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 _____	R 04/17/2024

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 04/17/2024, Surveyor conducted a verification visit at Wright Home. Eight deficiencies were identified. Three of 8 deficiencies were repeat violations. See Statement of Deficiency (SOD) #YGW211, dated 12/11/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider and its operation did not comply with all laws governing the Community-Based Residential Facility (CBRF). As a result of a verification survey, 8 deficiencies were identified. Three of 8 deficiencies were repeat violations. Findings include: On 04/10/2024, Surveyor initiated a verification survey. The survey resulted in 8 deficiencies. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.14(2)(h) Postings: License, Deficiencies, Revocation	N 196		

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

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N 196	Continued From page 1 83.17(1) Licensee Conduct Caregiver Background Check (repeat) 83.17(2)(a) Employees Screened For Communicable Disease (repeat) 83.27(2)(a) Admission Compatible With The License Class 83.31(4)(c) Involuntary Discharge Notice Requirement 83.37(1)(j) Proof-Of-Use Record 83.48(1)(b) Smoke And Heat Detectors Per Nfpa 72 (repeat) On 04/10/2024, Surveyor reviewed department documents and identified the provider was issued SOD YGW211, dated 12/11/2023 on 01/24/2024. Along with the SOD was the Notice and Order Letter, which identified Special Orders. The letter stated "1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to promote each resident's right to live in a safe, clean, comfortable, and homelike environment. The licensee shall resolve each additional environmental issue identified in Statement of Deficiency (SOD) YGW211. Potential health or safety hazards will be addressed immediately. The licensee will file and retain records (i.e., maintenance, purchase, and repair records) to verify that the environmental problems described in SOD YGW211 has been corrected. Acceptable documentation may include invoices, receipts, service reports, or contracts. WITHIN 45 DAYS of receipt of this notice, the licensee shall obtain and submit evidence of an inspection to the Assisted Living Regional Director at the Southern Regional Office at DHSDQABALSRO@dhs.wisconsin.gov for the fire detection system per Wis. Admin. Code §	N 196		

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N 196	Continued From page 2 DHS 83.48(3)(a). 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 5 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each resident with a copy of Statement of Deficiency YGW211 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request." On 04/10/2024 at 11:17 AM, Surveyor interviewed Administrator B. Surveyor expressed concern for ongoing issues with the provider's fire detection system. Administrator B acknowledged the 1st floor annunciator had stopped working during the survey. Administrator B stated s/he would be calling the provider's fire safety contractor right after the survey. Surveyor asked Administrator B if s/he had evidence the Special Orders contained in the Notice and Order letter dated 01/24/2024 were followed. Administrator B stated s/he never submitted documentation the fire detection system was fixed and notification to legal representatives was done verbally. Administrator B stated acknowledged s/he did not follow Special Orders contained in SOD YGW211.	N 196		
N 203	83.14(2)(h) Posting: license, deficiencies, revocations The licensee shall post the CBRF license, any statement of deficiency, notice of revocation and	N 203		

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N 203	Continued From page 3	N 203		

any other notice of enforcement action in a public area that is visually and physically available. A statement of deficiency shall remain posted for 90 days following receipt. Notices of revocation and other notices of enforcement action shall remain posted until a final determination is made.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not post the survey results from statement of deficiency (SOD) YGW211, issued on 01/24/2024.There was no posting or notice indicated where survey results were located.

Findings include:

On 04/10/2024, Surveyors conducted a verification visit and identified the following:

On 01/24/2024, SOD YGW211 and a Notice and Order letter were issued to the provider via email with the following deficiencies: 83.12(4)(c) Reporting Incidents With Serious Injury, 83.14(2)(j) Not Permit A Condition Of Substantial Risk, 83.17(1) Licensee Conduct Caregiver Background Check, 83.17(2)(a) Employees Screened For Communicable Disease, 83.19 Orientation, 83.20(2)(a)-(d) Department-Approved Training Courses, 83.21(1)-(3) All Employee Training, 83.35(1)(a) Pre-Admission And Ongoing Assessments, 83.35(3)(b) Service Plans Development: Parties Involved, 83.37(1)(e) Medication Regimen, Administration Review, 83.37(3)(g) Medication Storage: Controlled Substance, 83.38(1)(c) Leisure Time Activities, 83.41(2)(c) Nutrition: Menus, 83.48(1)(b) Smoke And Heat Detectors Per Nfpa 72, 83.48(3)(a) Fire Detections Systems Inspected Annually.

