

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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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 000}	<p>Initial Comments</p> <p>On 03/01/2023, Surveyor completed a verification survey and two complaint investigations at Finch House.</p> <p>Eight deficiencies were identified. Two complaints were substantiated.</p> <p>Three of the 4 repeat deficiencies are being cited for the 3rd time. (See SOD 44E012 dated 09/14/2022, SOD 44E011, dated 04/25/2022 and SOD RG4M11, dated 04/11/2019).</p> <p>One of the 4 repeat deficiencies are being cited for the 4th time. (See SOD 44E012 dated 09/14/2022, SOD 44E011, dated 04/25/2022 and SOD RG4M11, dated 04/11/2019).</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 5</p>	{N 000}		
N 165	<p>83.12(4)(c) Reporting incidents with serious injury</p> <p>A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a written report to the department within 3 working days after an incident or accident resulting in emergency room treatment for 1 of 1 resident (Resident 9)</p>	N 165		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

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N 165	<p>Continued From page 1</p> <p>reviewed. On 06/04/2022, 08/12/2022, 01/20/2023, and 02/03/2023, Resident 9 went to the emergency room for hyperglycemia (high blood sugar). There was no evidence the facility reported these incidents to the State Agency.</p> <p>Findings include:</p> <p>The provider is licensed as a class CNA (non-ambulatory), Community Based Residential Facility (CBRF) to provide care for residents that have been diagnosed with intellectual disabilities, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's or advanced age.</p> <p>DEPARTMENT RECORDS</p> <p>On 02/14/2023, Surveyor reviewed the provider's self-report history. The department did not receive a self-report for Resident 9's emergency room visits on 06/04/2022, 08/12/2022, 01/20/2023 or 02/03/2023, due to high blood sugar.</p> <p>RECORD REVIEW</p> <p>On 02/14/2023 at approximately 11:15 a.m., Surveyor reviewed Resident 9's records, including observation notes, incident reports, individualized service plan (ISP), and correspondence with Resident 9's family care team.</p> <p>Resident 9 was admitted on 04/15/2022, with diagnosis of autism disorder, developmental delay, and diabetes mellitus type 1. Resident 9's record indicated staff were responsible for administering her/his medications.</p> <p>06/04/2022, Resident 9's incident report indicated</p>	N 165		

Wisconsin Department of Health Services

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N 165	<p>Continued From page 2</p> <p>s/he was given 6 units of insulin when s/he was supposed to be given 12 units. Resident 9's blood sugar went up to 414. Resident 9 was sent to the emergency room.</p> <p>06/04/2022, Resident 9's after visit summary from emergency room stated Resident 9 was seen for, "Diabetes with high blood sugar."</p> <p>08/12/2022, Resident 9's incident report indicated Resident 9's blood sugar was taken at 7:07 p.m. and registered at 523. Caregiver (CG) L contacted doctor's office to inform of blood sugar readings. On call nurse (OC RN) Y instructed CG L to call 911.</p> <p>08/12/2022, Resident 9's after visit summary from emergency room stated Resident 9 was seen for, "Diabetes with high blood sugar."</p> <p>01/20/2023, Resident 9's incident report indicated Resident 9's blood sugar was taken at 5:45 p.m. and registered above 600. Caregiver (CG) M contacted doctor's office to inform of blood sugar readings. On call nurse advised CG M to call 911.</p> <p>02/03/2023, Resident 9's after visit summary from emergency room stated Resident 9 was seen for, "Hyperglycemia (High Blood Sugar)."</p> <p>INTERVIEWS</p> <p>On 02/14/2023 at 11:20 a.m., Surveyor interviewed Director of Operations (DOO) C who stated, "I saw the provider concern come through for the June 2022 emergency room visit. To my knowledge, it was not self-reported."</p> <p>On 02/16/2023 at 11:45 a.m., Surveyor interviewed Endocrinologist N who stated, "I'm</p>	N 165		

Wisconsin Department of Health Services

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N 165	<p>Continued From page 3</p> <p>glad you called. I sent an angry note to this facility a while ago." Endocrinologist N recalled meeting Resident 9 in August of 2022. S/He described a review of Resident 9's glucometer showed not testing consistently. S/He observed in his/her notes, "some days no testing whatsoever." Endocrinologist N reviewed notes and told Surveyor that on 08/12/2022, 01/20/2023 and 02/02/2023 Resident 9 had an emergency room visit for high blood sugars.</p> <p>On 02/22/2023 at 10:30 a.m., Surveyor interviewed Family Care Registered Nurse (FC RN) Z who stated, "I started with [Resident 9] 06/01/2022. S/He has had several ER (emergency room) visits for hyperglycemia; 06/04/2022, 06/29/2022, 08/12/2022, and 01/20/2023. When we would go to the facility, we would find the MARs were incorrect. The sliding scale was off because the staff was not following it correctly. We found ourselves educating the staff on how to document in the MARs. The new sliding scale issued at the end of December 2022 was finally noted at the end of January of 2023."</p> <p>On 03/01/2023 at approximately 12:05 p.m., Surveyor interviewed Director of Operations (DOO) C and asked when these incidents were reported to the department. DOO C stated, "I really don't believe that they were." DOO C reported s/he was aware of the reporting requirements and would ensure reports were sent in as required in the future.</p>	N 165		
N 196	<p>83.14(2)(a) Licensee ensures facility complies with laws</p> <p>The licensee shall ensure the CBRF and its operation comply with all laws governing the</p>	N 196		

Wisconsin Department of Health Services

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N 196	<p>Continued From page 4</p> <p>CBRF.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interviews, the provider and its operation did not comply with all laws governing the Community Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. The licensee did not comply with requirements and special orders outlined in a Notice and Order letter from the Department.</p> <p>As a result of this verification visit, a total of 8 violations have been issued. Four of the 8 violations repeat deficiencies were related to physical environment and administration supervising daily operations. Two of 2 complaints related to resident care and services were substantiated.</p> <p>Findings include:</p> <p>The provider is licensed as a Class CNA (nonambulatory) facility to care for 8 residents in the client groups irreversible dementia/Alzheimer's disease, advanced aged, intellectually disabled and emotionally disturbed/mental illness. Current census was 6. Four residents use wheelchairs, and 2 residents use wheeled walkers.</p> <p>On 02/14/2023, Surveyor reviewed Department records and identified the following:</p> <p>On 11/17/2022, the Department issued a Notice and Order letter with Statement of Deficiency (SOD) 44E012 dated 09/14/2022. The letter stated: "AS SOON AS PRACTICABLE AND</p>	N 196		

