STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017752	A. BUILDING: _____ B. WING _____	C 11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

(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 11/10/2023, Surveyors conducted a complaint investigation and standard survey at SV South Beloit West. Eight deficiencies were identified. Two of 8 deficiencies were repeat violations. See statement of deficiency (SOD) 00KH13, dated 12/08/2022, SOD 00KH12, dated 04/21/2022, and SOD 0QK211, dated 06/25/2020. The complaint was substantiated. Census: 14	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 received his/her insulin in the dosage prescribed by his/her practitioner on 3 occasions from 10/01/2023 - 11/07/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 00KH13, dated 12/08/2022, SOD 00KH12, dated 04/21/2022, and SOD 0QK211, dated 06/25/2020. Findings include:	N 352		

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
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N 352	Continued From page 1 On 11/08/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 03/01/2023 with diagnoses including type 2 diabetes mellitus. Surveyor reviewed Resident 1's prescriptions, which included Novolog FlexPen with a start date of 08/25/2023 and instructions to: "Inject per sliding scale, 140-189 2 units, 190-293 4 units, 240-289 6 units, 290-339 8 units, 340+ 10 units." The scheduled times of Novolog administration on Resident 1's medication administration record (MAR) - for 8:00 a.m, 12:00 p.m., and 5:00 p.m. - appeared to correlate with mealtimes. Surveyor observed Resident 1's MAR from 10/01/2023 - 11/07/2023 and observed the following 3 occasions in which Resident 1 received the incorrect dosage of insulin: - 10/25/2023 (noon dose): Blood sugar documented as 256 (within parameters for 6 units of administration), 8 units documented as administered - 10/25/2023 (5:00 p.m. dose): Blood sugar documented as 282 (within parameters for 6 units of administration), 8 units documented as administered - 11/04/2023 (5:00 p.m. dose): Blood sugar documented as 161 (within parameters for 2 units of administration), 4 units documented as administered At approximately 3:40 p.m., Surveyor interviewed Administrator A and House Manager B. Both acknowledged awareness of the medication errors that occurred and reported that the staff who committed them was recently taken off medication pass until s/he was retrained in medication administration.	N 352		

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N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) for 2 of 3 residents reviewed was implemented and followed as written. Resident 2's vitals and urine monitoring was not completed in accordance with his/her most recent ISP. Resident 2's weight was not taken on 1 of 2 weeks it was due, his/her oxygen saturation as measured by pulse oximetry was not taken on 12 of 13 days it was due, his/her respiration rate was not taken since his/her ISP review date of 10/26/2023, his/her urine color was not documented on 13 of 13 days it was due, and his/her urine output was not documented on 11 of 13 days it was due. Resident 3's weight and respiration rate was not monitored on 4 of 6 weeks in accordance with his/her most recent ISP. Findings include: Example 1 - Resident 2 On 11/08/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/16/2021 with diagnoses including unspecified urinary incontinence and spastic hemiplegia affecting his/her left side. Surveyor reviewed Resident 2's current ISP, most recently signed as reviewed on 10/26/2023, and observed the following:	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 388	Continued From page 3 - Under the "[Change of Condition (COC)]" section: "[Registered Nurse] from Transitions has requested daily observation and documentation of urine color and to measure oxygen level with [oxygen] sensor and document." - Under the "Toileting - Catheter" section: "Emptying and recording of output...Resident requires full assistance from Team Member for Recording[sic] Resident's output through the catheter to ensure no blockage or retention..." - Under the "Weekly Vitals" section: Documented that a list of vitals, including weight and respirations, were to be taken weekly with the annotation, "...If weight has decreased 5 pounds or increased 5 pounds notify house manager. If respiration is under 12 breaths or over 20 breaths per minute notify house manager." Within the ISP, Resident 2 was also documented as being on 2 L of oxygen at bedtime. Surveyor reviewed Resident 2's vitals monitoring from 10/26/2023 through 11/08/2023 and observed the following: - Weight: Recorded on 10/26/2023. There were no weight recordings from from 10/27/2023 through 11/07/2023 (when 1 would have been due). - Pulse oximetry: Recorded on 10/26/2023. There were no other recordings on the other 12 days they would have been due per Resident 2's ISP, including from 10/27/2023 through 11/07/2023. - Respirations: No respiration rate documentation (when at least 1 would have been due) Surveyor reviewed Resident 2's urine-related documentation (including output and color in accordance with his/her ISP) from 10/26/2023 through 11/07/2023 and observed the following 3	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