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N 203	Continued From page 4 The Department issued a posting of notices that included the following information: "According to Wis. Admin. Code DHS 83.13(3)(a) and 83.12(2)(h), each facility shall immediately upon receipt post next to its CBRF license, and in a public area that is visually and physically available, any citation/statement of deficiency, notice of revocation, notice of non-renewal, and any other notices of enforcement action. Citations and statements of deficiency shall remain posted for ninety (90) days following receipt. Notices of revocation, non-renewal, and other notices of enforcement action shall remain posted until a final determination is made." On 04/10/2024 at 9:45 AM, Surveyor conducted a tour of the facility. Surveyor could not locate a posting of the previous SOD YGW211. Surveyor asked Administrator B if s/he could show the Surveyor where the SOD was located. Administrator B could not locate the previous SOD. On 04/10/2024 at 11:17 AM, Surveyor conducted an exit conference and shared findings with Administrator B. Administrator B stated s/he recently took the SOD down to complete corrective actions and forgot to put it back up. Administrator B acknowledged the posting of notices should have remained posted for 90 days.	N 203		
{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	{N 219}		

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{N 219}	Continued From page 5 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: Based on record review and interview, the provider did not ensure complete background checks were conducted upon hired for 1 of 1 employee 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). This is a repeat deficiency. See Statement of Deficiency (SOD) YGW211, dated 12/11/2023. Findings include: On 04/10/2024, Surveyor reviewed employee records and identified the following: -Caregiver F was hired 03/29/2024 and his/her record did not include a BID form, DOJ, and IBIS letter. On 04/10/2024 at 11:17 AM, Surveyor interviewed	{N 219}		

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{N 219}	Continued From page 6 Administrator B. Administrator B stated s/he did not conduct a BID or DOJ background check on Caregiver F because s/he is still in training. Administrator B noted ongoing staffing issues are leading to requirements being missed. Administrator B acknowledged s/he should had Caregiver F at least complete a BID during on-boarding process.	{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 1 of 1 employee (Caregiver F) reviewed was screened for clinically apparent communicable disease including tuberculosis (TB). This is a repeat deficiency. See Statement of	{N 220}		

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{N 220}	Continued From page 7 Deficiency (SOD) YGW211, dated 12/11/2023. Findings include: On 04/10/2024, Surveyor reviewed employee records and identified the following: -Caregiver F had a hire date of 03/29/2024. Caregiver F's record did not contain documentation to show Caregiver F was screened for clinically apparent communicable disease including TB within 90 days of starting employment. On 04/10/2024 at 11:17 AM, Surveyor interviewed Administrator B. Administrator B stated Caregiver F was still in training but s/he was providing cares and helping residents with rewrapping wounds. Administrator B confirmed s/he did not complete TB tests or communicable disease screen for Caregiver B. Administrator B stated due to ongoing staffing challenges something are being missed.	{N 220}		
N 287	83.27(2)(a) Admissions compatible with the license class A CBRF may not admit or retain any of the following persons: A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04(2). This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider retained a non-ambulatory resident (Resident 2) that was not compatible with the provider's semi-ambulatory license.	N 287		

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N 287	Continued From page 8 Findings include: The provider had a class AS semi-ambulatory license to care for 8 residents in the client groups of advanced aged, developmentally disabled, emotionally disabled, physically disabled, irreversible dementia/Alzheimer's, and traumatic brain injury. A class CS license means residents may be ambulatory or semi-ambulatory and who are mentally and physically capable of responding to a fire alarm by exiting the CBRF without any help or verbal or physical prompting. "Semi-ambulatory" means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane, or a walker, according to DHS 83.02(51). DHS 83.02(34) states "non-ambulatory" means a person who is unable to walk but who may be mobile with the help of a wheelchair or other mobility devices. On 04/10/2024 at 9:00 AM, Surveyor toured the facility with Administrator B. 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 without any help or prompting."	N 287		

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N 287	Continued From page 9 On 04/10/2024 at 9:05 AM, Surveyor interviewed Administrator B. Administrator B stated Resident 2 had been using a wheelchair since the last survey (December 2023). Administrator B acknowledged the provider should not retain Resident 2 since their license did not support non-ambulatory residents. Administrator B stated the provider was hopeful Resident 2 had rebounded, but Resident 2 continued to need a higher level of care. Administrator B stated Resident 2 required transfer assistance and ambulated via wheelchair. Administrator B stated in February 2024, Resident 2 was served with 30-day notice and his/her MCO team was looking for alternative placement. Surveyor reviewed Resident 2's record. 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. Surveyor reviewed Resident 2's individual service plan (ISP) dated 03/14/2024. Resident 2's ISP documented: "Evacuation Capability in Emergency: No longer able to ambulate independently. Inclusa has been given written notice per state requirement. Physical Disabilities: Can transfer and stand, but not walking due to safety issues and potential for fall."	N 287		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary	N 328		