Wisconsin Department of Health Services

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N 196	<p>Continued From page 5</p> <p>WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements." Special orders included the development and implementation of corrective measures to ensure the administrator supervises the daily operation of the CBRF, the installation of any needed upgrades to the integrated smoke and heat detection system in order to meet the requirements specified by Wis. Admin. Code § DHS 83.48(6). including obtaining approval from the department before installing a smoke and heat detection system, submission of plans for review of any needed upgrades to the integrated smoke and heat detection system to the Office of Plan Review and Inspection (OPRI) and the licensee will retain documentation to evidence OPRI completed the plan review and approved of the proposed changes to the existing smoke and heat detection system. Additionally, the licensee will obtain documentation from the service contractor to verify effective operation of the system after completion of the approved scope of work.</p> <p>On 02/14/2023 at 9:15 a.m., Surveyor conducted an onsite verification visit of SOD 44E012 and two complaint investigations. Surveyor conducted interviews with administration, made observations of the general environment and resident safety factors (fire extinguishers and integrated heat detector in laundry room).</p> <p>The following deficiencies were identified:</p> <p>Surveyor identified 4 deficiencies which were repeat deficiencies: 83.12(4)(c) Reporting Incidents With Serious Injury 83.14(2)(a) Licensee Ensures Facility Complies</p>	N 196		

Wisconsin Department of Health Services

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N 196	<p>Continued From page 6</p> <p>With Laws 83.15(3)(a) Administrator Shall Supervise Daily Operations (repeat deficiency) 83.32(3)(h) Rights of Residents: Receive Medications 83.34(3) More Than \$200 Personal Funds from Resident 83.41(1)(c) Dishwashing (repeat deficiency) 83.47(4)(a) Fire Extinguishers: Type And Inspection (repeat deficiency) 83.48(8)(b) Integrated Heat Detector In Laundry Room (repeat deficiency)</p> <p>On 02/14/2023 at 10:20 a.m., Director of Operations (DOO) C stated, "I started warning [Licensee] E about some of these concerns last March. The [Licensee] E will have to answer to these concerns, since [Administrator] B was in here."</p> <p>On 03/01/2023, at 1:00 p.m., during the exit conference, DOO C explained [Licensee] E was out of the country and unavailable. DOO C confirmed s/he would be representing [Licensee] E. DOO C reported [Licensee] E, [Administrator] B were aware the SOD was processed in November of 2022. DOO C explained s/he sent a follow up email to [Administrator] B on 11/21/2022 in response to (SOD) 44E012 dated 09/14/2022.</p> <p>Surveyor observed email between DOO C and [Administrator] B dated 11/21/2022. [Administrator] B wrote, "Fortunately all citations has [sic] been met and completed outside of Integrated heat detector." DOO informed Surveyor that Administrator B was in charge of the corrections.</p> <p>DOO C stated s/he provided recommendations to [Licensee] E and [Administrator] B. DOO C</p>	N 196		

Wisconsin Department of Health Services

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N 196	<p>Continued From page 7</p> <p>recalled, "I am pretty sure that I cited this code as a potential outcome if we didn't get things together. I've been telling them this for the past year and a half. [Licensee] E and I began talking with the city of Greenfield about the integrated heat detector. I dropped the ball and neglected to follow up."</p>	N 196		
{N 214}	<p>83.15(3)(a) Administrator shall supervise daily operation</p> <p>The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.</p> <p>This Rule is not met as evidenced by: Based on interview, record review and observations, the administrator did not supervise the daily operation of the Community-Based Residential Facility (CBRF) including resident care and services, personnel, and physical plant.</p> <p>Administrator B did not provide the daily supervision necessary to ensure residents received proper care and treatment including supervising personnel and ensuring a safe environment.</p> <p>This requirement is being cited for the fourth time.</p>	{N 214}		

Wisconsin Department of Health Services

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{N 214}	<p>Continued From page 8</p> <p>See Statements of Deficiency SOD 44E012 dated 09/14/2022, SOD 44E011, dated 04/25/2022, and SOD RG4M11, dated 04/11/2019.</p> <p>Findings include:</p> <p>On 02/14/2023 at 9:15 a.m., Surveyors conducted an onsite verification visit of SOD 44E012 and two complaint investigations. Surveyor conducted interviews with administration, made observations of the general environment and resident safety factors (Resident 9's medication management, fire extinguishers and integrated heat detector in laundry room).</p> <p>On 02/14/2023 at 11:20 a.m., Director of Operations (DOO) C stated, "[Resident 9]'s original blood sugar incident was at the end of May 2022. [Resident 9] was hospitalized and treated. I don't believe it was self-reported to the Bureau. None of the staff had RN (registered nurse) delegation. By the end of May all the staff received delegation. But we kept having turnover. I don't know if [Administrator B] kept up with the RN delegations." DOO C described, "Three more incidents happened in June. We had new staff but didn't have the delegation again. The family care nurse looked through the glucometer and noted one number and then the log displayed a different number. I believe there was possibly another hospitalization in June."</p> <p>On 02/14/2023 at 1:40 p.m., Surveyor interviewed Caregiver M who stated, "On 12/29/2022, [Endocrinologist N] faxed blood sugar update that never reached management. No changes were made until the end of January. They went a whole month without being updated." Caregiver M recalled Lead Caregiver Q's last day was 12/28/2022. Lead Caregiver R started at facility</p>	{N 214}		

Wisconsin Department of Health Services

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{N 214}	<p>Continued From page 9</p> <p>on 01/01/2023 and never knew about Resident 9's blood sugar changes. "No one was here to catch the change." Surveyor asked Caregiver L if s/he had nurse delegation training through the facility. Caregiver L replied, "Yes, I know what I'm doing."</p> <p>On 02/16/2023 at 1:55 p.m., Surveyor interviewed Primary Physician S, who stated, "our office received a lot of calls due to high blood sugars. There's no way the sugar should go up if the caregivers were following the insulin regimen. Back in August of 2022, they called almost every day. [Resident 9] had very erratic blood sugars."</p> <p>On 03/01/2023, at 1:00 p.m., during the exit conference, DOO C explained s/he sent a follow up email to [Administrator B] on 11/21/2022 in response to SOD 44E012 dated 09/14/2022. Surveyor observed email between DOO C and [Administrator B] dated 11/21/2022. [Administrator B] wrote, "Fortunately all citations has [sic] been met and completed outside of Integrated heat detector." Surveyor asked DOO C who was supervising daily operations. DOO C explained, "On paper, it was [Administrator B]. On the flip side, the caregivers were telling me s/he was never there. It sounded like [Administrator B] had the lead caregivers doing everything."</p> <p>Administrator B did not ensure regulatory compliance as evidenced by the following 10 deficiencies, including the 4 repeat deficiencies, that were identified during the verification visit due to Administrator B not supervising the daily operation of the CBRF.</p> <p>The following 8 deficiencies were identified, including 4 repeat violations:</p>	{N 214}		

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{N 214}	Continued From page 10 83.12(4)(c) Reporting Incidents With Serious Injury 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.15(3)(a) Administrator Shall Supervise Daily Operations (repeat deficiency) 83.32(3)(h) Rights of Residents: Receive Medications 83.34(3) More Than \$200 Personal Funds from Resident 83.41(1)(c) Dishwashing (repeat deficiency) 83.47(4)(a) Fire Extinguishers: Type And Inspection (repeat deficiency) 83.48(8)(b) Integrated Heat Detector In Laundry Room (repeat deficiency)	{N 214}		
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 1 of 1 resident (Resident 9) received all prescribed medications in the dosages and at intervals prescribed by the practitioner. A review of the MARs (medication administration records), Blood Glucose Records (from 12/29/2022 to 02/03/2023) and the memory in the glucometer revealed inconsistencies between the recorded blood sugar readings and the actual	N 352		

