STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018329	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

(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 05/20/2024, with additional information gathered through 05/23/2024, Surveyors conducted a standard survey at Vista Care Mehrtens Avenue. Five deficiencies were identified. Census: 8	N 000		
N 344	83.32(2)(b) Post resident rights, grievance procedure Explanation of resident rights, grievance procedure, and house rules. The CBRF shall post copies of resident rights, grievance procedure and house rules in a prominent public place available to residents, employees and guests. This Rule is not met as evidenced by: Based on observation and interview, the provider did not post resident rights and grievance procedure in a prominent public place available to residents, employees, and guests. The provider had a different set of regulatory resident rights posted and did not have a grievance procedure posted in the facility. Findings include: The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, emotionally disturbed/mentally ill, and/or be alcohol/drug dependent. On 05/20/2024, Surveyors conducted a standard survey. At approximately 11:00 AM, Surveyors observed file cabinets in the corner of the dining room with	N 344		

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

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N 344	Continued From page 1 multiple postings on the wall above. Surveyors observed a poster on the wall titled "Client Rights Inpatient or Residential Services ...When you receive any type of service for a mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wis. Stat. 51.61(1) and Wis. Admin. Code ch. DHS 94." Surveyors did not observe any postings of DHS 83 resident rights and the provider's grievance procedure in the facility. At approximately 12:00 PM, Surveyor interviewed Area Director A who verified DHS 83 resident rights and the grievance procedure were not posted in the facility in a prominent public place available to residents, employees, and guests.	N 344		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, there was	N 389		

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N 389	Continued From page 2 no evidence 2 of 2 sample residents' (Resident 2 and Resident 4) individual service plans (ISP) were reviewed and revised based on assessment annually or when there was a change in resident needs, abilities or physical or mental condition. Resident 2's ISP did not reflect his/her updated behaviors and interventions related to behaviors including limitations in the community. Resident 4's ISP did not reflect his/her updated behaviors and interventions related to a completed county agreement limiting and/or denying access to food, cigarettes and lighters, and communication with a family member. The provider did not have evidence Resident 2 and Resident 4's ISP's were updated, reviewed, and signed annually and with changes. Findings include: The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, emotionally disturbed/mentally ill, and/or be alcohol/drug dependent. On 05/20/2024, Surveyors conducted a standard survey. RESIDENT 2 On 05/21/2024, Surveyor reviewed Resident 2's record and noted s/he was admitted to the facility on 10/26/2020 with diagnoses of other psychoactive substance abuse, schizophrenia, anxiety disorders, attention-deficit hyperactivity disorder, borderline intellectual functioning, and convulsions. Resident 2 had a legal guardian. Surveyor reviewed Resident 2's ISP and noted an "Effective Date" of 04/09/2024. Surveyor noted his/her ISP did not identify needs or risk related to being in the community related to drug-seeking, including anything about the time spent in the	N 389		

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N 389	Continued From page 3	N 389		

community. Surveyor reviewed Resident 2's BSP provided by Area Director A with date 10/29/2019. The BSP was not updated to reflect Resident 2's current residence and community supervision needs.

On 05/20/2024 at approximately 10:15 AM, Surveyor interviewed Caregiver B who said Resident 2 was only allowed to be in the community for 2 hours due to a history of drug-seeking behavior. S/he said this was agreed upon with his/her county case worker.

On 05/20/2024 at approximately 10:30 AM, Surveyor interviewed Area Director A who verified Resident 2 had limitations on hours in the community and was responsible to notify staff and/or update the log book near the entrance when s/he left and returned.

RESIDENT 4
On 05/22/2024, Surveyor reviewed Resident 4's record and noted s/he was admitted to the facility on 01/21/2021 with diagnoses of obesity, tobacco abuse and a history of substance abuse. Resident 4 was able to make his/her own decisions and his/her needs known. Surveyor reviewed Resident 4's ISP and noted a "Start Date" of 08/01/2023. Surveyor noted Resident 4's ISP did not identify whether Resident 4 had any behavioral needs and interventions related to behaviors.