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N 328	Continued From page 10 discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each involuntary discharge notice included justification for discharge listed under par. (b), a statement regarding the department review of the discharge, the name, address, and phone number of the regional office director, and the name, address, and phone number of the regional office of the board on aging and long-term care's ombudsman program for 1 of 1 resident. Resident 2 was issued a 30-day notice on 02/01/2024 which did not include required information. Findings include:	N 328		

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N 328	Continued From page 11 On 04/10/2024, Surveyor reviewed Resident 2's record. Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/15/2002 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. Surveyor reviewed Resident 2's involuntary discharge notice dated 02/01/2024. The documentation did not include a statement regarding the department review of the discharge, the name, address, and phone number of the regional office director, and the name, address, and phone number of the regional office of the board on aging and long-term care's ombudsman program. On 04/10/2024 at 9:30 AM, Surveyor interviewed Administrator B. Administrator B acknowledged during previous survey dated 12/11/2023, Resident 2 was using a wheelchair. Administrator B stated the provider was hopeful Resident 2 would rebound and start using his/her walker. Administrator B acknowledged Resident 2 continued to need the assistance of a wheelchair, so 30-day notice was issued on 02/01/2024. Administrator B stated Resident 2's case manager is currently exploring alternative placement. On 04/10/2024 at 11:17 AM, Surveyor interviewed Administrator B. Administrator B confirmed the provider issued Resident 2 a 30-day notice on 02/01/2024. Administrator B stated s/he was unaware of code requirements to include above information in Resident 2's 30-day notice. Administrator B stated in the future, the provider would ensure they were complaint with codes	N 328		

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N 328	Continued From page 12 related to involuntary discharge.	N 328		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain a proof-of-use record for schedule II drugs that included an audit that was signed and dated daily. Findings include: On 04/10/2024 at 10:15 AM, Administrator B and Surveyor observed the provider's medication cabinet which included Resident 2's and Resident 3's Morphine tablets. Administrator B stated Resident 2 and Resident 3 were on hospice. Administrator B counted Resident 2's Morphine which noted 10 tablets with a dispense date of 12/20/2023. Administrator B counted Resident 3's Morphine which noted 10 tablets with a dispense date of 10/30/2023. Surveyor asked if the provider completed daily audits of scheduled II medications. Administrator B stated staff did not complete daily audits of scheduled II medications. Administrator B stated s/he would work with	N 409		

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N 409	Continued From page 13 Licensee A to start documenting daily audits of scheduled II medications.	N 409		
{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 and interview, the provider failed to maintain their fire alarm system per NFPA 72. This deficiency had a potential to affect all 8 residents in the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) YGW211, dated 12/11/2023. Findings include: On 04/10/2024 at 9:15 AM, Surveyor observed the 1st floor annunciator panel working with a green power light illuminated and a display screen read "Normal." Administrator B showed the Surveyor the fire panel in the basement of the facility, which displayed the system as operating like normal. On 04/10/2024 at 9:30 AM, Surveyor interviewed Administrator B. Administrator B stated the	{N 535}		

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 _____	R 04/17/2024

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 535}	Continued From page 14 provider had their fire safety contractor come out to test the system on 02/01/2024 and the contractor did not share any concerns. Administrator B stated the provider had an electrician service the fire panel and was told the system is now working properly on 02/27/2024. On 04/10/2024 at 11:06 AM, Surveyor observed the 1st floor annunciator panel was no longer illuminated with a green power light and the display screen was blank. The annunciator panel would inform first responders and staff where in the facility an alarm is activated. Administrator B observed the annunciator panel and acknowledged this was a concern. Administrator B went to the fire panel in the basement and noted s/he wiggled some wires. Surveyor observed the 1st floor annunciator panel was now illuminated with a green power light and the display screen read "Normal." Administrator B stated s/he would be calling the electrical company to service fire panel and annunciator. On 04/17/2024 at 2:31 PM, Surveyor interviewed Electrical Company G. Electrical Company G stated they had not heard from Administrator B following the Surveyors on-site visit on 04/10/2024. Electrical Company G confirmed the provider's fire alarm system was serviced and operating properly on 02/27/2024.	{N 535}		