Wisconsin Department of Health Services

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N 352	<p>Continued From page 11</p> <p>reading from the glucometer memory.</p> <p>Resident 9 received incorrect doses of insulin resulting in 5 emergency room visits for hyperglycemia since 04/15/2022 (06/04/2022, 06/29/2022, 08/12/2022, 1/20/2023 and 02/02/2023).</p> <p>Findings include:</p> <p>On 09/14/2022, the Department received a complaint alleging Resident 9's medications were not logged correctly and there were gaps in documentation.</p> <p>On 02/14/2023 at approximately 11:15 a.m., Surveyor reviewed Resident 9's records, including observation notes, incident reports, individualized service plan (ISP), and correspondence with Resident 9's family care team. Resident 9 was admitted on 04/15/2022, with diagnosis of autism disorder, developmental delay, and diabetes mellitus type 1. Resident 9's record indicated staff were responsible for administering her/his medications.</p> <p>Medication Administration Record (12/16/2022 to 01/12/2023) Resident 9's MAR dated 12/16/2022, included Humalog insulin sliding scale as follows:</p> <p>0-80, no insulin 81-120 4 units 121-200 5 units > 200 6 units</p> <p>Surveyor reviewed Resident 9's medication administration record (MAR) from 12/16/2022 to 01/12/2023 for Humalog Kwikpen 100 unit/milliliter (ML) with injection times at 8:00 a.m.,</p>	N 352		