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N 388	Continued From page 4	N 388		

recordings:

- 11/05/2023 (12:54 p.m.): Urine output was 1200 (but no color documented)
- 11/07/2023 (2:01 p.m.): Urine output was 30 (but no color documented)
- 11/07/2023 (8:44 p.m.): Urine output was 30 (but no color documented)

Surveyor did not observe any evidence of urine output for 11 days it would have been due from 10/26/2023 through 11/04/2023, and 11/06/2023. Surveyor did not observe any evidence of urine color documentation for 13 of 13 days it would have been due.

At approximately 3:40 p.m., Surveyor interviewed Administrator A and House Manager B. Both confirmed Surveyor's observation that it did not seem like Resident 2's vitals and urine monitoring were being completed in accordance with his/her ISP. Administrator A reported that vitals monitoring has been a "weak spot" for staff and that s/he knew more training had to be done. Administrator A reported that the provider's electronic health record platform was not previously prompting staff to record Resident 2's urine output and color, and so that's why it was not being done consistently.

Example 2 - Resident 3

On 11/08/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/04/2018 with diagnoses including diabetes, coronary artery disease, and obstructive sleep apnea. Surveyor reviewed Resident 3's current ISP, most recently signed as reviewed on 05/15/2023, and observed the following:

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SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

(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 388	Continued From page 5 - Under the "Weekly Vitals" section: "Residents[sic] vitals must be taken 1x/weekly. Any concerns report to management and [medical doctor (MD)]." A list of vitals to be taken included respirations and weight. Within the ISP, Resident 2 was also documented as requiring a continuous positive airway pressure (CPAP) for nighttime use. Surveyor reviewed Resident 3's vitals monitoring from 10/01/2023 through 11/08/2023 and observed the following: - Weight: Recorded on 10/30/2023 and 11/06/2023. There were no recordings from 10/01/2023 through 10/29/2023 (when at least 4 recordings would have been due) - Respirations: Recorded on 10/30/2023 and 11/06/2023. There were no recordings from 10/01/2023 through 10/29/2023 (when at least 4 recordings would have been due) At approximately 3:40 p.m., Surveyor interviewed Administrator A and House Manager B. Both confirmed Surveyor's observation that it did not seem like Resident 3's weight and respiration monitoring was being completed in accordance with his/her ISP. Administrator A reported that vitals monitoring has been a "weak spot" for staff and that s/he knew more training had to be done.	N 388		
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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

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N 389	Continued From page 6 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, interview, and observation, the provider did not ensure that Resident 2's individual service plan (ISP) was updated to ensure adequate management of his/her suprapubic catheter. Resident 2's ISP did not include strategies to ensure appropriate placement of his/her catheter leg bag to allow for urine drainage. Based on staff report, Resident 2 was known to pull his/her catheter bag up to his/her thigh (which was observed to be level to, as opposed to below, his/her waist when s/he was in a seated position). Throughout the survey period, Resident 2 was observed seated in his/her wheelchair with his/her leg bag on his/her thigh, which continued despite staff interactions with him/her. This is a repeat deficiency. See Statement of Deficiency (SOD) 00KH13, dated 12/08/2022. Findings include: According to the Cleveland Clinic, "Always keep your urine bag below your bladder, which is at the level of your waist. This will prevent urine from flowing back into your bladder from the tubing and urine bag, which could cause an infection,"	N 389		

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	0017752	A. BUILDING: _____ B. WING _____	C 11/10/2023

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SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