On 05/23/2024, Surveyor reviewed Resident 4's "Client Rights Limitation or Denial" (CRLD) documentation approved by Resident 4's county case worker dated 05/31/2022. Surveyor noted "[Resident 4] will not have kitchen access (locked at all times), no cell phone access, no access to monetary funds, no access to cigarettes or lighter

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and no visitation with [family member] also a CBRF resident ...[Resident 3]'s limitation at the CBRF are required for safety and sanitary measures ...Reason for Limitation / Denial: [boxes checked for] Safety, Security, Treatment."

On 05/20/2024 at approximately 19:15 AM, Surveyor interviewed Caregiver B who stated Resident 4 had restrictions specific to staff locking up snacks and cereal due to Resident 4 overeating. Surveyor inquired whether all snacks were locked up and Caregiver B stated yes. Caregiver B and Surveyors observed chips and cereal locked in a room next to the kitchen and in the file cabinet next to the medication cabinets.

On 05/23/2024, Surveyor reviewed the department's provider file and did not find evidence of waiver requests submitted to the department or approved by the department related to resident rights limitation or denials for Resident 4.

On 05/22/2024 at approximately 1:00 PM, Surveyors interviewed Area Director A and inquired whether there were other versions of Resident 2 and Resident 4's ISPs. Area Director A indicated their system did not include dates of changes made to the ISP. Area Director A stated ISP reviews were completed every 6 months with county case managers and legal representatives, but they would upload review dates and signatures into resident records going forward. Area Director A verified there was not evidence of updates to Resident 2 and Resident 4's ISPs.

Area Director A stated Resident 4 had restrictions on visitors, cell phone usage, the use of lighters, and kitchen access. Area Director A acknowledged Resident 2 and Resident 4's ISP's

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N 389	Continued From page 5 were not updated to reflect behavioral needs and interventions.	N 389		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate 2 of 2 sample residents' (Resident 2 and Resident 4) mental or physical capability to respond to a fire alarm at least annually. Findings include: On 05/20/2024, Surveyors conducted a standard survey. On 05/21/2024, Surveyor reviewed Resident 2's record and noted s/he was admitted to the facility on 10/26/2020 with diagnoses of schizophrenia, other anxiety disorders, attention deficit hyperactivity disorder, and other psychoactive substance abuse. Surveyor noted 3 evacuation evaluations dated 10/26/2020, 09/07/2021 and 05/04/2022. No other evacuation evaluations were found in Resident 2's record. On 05/22/2024, Surveyor reviewed Resident 4's record and noted s/he was admitted to the facility on 01/21/2021 with a history of substance abuse and anxiety. Surveyor noted the documents provided for Resident 4's record did not include evacuation evaluations.	N 394		

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N 394	Continued From page 6 On 05/22/2024 at approximately 1:00 PM, Surveyors interviewed Area Director A who stated s/he thought they had evacuation evaluations for Resident 4, but could not locate any. Area Director A indicated evacuation evaluations were supposed to be done upon admission, annually and with changes in condition. Area Director A verified there was not evidence Resident 2 was evaluated for evacuation abilities since 2022, and Resident 4 had not been evaluated for evacuation abilities.	N 394		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.	N 406		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure an outdated medication was disposed of and a discharged resident's medications were disposed of per provider policy.

A card of Resident 2's as needed (PRN) Haloperidol 5 mg tablets expired on 11/09/2023 was located within current use medications in the medication cabinet.
A one-dose pill pocket of Resident 3's scheduled Lithium Carbonate ER 450 and Trazodone 50 mg dated 11/19/2023 was located freely in a drawer in the medication cabinet labeled "Meds 4 Destruction." Resident 3 discharged from the facility on 12/22/2023.

Findings include:

On 05/20/2024, Surveyors conducted a standard survey. At approximately 11:00 AM, Surveyors observed the medication cabinet with Caregiver B.