Wisconsin Department of Health Services

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N 352	<p>Continued From page 12</p> <p>12:00 p.m., and 4:00 p.m. In each date and time slot, caregivers initialed the time administered, blood sugar reading number, and where insulin was given. Surveyor noted injection site codes, denoted with a number, on the back side of the MAR for reference.</p> <p>Surveyor identified: 12/16/2022 at 4:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 12/25/2022 at 12:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 12/26/2022 at 4:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 12/28/2022 at 4:00 p.m., no initials in 'insulin given' and no site was recorded.</p> <p>New Insulin Physician's Order On 12/29/2022, Resident 9's new prescription summary issued by Endocrinologist N read, "Drug prescribed: Insulin Glargine 100 unit/ML subcutaneous solution pen-injector. Directions: inject 16 units into the skin daily. At 6:00 a.m."</p> <p>New Sliding Scale Insulin Physician's Order (12/29/2022 to 01/12/2023) On 12/29/2022, Resident 9's new prescription summary issued by Endocrinologist N read, "Give Lispro (Humalog) insulin shortly BEFORE each meal. If not eating-do not give Lispro insulin. Under 80 take no insulin, 80-100 take 3 units, 101-150 take 4 units, 151-200 take 6 units, 201-250 take 8 units, 251-300 take 10 units, over 300 take 12 units. Prime 2 units before each dose."</p> <p>Surveyor reviewed Resident 9's glucometer</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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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 352	<p>Continued From page 13</p> <p>memory including date and time of blood sugar readings and facility Blood Glucose Records-Units Administered documentation between 12/29/2022 and 02/03/2023. The following was identified:</p> <p>12/29/2022: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:11 a.m. Glucometer results: 398. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:58 p.m. Glucometer results: 229. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:48 p.m. Glucometer results: 252. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:35pm Glucometer results: 130. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 4 units Lispro insulin. (Incorrect dosing)</p> <p>12/30/2022: 6:00 a.m. Glucometer read time: 6:50 a.m. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 14</p> <p>insulin. 12:00 p.m. Glucometer read time: 12:57 p.m. Glucometer results: 184. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 6 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:46 p.m. Glucometer results: 459. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: None. There was no verification Resident 9 received her/his Lispro insulin.</p> <p>12/31/2022: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:30 a.m. Glucometer results: 315. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro insulin. 5:00 p.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro insulin. 8:00 p.m. Glucometer read time: 9:05pm Glucometer results: 178. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 6 units Lispro insulin. (Incorrect dosing)</p> <p>01/01/2023:</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 15</p> <p>6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing)</p> <p>8:00 a.m. Glucometer read time: 7:18 a.m. Glucometer results: 200. Blood Glucose Record-Units Administered: 6 units Lispro insulin.</p> <p>12:00 p.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro insulin.</p> <p>5:00 p.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro insulin.</p> <p>8:00 p.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro insulin.</p> <p>01/02/2023:</p> <p>6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing)</p> <p>8:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro insulin.</p> <p>12:00 p.m. Glucometer read time: 1:32 p.m. Glucometer results: 475. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>5:00 p.m. Glucometer read time: 5:46 p.m. Glucometer results: 381. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>8:00 p.m. Glucometer read time: 9:12 p.m.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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N 352	<p>Continued From page 16</p> <p>Glucometer results: 471. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>01/03/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:02 a.m. Glucometer results: 205. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:54 p.m. Glucometer results: 186. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:01 p.m. Glucometer results: 160. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 6 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:28 p.m. Glucometer results: 143. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 4 units Lispro insulin. (Incorrect dosing)</p> <p>01/04/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:02 a.m. Glucometer results: 381. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 17</p> <p>dosing) 12:00 p.m. Glucometer read time: 12:49 p.m. Glucometer results: 106. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 3 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:17 p.m. Glucometer results: 362. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:57 p.m. Glucometer results: 67. Blood Glucose Record-Units Administered: 0 units Lispro insulin.</p> <p>01/05/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:02 a.m. Glucometer results: 192. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 6 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 1:18 p.m. Glucometer results: 364. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:49 p.m. Glucometer results: 396. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:25 p.m. Glucometer results: 571. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 18</p> <p>01/06/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:09 a.m. Glucometer results: 369. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:57 p.m. Glucometer results: 124. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 4 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:22 p.m. Glucometer results: 415. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:18 p.m. Glucometer results: 397. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>01/07/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:28 a.m. Glucometer results: 313. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 1:05 p.m. Glucometer results: 190. Blood Glucose Record-Units Administered: 5. Resident 9 should</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 19</p> <p>have received 6 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:11 p.m. Glucometer results: 134. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 4 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:54 p.m. Glucometer results: 261. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 10 units Lispro insulin. (Incorrect dosing)</p> <p>01/08/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:21 a.m. Glucometer results: 310. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:57 p.m. Glucometer results: 279. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units Lispro insulin. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:09 p.m. Glucometer results: 334. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:46 p.m. Glucometer results: 204. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 8 units Lispro insulin. (Incorrect dosing)</p> <p>01/09/2023:</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 20</p> <p>6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing)</p> <p>8:00 a.m. Glucometer read time: 7:31 a.m. Glucometer results: 309. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>12:00 p.m. Glucometer read time: 1:05 p.m. Glucometer results: 353. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>5:00 p.m. Glucometer read time: 5:50 p.m. Glucometer results: 192. Blood Glucose Record-Units Administered: 4. Resident 9 should have received 6 units Lispro insulin. (Incorrect dosing)</p> <p>8:00 p.m. Glucometer read time: 10:03 p.m. Glucometer results: 259. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units Lispro insulin. (Incorrect dosing)</p> <p>01/10/2023:</p> <p>6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing)</p> <p>8:00 a.m. Glucometer read time: 7:16 a.m. Glucometer results: 132. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 4 units Lispro insulin. (Incorrect dosing)</p> <p>12:00 p.m. Glucometer read time: 2:50 p.m. Glucometer results: 456. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 21</p> <p>5:00 p.m. Glucometer read time: 5:57 p.m. Glucometer results: 260. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units Lispro insulin. (Incorrect dosing)</p> <p>8:00 p.m. Glucometer read time: 9:11 p.m. Glucometer results: 203. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 8 units Lispro insulin. (Incorrect dosing)</p> <p>01/11/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing)</p> <p>8:00 a.m. Glucometer read time: 7:03 a.m. Glucometer results: 360. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>12:00 p.m. Glucometer read time: 12:45 p.m. Glucometer results: 320. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>5:00 p.m. Glucometer read time: 5:47 p.m. Glucometer results: 302. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units Lispro insulin. (Incorrect dosing)</p> <p>8:00 p.m. Glucometer read time: 8:57 p.m. Glucometer results: 167. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 6 units Lispro insulin. (Incorrect dosing)</p> <p>01/12/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 22</p> <p>no verification Resident 9 received her/his 16 units Glargine insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:58 a.m. Glucometer results: 286. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units Lispro insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 1:01 p.m. Glucometer results: 112. Blood Glucose Record-Units Administered: 4 units Lispro insulin. 5:00 p.m. Glucometer read time: 6:11 p.m. Glucometer results: 211. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units Lispro insulin. (Incorrect dosing) 8:00 p.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his Lispro insulin. (Incorrect dosing)</p> <p>Sliding Scale Insulin on MAR (01/13/2023 to 02/09/2023) Surveyor reviewed Resident 9's MAR dated 01/13/2023 to 02/09/2023: "Humalog Kwikpen 100 unit/ML. Inject subcutaneously per sliding scale three times daily shortly before meals; (if not eating- do not give insulin) (if blood sugar is < 80=0 units, 80-100= 3U (units), 101-150=5U (units); 151-200=6U (units); 201-[sic]."</p> <p>Medication Administration Records dated 01/13/2023 to 02/09/2023 Surveyor identified Resident 9 had two MARs dated 01/13/2023 to 02/09/2023. The first MAR recorded administration from 01/13/2023 to 01/30/2023. Surveyor identified sliding scale insulin instruction was incomplete on the MAR used from 01/13/2023 to 01/30/2023. The MAR did not provide written instruction beyond blood sugar reading of 201.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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N 352	<p>Continued From page 23</p> <p>The second MAR recorded administration from 01/31/2023 to 02/09/2023. Surveyor identified information added to the sliding scale: 201-250=8U (units); 251-300=10U (units); >300-12U (units).</p> <p>First Medication Administration Record (administration from 01/13/2023 to 01/30/2023) Resident 9's first MAR dated 01/13/2023 to 02/09/2023 instructed: "Humalog Kwikpen 100 unit/ML. Inject subcutaneously per sliding scale three times daily shortly before meals; (if not eating- do not give insulin) (if blood sugar is < 80=0 units, 80-100= 3U (units), 101-150=5U; 151-200=6U; 201-[sic]."</p> <p>Surveyor observed no documentation for time administered, blood sugar reading number, and where insulin was given from 01/13/2023 to 01/30/2023.</p> <p>From 01/13/2023 to 01/30/2023 The MAR did not have any caregiver initials indicating medication was administered to Resident 9.</p> <p>Surveyor noted there were no insulin parameters written in MAR for blood sugar readings over 201.</p> <p>Surveyor reviewed Resident 9's MAR dated 01/13/2023 to 02/09/2023 for Humalog Kwikpen 100 unit/ML with injection times at 8:00 a.m., 12:00 p.m., and 4:00 p.m. In each date and time slot, Surveyor observed caregiver initialed the time administered, blood sugar reading number and where insulin was given. Surveyor observed injection site codes, denoted with a number, on the back side of the MAR for reference. The following was identified regarding Humalog administration:</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 24</p> <p>01/25/2023 at 4:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/26/2023 at 4:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/27/2023 at 4:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/28/2023 at 8:00 a.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/28/2023 at 12:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/29/2023 at 8:00 a.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/29/2023 at 12:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/30/2023 at 8:00 a.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded. 01/30/2023 at 12:00 p.m., no blood sugar recorded, no initials in 'insulin given' and no site was recorded.</p> <p>Second Medication Administration Record (administration from 01/31/2023 to 02/09/2023) Surveyor reviewed a second MAR dated 01/13/2023 to 02/09/2023 for Humalog Kwipen 100 unit/ML (milliliters) with an addition to the original sliding scale: 201-250=8U (units); 251-300=10U (units); >300-12U (units).</p> <p>Caregiver initials were observed from 01/31/2023 to 02/09/2023 only.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 25</p> <p>The sliding scale instructions read, "Humalog Kwikpen 100 unit/ML. Inject subcutaneously per sliding scale three times daily shortly before meals; (if not eating- do not give insulin) (if blood sugar is < 80=0 units, 80-100= 3U (units), 101-150=5U (units); 151-200=6U (units); 201-250=8U (units); 251-300=10U (units); >300-12U (units). Do not give if not eating. Prime with 2 units before use."</p> <p>New Sliding Scale Insulin On 01/27/2023 at 8:27 a.m., the provider received fax from Endocrinologist N indicating new insulin scale updated 12/29/2022.</p> <p>Resident 9's new order: Lantus 16 units once daily. Humalog shortly before a meal. Based on blood sugar before meal. Hold if not eating. Breakfast, lunch and dinner scale: < 80 hold, 80-100 3 units, 100-150 4 units, 151-200 6 units, 201-250 8 units, 251-300 10 units, over 300 12 units.</p> <p>On 01/27/2023, the provider received fax from Pharmacy Technician (PT) CC reading, "Please fax updated MAR with changes made on 12/29/22 for both Lantus Solostar and Humalog Kwikpen 100 unit/ML to 414-235-8173. Thank you."</p> <p>On 01/27/2023, the provider received fax from Pharmacy Technician (GPT) DD reading, "Facility is saying they didn't get a MAR for the current Humalog dosing. Please reprint and send a MAR for the Humalog and the current Lantus on it to the facility. (If they didn't get the Humalog I doubt they have the Lantus MAR as both we changed on the same day). Please make sure this is sent today."</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 26</p> <p>Surveyor noted from 12/29/2022 to 2/01/2023, Resident 9 received the wrong doses of insulin. The provider did not follow the new sliding scale guidelines updated 12/29/2023. Facility did not recognize the error until 01/27/2023. New MARs began with updated sliding scale on 01/31/2023.</p> <p>01/13/2023: 8:00 a.m. Glucometer read time: 7:33 a.m. Glucometer results: 264. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 1:05 p.m. Glucometer results: 357. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:27 p.m. Glucometer results: 575. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:04 p.m. Glucometer results: 254. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 10 units. (Incorrect dosing)</p> <p>01/14/2023: 8:00 a.m. Glucometer read time: 7:01 a.m. Glucometer results: 289. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:36 p.m. Glucometer results: 248. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:03 p.m. Glucometer results: HI. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:33 p.m. Glucometer results: 435. Blood Glucose</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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N 352	<p>Continued From page 27</p> <p>Record-Units Administered: 0. Resident 9 should have received 12 units. (Incorrect dosing)</p> <p>Surveyor reviewed One Touch Ultra Glucometer user guide, page 18. HI is defined, "if the result was above 600/mg/dL (deciliter)."</p> <p>01/15/2023: 8:00 a.m. Glucometer read time: 7:13 a.m. Glucometer results: 241. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:59 p.m. Glucometer results: 144. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 4 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:58 p.m. Glucometer results: 221. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:18 p.m. Glucometer results: 135. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 4 units. (Incorrect dosing)</p> <p>01/16/2023: 8:00 a.m. Glucometer read time: 8:49 a.m. Glucometer results: 447. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:51 p.m. Glucometer results: 245. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 8 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his insulin. 8:00 p.m. Glucometer does not indicate a blood sugar reading taken. Blood Glucose Record Time: 8:00 p.m. Blood Glucose Record: Blood</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 28</p> <p>Glucose: left blank. Units Administered: 0. (Incorrect dosing)</p> <p>01/17/2023: 8:00 a.m. Glucometer read time: 7:14 a.m. Glucometer results: 142. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 4 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:38 p.m. Glucometer results: 107. Blood Glucose Record-Units Administered: 4 units. 5:00 p.m. Glucometer read time: 5:52 p.m. Glucometer results: 358. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:47 p.m. Glucometer results: 322. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units. (Incorrect dosing)</p> <p>01/18/2023: 8:00 a.m. Glucometer read time: 7:13 a.m. Glucometer results: 316. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:56 p.m. Glucometer results: 226. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:51 p.m. Glucometer results: 314. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:15 p.m. Glucometer results: 86. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 3 units. (Incorrect dosing)</p> <p>01/19/2023: 8:00 a.m. Glucometer read time: 9:20 a.m.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 29</p> <p>Glucometer results: 342. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 2:28 p.m. Glucometer results: 301. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:08 p.m. Glucometer results: 292. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:53 p.m. Glucometer results: 116. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 4 units. (Incorrect dosing)</p> <p>01/20/2023: 8:00 a.m. Glucometer read time: 7:01 a.m. Glucometer results: 165. Blood Glucose Record-Units Administered: 6 units. 12:00 p.m. Glucometer read time: 12:53 p.m. Glucometer results: 163. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 6 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:06 p.m. Glucometer results: HI. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:58 p.m. Glucometer results: 415. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units. (Incorrect dosing)</p> <p>Emergency Room Visit- High Blood Sugar 01/20/2023, Resident 9's incident report indicated Resident 9's blood sugar was taken at 5:45 p.m. and registered above 600. Caregiver (CG) M contacted doctor's office to inform of blood sugar readings. On call nurse advised CG M to call 911. Resident 9 was sent to the</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 30</p> <p>emergency room via ambulance.</p> <p>01/21/2023: 8:00 a.m. Glucometer read time: 7:31 a.m. Glucometer results: 378. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 1:18 p.m. Glucometer results: 311. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:42 p.m. Glucometer results: 99. Blood Glucose Record-Units Administered: 4. Resident 9 should have received 3 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:24 p.m. Glucometer results: HI. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units. (Incorrect dosing)</p> <p>01/22/2023: 8:00 a.m. Glucometer read time: 7:13 a.m. Glucometer results: 324. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 1:00 p.m. Glucometer results: 241. Blood Glucose Record-Units Administered: 4. Resident 9 should have received 8 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:15 p.m. Glucometer results: 100. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 3 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 8:32 p.m. Glucometer results: 181. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 6 units. (Incorrect dosing)</p> <p>01/23/2023: 8:00 a.m. Glucometer read time: 6:59 a.m.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 31</p> <p>Glucometer results: 217. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:45 p.m.</p> <p>Glucometer results: 227. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:56 p.m.</p> <p>Glucometer results: HI. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:41 p.m.</p> <p>Glucometer results: 358. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units. (Incorrect dosing)</p> <p>01/24/2023: 8:00 a.m. Glucometer read time: 7:11 a.m. Glucometer results: 294. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 2:06 p.m.</p> <p>Glucometer results: 158. Blood Glucose Record-Units Administered: 4. Resident 9 should have received 6 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 5:54 p.m.</p> <p>Glucometer results: 344. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:17 p.m.</p> <p>Glucometer results: 125. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 4 units. (Incorrect dosing)</p> <p>01/25/2023: 8:00 a.m. Glucometer read time: 7:48 a.m. Glucometer results: 353. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:26 p.m.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 32</p> <p>Glucometer results: 118. Blood Glucose Record-Units Administered: 4 units. 5:00 p.m. Glucometer read time: 5:33 p.m. Glucometer results: 389. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:44 p.m. Glucometer results: 444. Blood Glucose Record-Units Administered: 2. Resident 9 should have received 12 units. (Incorrect dosing)</p> <p>01/26/2023: 8:00 a.m. Glucometer read time: 7:22 a.m. Glucometer results: 228. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units. (Incorrect dosing) 12:00 p.m. Glucometer read time: 12:49 p.m. Glucometer results: 141. Blood Glucose Record-Units Administered: 5. Resident 9 should have received 4 units. (Incorrect dosing) 5:00 p.m. Glucometer read time: 6:23 p.m. Glucometer results: 302. Blood Glucose Record-Units Administered: Nothing recorded. Resident 9 should have received 12 units. (Incorrect dosing) 8:00 p.m. Glucometer read time: 9:22 p.m. Glucometer results: 459. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units. (Incorrect dosing)</p> <p>01/27/2023: 8:00 a.m. Glucometer read time: 9:03 a.m. Glucometer results: 592. Blood Glucose Record-Units Administered: 12 units. 12:00 p.m. Glucometer read time: 12:53 p.m. Glucometer results: 91. Blood Glucose Record-Units Administered: 3 units. 5:00 p.m. Glucometer read time: 5:57 p.m. Glucometer results: 287. Blood Glucose Record-Units Administered: 10 units.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 33</p> <p>8:00 p.m. Glucometer read time: 9:10 p.m. Glucometer results: 190. Blood Glucose Record-Units Administered: missed documentation. Resident 9 should have received 6 units. (Incorrect dosing)</p> <p>01/28/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Lantus insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 8:00 a.m. Glucometer results: 233. Blood Glucose Record-Units Administered: 16. Resident 9 should have received 8 units Humalog insulin. (Incorrect dosing) 12:00 p.m. Glucometer read time: 1:05 p.m. Glucometer results: 165. Blood Glucose Record-Units Administered: 6 units Humalog insulin. 5:00 p.m. Glucometer read time: 5:50 p.m. Glucometer results: 395. Blood Glucose Record-Units Administered: 12 units Humalog insulin. 8:00 p.m. Glucometer read time: 8:05 p.m. Glucometer results: 350. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units Humalog insulin. (Incorrect dosing)</p> <p>01/29/2023: 6:00 a.m. Glucometer read time: 7:19 a.m. Glucometer results: 367. Blood Glucose Record-Units Administered: 16 units Lantus insulin. 8:00 a.m. Glucometer read time: 9:52 a.m. Glucometer results: 213. Blood Glucose Record-Units Administered: 8 units Humalog insulin.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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N 352	<p>Continued From page 34</p> <p>12:00 p.m. Glucometer read time: 12:57 p.m. Glucometer results: 93. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 3 units Humalog insulin. (Incorrect dosing)</p> <p>5:00 p.m. Glucometer read time: 5:45 p.m. Glucometer results: 380. Blood Glucose Record-Units Administered: 12 units Humalog insulin.</p> <p>8:00 p.m. Glucometer read time: 10:03 p.m. Glucometer results: 147. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 4 units Humalog insulin. (Incorrect dosing)</p> <p>01/30/2023:</p> <p>6:00 a.m. Glucometer read time: 7:52 a.m. Glucometer results: 169. Blood Glucose Record-Units Administered: 16 units Lantus insulin.</p> <p>8:00 a.m. Glucometer read time: 10:37 a.m. Glucometer results: 569. Blood Glucose Record-Units Administered: 12 units Humalog insulin.</p> <p>12:00 p.m. Glucometer read time: 12:47 p.m. Glucometer results: 230. Blood Glucose Record-Units Administered: 8 units Humalog insulin.</p> <p>5:00 p.m. Glucometer read time: 5:58 p.m. Glucometer results: 273. Blood Glucose Record-Units Administered: 12. Resident 9 should have received 10 units Humalog insulin. (Incorrect dosing)</p> <p>8:00 p.m. Glucometer read time: 10:10 p.m. Glucometer results: 149. Blood Glucose Record-Units Administered: 0 units Humalog insulin. Resident 9 should have received 4 units Humalog insulin. (Incorrect dosing)</p> <p>01/31/2023:</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 35</p> <p>6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Lantus insulin. (Incorrect dosing)</p> <p>8:00 a.m. Glucometer read time: 7:05 a.m. Glucometer results: 228. Blood Glucose Record-Units Administered: 8 units Humalog insulin.</p> <p>12:00 p.m. Glucometer read time: None. There was no verification Resident 9 received her/his Humalog insulin.</p> <p>5:00 p.m. Glucometer read time: 6:02 p.m. Glucometer results: 474. Blood Glucose Record-Units Administered: 12 units Humalog insulin.</p> <p>8:00 p.m. Glucometer read time: 9:22 p.m. Glucometer results: 531. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 12 units Humalog insulin. (Incorrect dosing)</p> <p>Incident Report-High Blood Sugar On 01/31/2023, Resident 9's incident report indicated Resident 9's blood sugar was taken at 8:00 p.m. and registered above 500. Caregiver M contacted doctor's office to inform of blood sugar readings. On call nurse advised resident to be given milk and water. Caregiver M rechecked blood sugars at 8:25 p.m. Blood sugars dropped 'significantly' Caregiver M, "called management and cancelled pending ER visit."</p> <p>02/01/2023: 6:00 a.m. Glucometer read time: 7:22 a.m. Glucometer results: 349. Blood Glucose Record-Units Administered: 16 units Lantus insulin.</p> <p>8:00 a.m. Glucometer read time: 8:17 a.m. Glucometer results: 187. Blood Glucose Record-Units Administered: 6 units Lantus insulin.</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 36</p> <p>12:00 p.m. Glucometer read time: 1:05 p.m. Glucometer results: 135. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 4 units Lantus insulin. (Incorrect dosing)</p> <p>5:00 p.m. Glucometer read time: 6:03 p.m. Glucometer results: 291. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 10 units Lantus insulin. (Incorrect dosing)</p> <p>8:00 p.m. Glucometer read time: 9:05 p.m. Glucometer results: 215. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 8 units Lantus insulin. (Incorrect dosing)</p> <p>02/02/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Lantus insulin. (Incorrect dosing)</p> <p>8:00 a.m. Glucometer read time 7:59 a.m. Glucometer results: 149. Blood Glucose Record-Units Administered: 4. Resident 9 should have received 6 units Lantus insulin. (Incorrect dosing)</p> <p>12:00 p.m. Glucometer read time: 12:44 p.m. Glucometer results: 202. Blood Glucose Record-Units Administered: 6. Resident 9 should have received 8 units Lantus insulin. (Incorrect dosing)</p> <p>5:00 p.m. Glucometer read time: 6:01 p.m. Glucometer results: 321. Blood Glucose Record-Units Administered: 4. Resident 9 should have received 12 units Lantus insulin. (Incorrect dosing)</p> <p>8:00 p.m. Glucometer read time: 9:00 p.m. Glucometer results: 181. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 6 units Lantus insulin. (Incorrect</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 37</p> <p>dosing)</p> <p>02/03/2023: 6:00 a.m. Glucometer read time: None. Blood Glucose Record-Units Administered: There was no verification Resident 9 received her/his 16 units Lantus insulin. (Incorrect dosing) 8:00 a.m. Glucometer read time: 7:03 a.m. Glucometer results: 169. Blood Glucose Record-Units Administered: 6 units Lantus insulin. 12:00 p.m. Glucometer read time: 12:36 p.m. Glucometer results: 140. Blood Glucose Record-Units Administered: 4 units Lantus insulin. 5:00 p.m. Glucometer read time: 5:38 p.m. Glucometer results: 558. Blood Glucose Record-Units Administered: 12 units Lantus insulin. 8:00 p.m. Glucometer read time: 8:17 p.m. Glucometer results: 244. Blood Glucose Record-Units Administered: 0. Resident 9 should have received 8 units Lantus insulin. (Incorrect dosing)</p> <p>Emergency Room Visit- High Blood Sugar On 02/03/2023, Resident 9's after visit summary from emergency room (ER) stated Resident 9 was seen for, "Hyperglycemia (High Blood Sugar)."</p> <p>On 02/03/2023, Resident 9's incident report indicated Resident 9's blood sugar was taken before dinner and registered above 500. Caregiver L contacted doctor's office to inform of blood sugar readings. Doctor advised Caregiver L to call 911. Resident was taken to ER.</p> <p>INTERVIEWS:</p> <p>On 02/14/2023 at 9:24 a.m., Caregiver M informed Surveyor, "[Resident 9]'s sliding scale</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 352	<p>Continued From page 38</p> <p>insulin has been a roller coaster for the past two months."</p> <p>On 02/14/2023 at 11:00 a.m., Director of Operations (DOO) C stated, "There was a significant amount of med (medication) errors in May and June because Caregivers did not have the RN delegations."</p> <p>On 02/14/2023 at 12:05 p.m., Surveyor observed conversation between DOO C and Caregiver M. DOO C questioned how caregivers knew when to call Resident 9's primary physician and what symptoms to be concerned about. Caregiver M stated, "I was just always told to call the nurse. I never found anything written to direct me."</p> <p>On 02/14/2023 at 1:03 p.m., Surveyor interviewed Caregiver M who stated, "Resident 9's blood sugars are really messed up. Some caregivers only gave him/her 5 units at 6:00 a.m. S/He was supposed to get 16 units. You'll see. Just look at the glucose records."</p> <p>On 02/14/2023 at 1:34 p.m., Surveyor interviewed Caregiver L who stated, "Resident 9 had a lot of blood sugar issues. I just tried to watch the white board by the med (medication) cart for any updates. Surveyor asked Caregiver L if s/he had nurse delegation training through the facility. Caregiver L replied, "I think so. I don't really remember."</p> <p>On 02/14/2023 at 1:40 p.m., Surveyor interviewed Caregiver M who stated, "On 12/29/2022, [Endocrinologist N] faxed blood sugar update. I don't think it ever reached the management. No changes were made until the end of January. They went a whole month without being updated." Caregiver M recalled Lead Caregiver Q's last day</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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--------------------------------------------------------	---------------------------------------------------------------------------------------