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N 389	Continued From page 7 (Source: Cleveland Clinic, Urine drainage bag and leg bag care, December 03, 2020, https://my.clevelandclinic.org/health/articles/14832-urine-drainage-bag-and-leg-bag-care (retrieval date - November 01, 2023).). On 11/08/2023, at approximately 9:25 a.m., Surveyor interviewed Resident 2, who was sitting in his/her manual wheelchair in the living room. Surveyor observed a mass underneath Resident 2's pants at his/her right upper thigh, consistent in size with a catheter leg bag (Photo 4). Resident 2 confirmed that it was his/her catheter leg bag on his/her right upper thigh. Surveyor observed that with Resident 2's seated position in his/her wheelchair, the placement of the catheter bag on his/her upper thigh was approximately level to his/her waist. Resident 2 reported that s/he needed assistance due to it feeling like his/her catheter was leaking, and was later observed asking staff for assistance. At approximately 9:55 a.m., Surveyor observed Resident 2 in his/her room. Resident 2 was sitting in his/her recliner, which was reclined back. Surveyor observed the same mass underneath Resident 2's right pant leg at his/her upper thigh which was consistent in size with his/her catheter leg bag. Resident 2 confirmed that was still his/her leg bag. Surveyor observed that with Resident 2's reclined position his/her right thigh (where his/her leg bag was secured to) was elevated compared to his/her waist. Surveyor observed an adaptive lift in Resident 2's room and asked Resident 2 about it. Resident 2 reported s/he had to use it with staff assistance for all transfers, and that staff had assisted him/her earlier into his/her recliner. At approximately 12:41 p.m., Surveyor observed	N 389		

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N 389	Continued From page 8 Resident 2 in his/her room again. Resident 2 was seated in his/her manual wheelchair, with the mass consistent with his/her catheter leg bag still on his/her right upper thigh, approximately level with his/her waist. At approximately 12:47 p.m., Surveyor interviewed Lead Caregiver C. Surveyor asked Lead Caregiver C about Resident 2's leg bag placement and whether s/he noticed any urine drainage issues with the placement on his/her upper thigh. Lead Caregiver C replied that s/he sometimes noticed a problem with Resident 2's urine drainage. Lead Caregiver C reported that sometimes staff put the bag at Resident 2's calf but s/he sometimes pulls it up. Lead Caregiver C reported that s/he knew this morning that Resident 2's leg bag was secured to his/her calf. Surveyor reported that since approximately 9:25 a.m. that morning, s/he consistently observed Resident 2's leg bag on his/her upper thigh, even in between times Resident 2 would have been interacting with staff, such as Surveyor's observation of Resident 2 requesting catheter assistance earlier that morning and during transfers back and forth from his/her recliner to his/her wheelchair. Lead Caregiver C reported that s/he would talk to the other staff about making sure they checked his/her catheter bag placement more. At approximately 1:05 p.m., Surveyor observed Lead Caregiver C assisting Resident 2 in his/her bathroom. After assisting Resident 2 back to his/her wheelchair, Lead Caregiver C left Resident 2's room. Resident 2 then ambulated in his/her manual wheelchair out of his/her room. Surveyor observed the mass consistent with Resident 2's leg bag on his/her right upper thigh. Resident 2 confirmed that what Surveyor	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017752	A. BUILDING: _____ B. WING _____	C 11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

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N 389	Continued From page 9	N 389		

observed was his/her leg bag. Surveyor asked Resident 2 if Lead Caregiver C had offered or attempted to move his/her leg bag down from his/her thigh. Resident 2 replied, "Not that I can recall." Surveyor did not observe through Resident 2's pants any masses indicative of excess tubing (given the bag placement at his/her thigh as opposed to his/her calf per Lead Caregiver C's above report).

On 11/08/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/16/2021 with diagnoses including unspecified urinary incontinence and spastic hemiplegia affecting his/her left side. Surveyor reviewed Resident 2's current ISP, most recently signed as reviewed on 10/26/2023, and observed the following:

- Under the "Toileting - Catheter" section: "Emptying and recording of output. Changing from night bag to leg bag daily. Staff to flush (irrigate the catheter 2x daily)...Report to [house manager] concerns. At night check to make sure catheter tube does not have a kink in it." Within this section, the goals for Resident 2 were documented as, "Free from Blockage/retention and and[sic] have adequate output..."