RESIDENT 2
Surveyors reviewed medication cards and noted Resident 2's unit dose medication card containing PRN Haloperidol 5 mg, which contained 20 pills amongst other medication in current use in the medication cabinet. Surveyor noted the label listed a dispensed date of 05/15/2023 and a "Do Not Use Beyond" date of 11/09/2023. Surveyor reviewed Resident 2's May 2024 Medication Administration Record (MAR) and noted Resident 2 had not taken PRN Haloperidol in the past month.
Surveyor inquired with Caregiver B how often medications were checked for expiration dates

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N 406	Continued From page 8 and Caregiver B indicated all staff watch for them. RESIDENT 3 Caregiver B opened a drawer labeled "Meds 4 Destruction" and Surveyor noted the drawer contained an empty lock box, bodily fluid spill kit, first aid kit, loose papers, bandages, and gauze wrap. Surveyor noted a lone pill pocket located in the drawer below the drawer handle hardware. Surveyor observed a single bubble pack with Resident 3's name, the date for administration, and the medications in the pill pocket which were: Lithium Carbonate ER 450 and Trazodone 50 mg dated 11/19/2023. Surveyor inquired with Caregiver B about the medications and Caregiver B stated Resident 3 was no longer a resident at the facility and s/he did not know the medications were still in the drawer. Surveyor noted there were no orders at the facility to retain Resident 3's medication. Surveyor inquired with Caregiver B what the destruction process was and Caregiver B said s/he "believed" medications were to be put in the (Meds 4 Destruction) drawer and Manager C takes them from there to be destroyed, but s/he did not feel everyone did that. Surveyor reviewed the provider's Medication Administration Policy dated 06/01/2023 and noted: "G. Medication Disposal and Destruction 1. The medication cabinet will be audited monthly to dispose of any expired or discontinued medications. 2. Medications may be returned to the pharmacy, disposed of at a local police department or other authorized facility, or destroyed in the home. All disposal/destruction requires the witness of 2 employees and each medication disposal/destruction shall be	N 406		

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N 406	Continued From page 9 documented on a Medication Destruction Log. This log will be kept in the EHR. [electronic health record]." On 05/23/2024 at approximately 3:33 PM, Area Director A reported Resident 3's date of discharge was 12/22/2023. On 05/22/2024 at approximately 1:00 PM, Surveyors interviewed Area Director A who acknowledged Resident 2's outdated PRN Haloperidol and Resident 3's scheduled Lithium and Trazodone were in the medication cabinet and not destroyed within 30 days or destroyed per provider policy.	N 406		
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 provide a living environment that was safe, clean, comfortable, and homelike. -Food was not maintained in a sanitary manner. -The facility baseboards, air vents, and resident bathrooms were unclean. -An unenclosed, unsecured room located at the entrance of the facility contained sharp objects and tools that posed a safety risk. At least one resident was identified to have self-injurious behaviors with the use of sharp objects.	N 481		

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N 481	Continued From page 10 -Resident 2's room had damage to the walls, bed, and dresser which were provided by the facility. Findings include: The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, emotionally disturbed/mentally ill, and/or be alcohol/drug dependent. On 05/20/2024, Surveyors conducted a standard survey. At approximately 10:06 AM, Surveyors toured the facility with Caregiver B. Surveyors observed the following: COMMON AREAS -The freezer had an unsealed, undated plastic bag of "taters." -The refrigerator had an unsealed, unlabeled half-stick of butter; an unlabeled Tupperware of pasta-like food; an unlabeled, unsealed aluminum foil covered bowl with a pound cake-like food; and an uncovered, unlabeled full pitcher of red juice-like liquid. -The refrigerator and freezer shelves and floors had liquid-like stains and left-over food debris. -The microwave plate and floor had yellow food-like splatter and left-over food debris. -An approximately 2 feet by 2 feet ceiling vent located right off the kitchen had debris and dust-like covering across some air passages. -The hallway end wall located to the left of the kitchen had an approximately 3-inch divot in the drywall which exposed the metal mesh. -A folding chair was approximately 1 foot from the furnace in the mechanical room. -An approximately 2 feet by 2 feet ceiling vent located in the resident hallway to the right of the	N 481		

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entrance had a thick, dust-like covering across all air passages.
-The front entrance hall closet floor had sidewalk salt-like debris and dirt.
-The front common area had 2 accent chairs with visible wear to the cushion of the seats.
-The resident hallway walls had flat baseboard trim that had visible gray, dust-like covering throughout the entirety of the hallways.