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N 352	<p>Continued From page 39</p> <p>was 12/28/2022. Lead Caregiver R started at facility on 01/01/2023 and never knew about Resident 9's blood sugar changes. "No one was here to catch the change." Surveyor asked Caregiver M if s/he had nurse delegation training through the facility. Caregiver M replied, "Yes, I know what I'm doing."</p> <p>On 02/16/2023 at 9:54 a.m., Surveyor interviewed Home Care Registered Nurse (HC RN) O who stated, "I worked with [Resident 9] for over a year. I was very concerned. There were so many incidents with insulin at that facility. I talked with [Administrator B] multiple times, and s/he said his/her nurse could watch over things. However, when I interviewed the nurse, s/he said, 'No. I'm just a consultant.'"</p> <p>On 02/22/2023 at 10:30 a.m., Surveyor interviewed Family Care Registered Nurse (FC RN) Z who stated, "I started with Resident 9 06/01/2022. S/He has had several ER visits for hyperglycemia. In his/her chart, I see 06/04/2022, 06/29/2022, 08/12/2022 and 01/20/2023 emergency room visits. When we would go to the facility, we would find the MARs were incorrect. The sliding scale was off because the staff was not following it correctly. We found ourselves educating the staff on how to document in the MARs. The new sliding scale issued at the end of December 2022 was finally noted at the end of January of 2023."</p> <p>FC RN Z told Surveyor that three high priority placement referrals had been created to remove Resident 9 from facility due to staff's lack of knowledge and understanding.</p> <p>On 03/01/2023, at 1:14 p.m., during the exit conference, Surveyor asked DOO C who was</p>	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
--------------------------------------------------	--------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
--------------------------------------------------------	---------------------------------------------------------------------------------------