At approximately 3:40 p.m., Surveyor interviewed Administrator A and House Manager B. House Manager B confirmed that Resident 2 was known to pull his/her leg bag up when placed on his/her calf. Surveyor explained his/her earlier conversation with Lead Caregiver C and the observation between Lead Caregiver C and Resident 2 and reported that it didn't seem like at least that day based on Surveyor's observations, staff attempted to correct Resident 2's leg bag position. House Manager B acknowledged

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SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

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N 389	Continued From page 10 Surveyor's concern that based on what s/he could see through Resident 2's pant leg that it did not seem like Resident 2 currently had enough tubing to place his/her leg bag at his/her calf. House Manager B reported that s/he would follow up on this concern. On 11/10/2023, at approximately 9:35 a.m., Surveyor interviewed Nurse D from Resident 2's home health agency. Nurse D reported s/he was one of the nurses who used to assist with Resident 2's home health catheter management but that since the end of September 2023, approximately when Resident 2's suprapubic catheter was placed, that this service ended and his/her catheter had been solely managed by the provider's staff and Resident 2's urologist. Nurse D reported that proper wear of Resident 2's leg bag when s/he is seated would be at his/her calf to ensure adequate drainage. Nurse D reported that s/he wasn't sure if the provider had extension tubing for Resident 2. Nurse D reported that if Resident 2's catheter didn't drain adequately there was a risk for his/her urine to back up and put him/her at increased risk for urinary tract infections.	N 389		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017752	A. BUILDING: _____ B. WING _____	C 11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

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N 397	Continued From page 11 one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present during the overnight of 09/12/2023 into 09/13/2023. Findings include: On 09/13/2023, the Department received a complaint alleging concerns with unqualified staff working overnight shifts. On 11/08/2023, Surveyor conducted a complaint investigation and reviewed staff records. The following was found: DHS Chapter 83 defines "Qualified resident care staff" as an employee who has successfully completed all of the applicable training and orientation under subch. IV. Caregiver F hired 08/31/2023, had not received training in First Aid and Choking. Surveyor verified on the CBRF training registry, Caregiver F had not received training in First Aid and	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT WEST	2156 HOUSE ST BELOIT, WI 53511

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N 397	Continued From page 12 Choking. Surveyor reviewed the provider's staff schedule, which indicated Caregiver F was the only staff member present during the overnight of 09/12/2023 to 09/13/2023. At approximately 3:40 p.m., Surveyor interviewed Administrator A and House Manager B. House Manager B reviewed Caregiver F's CBRF training and confirmed s/he did not receive training or met an exemption for First Aid and Choking. House Manager B stated Caregiver F had shadowed 5 previous shifts and s/he had prior experience working in assisted living facilities. House Manager B acknowledged s/he did not know overnight staff working alone had to have all training completed prior to 90 days.	N 397		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017752	A. BUILDING: _____ B. WING _____	C 11/10/2023

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(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 408	Continued From page 13 medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plan (ISP) for 1 of 2 residents reviewed included the rationale for use and detailed description of the behaviors indicating the need for administration of as needed (PRN) psychotropic medication. The ISP for Resident 1, who was prescribed PRN Lorazepam and administered it twice, did not include the rationale for use and a detailed description of the behaviors indicating the need for its use. Findings include: On 11/08/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 03/01/2023 with diagnoses including dementia and major depressive disorder, recurrent. Surveyor reviewed Resident 1's prescriptions, which included Lorazepam 2 mg/mL solution with instructions to, "Give 0.5 mg (0.25 mL) by mouth or under tongue every 4 hours as needed for anxiety, agitation, or nausea." Surveyor reviewed Resident 1's medication administration records (MARs) from 10/01/2023 - 11/08/2023, and observed the following 2 administrations of his/her PRN Lorazepam: - 10/25/2023 (4:19 a.m.): The entry documented, "Indicate behaviors observed by staff, why is medication being administered:," to which staff documented, "in and out of bed."	N 408		

