450	Continued From page 24 the provider's refrigerator and observed breakfast written on a daily menu. Surveyor did not observe lunch or dinner filled out. Surveyor observed lunch being served to residents at 12:00 PM. On 12/11/2023 at 1:32 PM, Surveyor interviewed Caregiver C regarding the missing menu. Caregiver C stated the facility does not use a menu and instead try to plan a daily menu based off what food is available. On 12/11/2023 at 1:35 PM, Surveyor interviewed Licensee A. Licensee A confirmed the facility does not use a menu and caregivers cook what food is available. Licensee A stated due to ongoing staffing changes, the menu is being overlooked. Licensee A stated s/he would like to see staff at least create a daily menu 24 hours before the next meal. Licensee A stated s/he will work with staff to create a daily menu.	N 450		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the smoke	N 535		

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N 535	Continued From page 25 and heat detectors were maintained in accordance with the National Fire Alarm Code (NFPA 72). This had the potential to affect 8 residents in the facility. Findings include: The provider is licensed as a class AS (semi-ambulatory) community based residential facility (CBRF) to care up to 8 residents in the following client groups: physically disabled, advanced age, irreversible dementia/Alzheimer's, developmentally disabled, traumatic brain injury, and emotionally disturbed/mental illness. On 12/11/2023, Surveyor conducted a standard survey and identified the following: On 12/11/2023 at 9:32 AM, Surveyor toured the provider's environment including 8 resident bedrooms. During the survey, the Surveyor noticed each smoke detector and heat detector was not illuminated indicating it was not functional. Surveyor observed the provider's fire annunciator on the first floor just outside the kitchen. The annunciator was off and not functioning. On 12/11/2023 at 9:40 AM, Surveyor interviewed Licensee A and asked about the provider's fire alarm system. Licensee A stated the fire alarm system had not been working for at least the last month. Licensee A stated if the alarm system is plugged in, it will read an error message and also will trigger the alarm until unplugged. Surveyor asked Licensee A if s/he had called their fire safety contractor to address the issue. Licensee A stated "no", we wanted to try some other things before going that route.	N 535		

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N 535	Continued From page 26 On 12/11/2023 at 10:21 AM, Surveyor interviewed Administrator B regarding the provider's fire alarm system. Administrator B confirmed the fire alarm system had not been working for at least a month. Administrator B stated the provider had their fire inspection completed in early November 2023 and told the inspector s/he would have their fire alarm system inspected immediately. Surveyor asked if an updated 2023 fire alarm inspection was completed. Administrator B stated "no, we wanted to try a few additional things, before going that route." Administrator B stated his/her husband/wife was the maintenance person for the facility and s/he was going to try to figure out the problem. Administrator B took the Surveyor downstairs to the basement to the see the provider's fire panel. Surveyor observed a fire panel that was not plugged in or functioning. Administrator B demonstrated plugging the fire alarm system in and an alarm was triggered right away throughout the home. Administrator B stated the provider is having money issues and does not know how it would come up with the funds to repair the system. Surveyor reviewed the provider's smoke and heat annual inspection dated 11/14/2022 which documented the provider had 20 smoke detectors, 8 heat detectors, and 6 pull stations throughout the facility. The provider did not ensure the smoke and heat detectors were maintained in accordance with NFPA 72. The provider's fire alarm system had not been functioning for at least a month and as of 12/11/2023, repairs had not been completed. Cross Reference: N0538 DHS 83.48(3)(a) Fire Detections Systems Inspected Annually	N 535		

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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 interview, the provider did not ensure the facility's fire detection system was inspected, cleaned and tested annually by certified or trained and qualified personnel. The facility had not had an inspection of the fire detection system in 2023. Findings include: On 12/11/2023 at 9:32 AM, Surveyor requested documentation of the provider's environmental records, including fire detection systems inspections completed in the past 2 years from Administrator B. Surveyor reviewed the provider's smoke and heat annual inspection dated 11/14/2022. Surveyor was unable to locate documentation of fire detection inspection for year 2023. On 12/11/2023 at 1:15 PM, Surveyor discussed the above concern with Licensee A and Administrator B. Administrator B confirmed a 2023 fire detection system inspection was not completed. Administrator B stated due to the fire detection system not functioning right now, the provider was worried where the funds would come from to repair the issue along with the annual inspection. Surveyor expressed concern	N 538		

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N 538	Continued From page 28 about the current status of the provider's fire detection system and lack of annual inspection not completed. Administrator B acknowledged an understanding of the concerns and noted they would be calling their fire safety contractor today. Cross Reference: N0535 DHS 83.48(1)(b) Smoke And Heat Detectors Per Nfpa 72	N 538		