(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 352	Continued From page 40 supervising daily operations. DOO C explained "On paper, it was [Administrator B]. On the flip side, the caregivers were telling me s/he was never there. It sounded like [Administrator B] had the lead caregivers doing everything." Surveyor asked who, specifically, was monitoring Resident 9's blood sugars and changes. DOO C stated, "I don't think anyone was to be honest with you. I don't think there was any monitoring. [Resident 9's] blood sugars were like a roller-coaster of really not having the right protocols in place." Cross Reference N0431 83.38(1)(g) Health Monitoring	N 352		
N 370	83.34(3) More than \$200 personal funds from resident Funds in excess of \$200. A CBRF receiving more than \$200 of personal funds from a resident shall deposit funds in excess of \$200 in an interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure resident funds in excess of \$200 were placed in an interest-bearing account for all residents with funds managed by the provider for 1 of 1 resident. Resident 4 had \$300 of uncashed checks in the petty cash box. Findings include: On 02/14/2023 at 9:55 a.m., Surveyor observed three checks made out to Finch House, in the	N 370		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
--------------------------------------------------	--------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
--------------------------------------------------------	---------------------------------------------------------------------------------------

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N 370	<p>Continued From page 41</p> <p>amount of one hundred dollars each. The memo line read, "[Resident 4] allowance." The checks were each made out by Representative Payee (RP) GG and dated 12/02/2022, 01/03/2023, and 02/03/2023.</p> <p>On 02/14/2023 at 9:58 a.m., Director of Operations (DOO) C opened and reviewed house petty cash box. DOO C stated, "I don't know why these checks are here."</p> <p>On 02/22/2023 at 11:19 a.m., Surveyor requested to review Resident 4's signed consent to manage funds documentation and financial ledgers from December 2022 to present via email.</p> <p>On 02/23/2023, DOO C returned Resident 4's ledger via email. The ledger was dated 10/21/2022. The ledger indicated that Resident 4 had \$96.00 in petty cash.</p> <p>On 02/23/2023 at 9:02 a.m. DOO C wrote, "I could not locate a consent to manage funds form that we had seen in other residents at the facility. I also could only locate one ledger that was in the box that [Caregiver M] opened while we were there. It is attached. I have sent a request to [Administrator B] for his/her copy of the consent form along with any and all ledgers pertaining to the date range requested. If I receive these from him/her prior to the deadline I will send them along." Surveyor received no further documentation.</p> <p>Resident 4 had a total of \$300 in his/her account managed by provider on 02/14/2023.</p> <p>Interviews:</p> <p>On 02/23/2023 at 4:06 p.m., Surveyor interviewed</p>	N 370		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
--------------------------------------------------	--------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
--------------------------------------------------------	---------------------------------------------------------------------------------------