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	0017752	A. BUILDING: _____ B. WING _____	C 11/10/2023

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N 408	Continued From page 14 - 10/29/2023 (5:30 a.m.): The entry documented, "Indicate behaviors observed by staff, why is medication being administered:," to which staff documented, "Transferring [him/herself] without assistance from staff." Surveyor reviewed Resident 1's current individual service plan (ISP), most recently reviewed on 09/25/2023. Surveyor did not observe any rationale for use or detailed description of the behaviors indicating the need for Resident 1's PRN Lorazepam administration. At approximately 3:40 p.m., Surveyor interviewed Administrator A and House Manager B. House Manager B confirmed that the information was not in Resident 1's ISP.	N 408		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid	N 431		

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N 431	Continued From page 15 intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the health for 2 of 4 residents was monitored. Out of 8 occasions in October 2023 when Resident 1's blood sugar levels were within parameters to notify his/her medical provider, staff notified the medical provider on 0 occasions. Out of 12 occasions in October and November 2023 when Resident 3's blood pressures were within parameters to notify his/her medical provider, staff notified the medical provider on 0 occasions. Findings include: Example 1 - Resident 1 On 11/08/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 03/01/2023 with diagnoses including type 2	N 431		

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N 431	Continued From page 16 diabetes mellitus. Surveyor reviewed Resident 1's prescriptions, which included Novolog FlexPen with a start date of 08/25/2023 and instructions to: "Inject per sliding scale, 140-189 2 units, 190-293 4 units, 240-289 6 units, 290-339 8 units, 340+ 10 units." The scheduled times of Novolog administration on Resident 1's medication administration record (MAR) - for 8:00 a.m, 12:00 p.m., and 5:00 p.m. - appeared to correlate with mealtimes. An annotation in the instructions documented, "Call [medical doctor] if [blood sugar] is less than 60 or over 400." Surveyor observed Resident 1's MAR from 10/01/2023 - 11/07/2023 and observed the following 8 occasions in which Resident 1's blood sugar was within the medical provider notification parameters: - 10/02/2023 (morning): Blood sugar documented as 58 - 10/04/2023 (morning): Blood sugar documented as 50 - 10/05/2023 (morning): Blood sugar documented as 39 - 10/05/2023 (evening): Blood sugar documented as 464 - 10/20/2023 (noon): Blood sugar documented as 51 - 10/21/2023 (morning): Blood sugar documented as 47 - 10/21/2023 (noon): Blood sugar documented as 42 - 10/27/2023 (morning): Blood sugar documented as 58 There was no evidence in Resident 1's record of his/her medical provider having been notified of the above 8 occasions.	N 431		

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N 431	Continued From page 17 At approximately 3:00 p.m., Surveyor interviewed House Manager B. House Manager B reported that physician communications were typically documented in residents' observation notes. House Manager B reported that s/he was the one who typically communicated with medical providers to provide notification of vitals outside of normal parameters, but that staff were supposed to inform him/her of these occasions first. House Manager B reported that if communications were not documented in the observation notes than it was due to staff not informing him/her of the vitals. Example 2 - Resident 3 On 11/08/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/04/2018 with diagnoses including coronary artery disease. Surveyor reviewed Resident 3's prescriptions, which included the following: - Amlodipine 2.5 mg tablet with instructions to, "Take 1 tablet by mouth daily for [hypertension]. Call if [systolic blood pressure] less than 90 or greater than 160, call if heart rate less than 55 or greater than 110." - Metoprolol tartrate 25 mg tablet with instructions to, "Take 1 tablet by mouth 2 times daily to lower blood pressure. Call if [systolic blood pressure] less than 90 or greater than 160, call if heart rate less than 55 or greater than 110." Surveyor reviewed Resident 3's MARs from 10/01/2023 - 11/07/2023, and observed the following 12 occasions in which Resident 3's blood pressure was within notification parameters:	N 431		

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N 431	Continued From page 18	N 431		

