STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008657	A. BUILDING: _____ B. WING _____	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SONRISAS ASSISTED LIVING	315 LLANOS ST VERONA, WI 53593

(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
M 000	INITIAL COMMENTS On 09/04/2024, with information gathered through 09/06/2024, Surveyor conducted a standard licensure survey at Sonrisas Assisted Living. Three deficiencies were identified. One of 3 deficiencies was a repeat violation (see Statement of Deficiency (SOD) 0UTG11). Census: 4	M 000		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 staff members (Manager B and Caregiver C) received annual training related to the rights of residents, medications, and standard precautions in 2022 and 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 0UTG11, dated 08/18/2022. Findings include: On 09/03/2024, Surveyor reviewed Manager B's	M 246		

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

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M 246	Continued From page 1 and Caregiver C's record. Manager B was hired 06/07/2008. Manager B's record did not contain medication administration training in 2022. Manager B's record did not contain resident rights training or standard precautions training in 2023. Caregiver C was hired 07/24/2021. Caregiver C's record did not contain resident rights training in 2023. On 09/04/2024, at approximately 11:30 AM, Surveyor interviewed Manager B. Manager B stated s/he would review the continuing education program the provider was utilizing to ensure all required topics were covered.	M 246		
M 352	88.05(4)(f) RESIDENT INCAPABLE OF SELF EVACUATION resident incapable of self evacuation. If a resident who is incapable of self-evacuation in an emergency is present in the home, the licensee or service provider shall be in the home. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure there was adequate staff to evacuate 1 of 1 resident (Resident 1). Findings include: The provider is licensed to care for 4 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's, and advanced aged.	M 352		

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M 352	Continued From page 2 Resident 1 admitted to the home, 07/07/2020, and was on hospice. On 09/04/2024, at approximately 10:50 AM, Surveyor arrived at the home and was greeted by Caregiver C. Caregiver C was the only caregiver in the home with the 4 residents, who were on hospice. On 09/04/2024, at approximately 11:15 AM, Surveyor observed Resident 1 sleeping in his/her hospital bed. On 09/04/2024, Surveyor reviewed Resident 1's record. Resident 1's "Individual Service Plan," dated 07/2024, documented: "Evacuation Capability in Emergency: Wheelchair or 2-person assist needed for evacuation." "Transfers: No weight bearing." On 09/06/2024 at 7:32 AM, Surveyor emailed Licensee A and requested the staff schedule for August and September 2024. On 09/06/2024 at 7:57 PM, Licensee A submitted the schedules which documented one staff person from 6:00 AM to 2:00 PM, one staff person from 2:00 PM to 10:00 PM, and one staff person 10:00 PM to 6:00 AM. On 09/07/2024 at 5:57 AM, Surveyor emailed Licensee A asking for clarification as Resident 1 was a two person assist and there was only one staff member scheduled.	M 352		

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M 408	Continued From page 3	M 408		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident was assessed to identify his/her needs in the areas of activities of daily living and health in the home. Resident 1 had 1/2-size side rails up on both sides of his/her bed. The provider had used these potentially dangerous devices without any assessment of the need or purpose, the potential for injury, whether the devices meet the definition of a restraint, and no exploration of alternatives to the side rails. In addition, the provider had not applied for a waiver of the code prohibiting the use of a restraint. Findings include: "Potential Risks of Bed Rails 1. Create a source of known morbidity and mortality such as: o Strangling, suffocation, serious bodily injury, * or death when patients or parts of their bodies are caught between rails, the openings of the rails, or	M 408		

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M 408	Continued From page 4	M 408		

between the bed rails and mattress. 2. Impede patients from safely getting out of bed: o Patients crawl over rails and fall from greater heights increasing the risk for serious injury. o Patients attempt to get out of bed over the foot board. 3. Restrain patients in many circumstances: o Hinder patients from independently getting out of bed thereby confining them to their beds. o Create a barrier to performing routine activities such as going to the bathroom. 4. Can create negative psychological effects: o Create undignified personal image. o Alter patient self-esteem. o Contribute to patient isolation. o Confinement can cause patients to be incontinent. The potential risks can be exacerbated by: o Improper match of the bed rail to bed frame. o Improper installation. o Objects such as holders or supports that remain when the bed rail is removed." (Source: DHS website, Assisted Living and Adult Day Care Centers: Standards of Practice Resources, April 2003, https://www.dhs.wisconsin.gov/regulations/assisted-living/standards.htm (retrieval date - September 04, 2024).)

On 09/04/2024, at approximately 11:15 AM, Surveyor observed Resident 1 sleeping in his/her bed. Resident 1's bed was a hospital bed that contained 1/2-size side rails up on both sides of the bed.

On 09/04/2024, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the home, 07/07/2020, and was on hospice.

Resident 1's "Individual Service Plan," dated 07/2024, documented:
"Supervision: 24-hour supervision."

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M 408	Continued From page 5 "Capacity for Self Care: Needs total assistance." "Capacity for Self Direction: Makes needs known." "Nursing Procedures: Resident will be free of skin breakdown; will be comfortable with frequent repositioning." "General Health: Resident has had several seizures." "Physical Disabilities; Mobility/Transfer: Needs EZ stand for transfers." "Wandering/Exit Seeking: No longer gets up by self." "Aggressive/Combative: Occasionally has brief episodes of agitation; usually is calm." Resident 1's record did not contain a bedrail assessment. On 09/04/2024, at approximately 11:45 AM, Surveyor interviewed Manager B. Manager B stated s/he did not know a bedrail assessment had to be completed if the bedrails came with the hospital bed. Manager B stated s/he would start utilizing a bedrail assessment.	M 408		