-An unenclosed room located directly to the right of the entrance, identified by Caregiver B as the Resident 1's "bike EMT room," had the following tools and materials on the floor: a needle nose pliers, hammer, curved crowbar, wire cutter, ½ inch drill bit, wrench, loose screws, wire brush, loose bike wires, and an open tool box with a wire cutter, multiple wrenches. Surveyors noted debris, jumper cables, multiple bikes and bike parts, a rug, and other personal belongings. Surveyor noted you could see the tools on the floor upon entry into the front door of the facility.

At approximately 10:26 AM, Surveyors interviewed Caregiver B who stated Resident 2 had a history of self-injurious behaviors including cutting, using razor blades, knives, scissors, and any sharp objects s/he could find. Surveyor inquired whether Resident 2 had any recent incidents of cutting and Caregiver B said yes. Surveyor asked Caregiver B whether Resident 2 had access to the room with the bikes and Caregiver B said yes, all residents walk past it multiple times a day. Caregiver B indicated they provided reminders to Resident 1 to clean up his/her tools, but s/he did not always do that.

BATHROOMS
-The resident bathroom located in the resident room hallway to the right of the entrance had

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urine-like stains around the base of the toilet.
The bathroom floor tile had debris and the grout was blackened.
The shower had 1 inch by 1inch tiles on the floor and 12 inch by 12 inch tiles on the walls. The tile grout varied in shade from white to black throughout the entirety of the shower floor. The shower floor had debris, unidentified material and garbage, a clump of hair, white and black spots, and orange and black staining where the floor tile met the wall tile. The metal threshold of the shower floor had black, dirt-like markings spanning the proximity of the shower.

-The resident bathroom located in the resident room hallway to the left of the entrance had tile floor with blackened grout.
The tile shower floor had debris, at least 3 used and broken soap bars, the tile grout varied in shade from gray to black. An approximately 2 feet by 4 feet shower foam shower mat had orange, brown, and black staining throughout and at least 4 pieces of used, broken soap bars.

At approximately 10:37 AM, Surveyors interviewed Caregiver B who stated the residents had responsibility to clean up after themselves in the bathroom. Surveyor inquired whether staff clean and Caregiver B said most of the cleaning was done on night shift when residents were sleeping.

RESIDENT 2
At approximately 11:35 AM, Surveyors, Area Director A, and Resident 2 toured Resident 2's room. Surveyors observed the following:
-Multiple black lines and scuff-like marks spanning the proximity of Resident 2's back wall and side wall.
-Resident 2's dresser had at least 3 missing

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VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

(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 13 drawer faces. -Resident 2's bed frame had a box spring that appeared to have weakened wood slats and be worn. His/her unmade mattress was on the floor next to the bed. -An approximately 4 inch by 6 inch punch-like circular damage to the dry wall located above Resident 2's bed frame. Surveyor interviewed Resident 2 who stated s/he did not know what happened to the wall and indicated it had been there since s/he moved in. S/he said the box spring hurt his/her back and so s/he slept on his/her mattress on the floor. Resident 2 said the facility provided the bed and dresser. At approximately 12:45 PM, Surveyors interviewed Manager C who acknowledged awareness of the marks on Resident 2's wall and Resident 2 having concerns with his/her box spring. On 05/22/2024 at approximately 1:00 PM, Surveyors interviewed Area Director A who acknowledged concerns with the cleanliness, damage, and safety of the facility environment.	N 481		