- 10/01/2023 (evening): Blood pressure documented as 176/81
- 10/04/2023 (evening): Blood pressure documented as 185/91
- 10/07/2023 (evening): Blood pressure documented as 166/82
- 10/16/2023 (evening): Blood pressure documented as 167/76
- 10/17/2023 (morning): Blood pressure documented as 163/84
- 10/21/2023 (morning): Blood pressure documented as 165/84
- 10/24/2023 (morning): Blood pressure documented as 193/76
- 10/25/2023 (evening): Blood pressure documented as 204/79
- 10/29/2023 (morning): Blood pressure documented as 163/93
- 11/02/2023 (morning): Blood pressure documented as 195/91
- 11/03/2023 (evening): Blood pressure documented as 181/73
- 11/04/2023 (evening): Blood pressure documented as 190/74

There was no evidence in Resident 3's record of his/her medical provider having been notified of the above 12 occasions.

At approximately 3:00 p.m., Surveyor interviewed House Manager B. House Manager B reported that physician communications were typically documented in residents' observation notes. House Manager B reported that s/he was the one who typically communicated with medical providers to provide notification of vitals outside of normal parameters, but that staff were supposed to inform him/her of these occasions first. House Manager B reported that if communications were not documented in the

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N 431	Continued From page 19 observation notes than it was due to staff not informing him/her of the vitals.	N 431		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 of 2 common resident sink areas and 1 of 1 staff sink areas had dispensers for single use paper towels, cloth towel dispensing units enclosed for protection, or electric hand dryers. Findings include: On 11/08/2023, while touring the environment, at approximately 10:08 a.m. Surveyor observed the east resident bathroom located at the end of the hall. An empty paper towel dispenser was observed on the wall to the left of the sink. A stack of paper towels was observed sitting on top of the dispenser (Photo 1). Surveyor did not observe any other hand drying receptacles in the bathroom. At approximately 10:11 a.m., Surveyor observed the west resident bathroom located at the end of the other hall and did not observe any hand drying receptacles (Photos 2 and 3). At approximately 2:30 PM, Surveyor observed the	N 612		

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N 612	Continued From page 20 east and west resident bathrooms located at the end of both halls. In the east bathroom, an empty paper towel dispenser was observed on the wall to the left of the sink. A stack of paper towels was observed sitting on top of the dispenser. In the west bathroom, Surveyor did not observe any hand drying receptacles. At approximately 2:44 p.m., Surveyor observed the staff bathroom located in the laundry room. A large roll of paper towel was observed sitting on a stand near the sink. Surveyor did not observe any other hand drying receptacles in the bathroom. At approximately 3:40 p.m., Surveyors interviewed Administrator A and House Manager B. House Manager B reported s/he wasn't sure why the west bathroom did not have a dispenser but reported that it used to. House Manager B reported that the other bathrooms' dispensers were on maintenance staff's list to address.	N 612		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every	Z 010		

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Z 010	Continued From page 21 reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not make reasonable efforts to contact the clerk of courts to obtain copies of the criminal complaints after 1 of 1 employee (Caregiver E) was charged with the following crimes: Battery and Disorderly Conduct. Findings include: On 11/08/2023, Surveyor reviewed employee records and identified the following: Caregiver E was hired on 09/21/2023. A criminal background check was completed by the Department of Justice (DOJ), dated 09/13/2023, indicated Caregiver E was charged of the following crimes which requires the provider to obtain copies of the criminal complaint: On 07/21/2022, Caregiver E was charged in	Z 010		

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Z 010	Continued From page 22 violation of Wisconsin State Statute 940.19(1) Battery, the Disposition, dated 07/22/2022, noted "Amended by Prosecutor." On 07/21/2022, Caregiver E was charged in violation of Wisconsin State Statute 947.01(1) Disorderly Conduct, the Disposition, dated 07/22/2022, noted "Charge Issued." At approximately 3:40 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A confirmed s/he did not reach out to the county Caregiver E was charged in to obtain the criminal complaint. Administrator A noted s/he had a previous manager who was supposed to review background checks upon hire.	Z 010		