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N 370	<p>Continued From page 42</p> <p>Care Manager (CM) FF, who stated, "[Resident 4's] family care MCP (member centered plan) from October 2022 read, 'CBRF (Community Based Residential Facility) will assist him/her with small financial transactions as needed.' The newer MCP says s/he has a representative payee assisting with his/her money." CM FF confirmed the representative payee was RP GG.</p> <p>On 03/01/2023 at 1:30 p.m., Surveyor conducted an exit conference with DOO O and reviewed concerns regarding Resident 4's financial ledgers not being current and Resident 4 having \$300 of uncashed checks. DOO O commented that they would be working with Resident 4's representative payee to get the money moved to a savings account.</p>	N 370		
N 431	<p>83.38(1)(g) Health monitoring.</p> <p>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 intake and acceptance of diet. The CBRF shall</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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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 431	<p>Continued From page 43</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure health monitoring for 1 of 1 resident. Resident 9 had insulin dependent diabetes and the provider did not implement updated physician's orders, which resulted in 3 emergency room visits for hyperglycemia. Findings include:</p> <p>On 02/14/2023, Surveyor reviewed Resident 9's record. Resident 9 was admitted on 04/15/2022, with diagnosis of autism disorder, developmental delay, and diabetes mellitus type 1. Resident 9's individualized service plan (ISP), dated 05/20/2022, identified medications administered by staff. Resident 9's ISP indicated Resident 9 had poorly controlled diabetes. Staff will encourage Resident 9 to watch his/her sugar consumption.</p> <p>On 02/14/2023, Surveyor reviewed Resident 9's physician orders and medication administration records (MARs) for the time-period of 08/10/2022 to 02/10/2023 and identified the following:</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
--------------------------------------------------	--------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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N 431	<p>Continued From page 44</p> <ul style="list-style-type: none"> - On 08/10/2022, Resident 9's physician's order issued by Primary Physician (PMD) S read, "Inject 15 units into the skin daily AND 5 units nightly. (15 units at 8:00 a.m. and 5 units at 8:00 p.m. starting 08/10/22) New dosing. Prime 2 units before each dose." - On 08/17/2022, Resident 9's new prescription summary issued by Endocrinologist N read, "Insulin Glargine 100 unit/ML (milliliters) subcutaneous solution pen-injector. 15 units once daily at 8:00 a.m. (starting 8/10/22) New dosing. Prime 2 units before each dose." - On 08/18/2022, Endocrinologist N sent updated insulin regimen, "Lantus 15 units at 8:00 a.m. Humalog 6 am, noon, 5 pm with meals. 80 hold. 81-100 2 units, 101-150 3 units, 151-200 4 units, 201-250 5 units, 251-300 6 units, 301-350 7 units, 351-400 8 units, call MD > 400." - On 08/23/2022, letter issued by Endocrinologist N read, "Insulin regimen: Lantus 15 units at 8:00 a.m. and 5 units at 8:00 p.m. Humalog 6 am, noon, 5 pm with meals. 80-hold. 81-100 1 unit, 101-150 2 units, 151-200 3 units, 201-250 4 units, 251-300 5 units, 301-350 6 units, 351-400 7 units, call MD > 400." - On 08/24/2022, Resident 9's new prescription summary issued by Endocrinologist N read, "Insulin Lispro 100 unit/ML (milliliter) subcutaneous solution cartridge (HumaLOG Cartridge). Use before each meal when food is sitting in front of you. BS (blood sugar) < 80 hold, BS (blood sugar) 80-100=1 unit, BS (blood sugar) 101-150= 2 units, BS (blood sugar) 151-200= 3 units, BS (blood sugar) 201-250= 4 units, BS (blood sugar) 251-300= 5 units, BS (blood sugar) 	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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N 431	<p>Continued From page 45</p> <p>301-350= 6 units, BS (blood sugar) 351-400= 7 units, > 400=call MD."</p> <p>- On 08/29/2022, Resident 9's new prescription summary issued by Endocrinologist N read, "Insulin Lispro (1 unit dial) 100 unit/ML (milliliter) subcutaneous solution pen-injector (Humalog KwikPen). Under 80 hold insulin and give after meal, 81-120 give 4 units, 121-200 give 5 units, > 200 give 6 units."</p> <p>- On 08/29/2022, Resident 9's new prescription summary issued by Endocrinologist N read, "Drug prescribed: Insulin Glargine 100 unit/ML (milliliters) subcutaneous solution pen-injector. Directions: inject 15 units into the skin daily. At 6:00 a.m."</p> <p>- On 08/29/2022, Endocrinologist N sent updated insulin regimen: "Lantus 15 units every morning at 6:00 a.m. Humalog with meals. Under 80 hold and give after meal. 81-120 give 4 units, 121-200 5 units, anything 201 and higher, give 6 units. Call with BG (blood glucose) log in 1 week. Do not call with individual blood sugars. If patient has blood sugar under 70 and has symptoms of low blood sugar treat with 15 grams of carb (4 ounces of juice) and repeat blood sugar check. If blood sugar remains under 70 and patient continues to have symptoms, please seek emergency care. If blood sugars are higher than 300 for 2 days in a row and patient has abdominal pain, nausea and vomiting, please seek emergency care. Please call with any questions/concerns."</p> <p>- From 12/16/2022 to 01/12/2023, Resident 9's medication administration record (MAR) Resident 9's blood glucose level was to be tested 4 times a day and as needed (8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m.)</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 46</p> <ul style="list-style-type: none"> - On 12/29/2022, Resident 9's physician's order issued by Endocrinologist N prescribed Insulin Glargine 100 unit/ML subcutaneous solution pen-injector. Directions: inject 16 units into the skin daily at 6:00 a.m. - On 12/29/2022, Resident 9's physician's order issued by Endocrinologist N read to give Lispro (Humalog) insulin shortly BEFORE each meal. If not eating-do not give Lispro insulin. Under 80 take no insulin, 80-100 take 3 units, 101-150 take 4 units, 151-200 take 6 units, 201-250 take 8 units, 251-300 take 10 units, over 300 take 12 units. Prime 2 units before each dose. - On 01/13/2023 to 02/09/2023, Resident 9 had two MARs. - On 01/13/2023 to 02/09/2023, Resident 9's first MAR identified sliding scale insulin on Humalog Kwikpen 100 unit/ML. Inject subcutaneously per sliding scale three times daily shortly before meals; (if not eating- do not give insulin) (if blood sugar is < 80=0 units, 80-100= 3U (units), 101-150=5U (units); 151-200=6U (units); 201-[sic]." The MAR did not provide written instruction beyond blood sugar reading of 201. - On 01/13/2023 to 02/09/2023, Resident 9's second MAR identified Humalog Kwikpen 100 unit/ML (milliliters) with the addition to the original sliding scale of 201-250=8U (units); 251-300=10U (units); >300-12U (units). On 02/14/2023, Surveyor reviewed Resident 9's emergency room documentation for the time-period of 06/04/2022 to 02/03/2023. Surveyor identified the following: - On 06/04/2022, Resident 9's after visit summary 	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 47</p> <p>from emergency room stated Resident 9 was seen for, "Diabetes with high blood sugar."</p> <p>- On 08/12/2022, Resident 9's after visit summary from emergency room stated Resident 9 was seen for, "Diabetes with high blood sugar."</p> <p>- On 02/03/2023, Resident 9's after visit summary from emergency room stated Resident 9 was seen for, "Hyperglycemia (High Blood Sugar)."</p> <p>According to the Mayo Clinic website, "High blood sugar is also called Hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart ...Symptoms Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL) ... Symptoms of hyperglycemia develop slowly over several days or weeks. The longer blood sugar levels stay high, the more serious symptoms may become ... Later signs and symptoms If hyperglycemia isn't treated, it can cause toxic acids, called ketones, to build up in the blood and urine. This condition is called ketoacidosis. Symptoms include Fruity-smelling breath, Dry mouth, Abdominal pain, Nausea and vomiting, Shortness of breath, Confusion, Loss of consciousness ...Seek immediate help from your care provider or call 911 if: Your blood glucose levels stay above 240 mg/dL (13.3 mmol/L) and you have symptoms of ketones in your urine ...Emergency complications: Diabetic Ketoacidosis. This condition develops when you don't have enough insulin in your body. When this happens, glucose can't enter your cells for</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 48</p> <p>energy. Your blood sugar level rises, and your body begins to break down fat for energy. When fat is broken down for energy in the body, it produces toxic acids called ketones. Ketones accumulate in the blood and eventually spill into the urine. If it isn't treated, diabetic ketoacidosis can lead to a diabetic coma that can be life-threatening." (Source: The Mayo Clinic Website, Hyperglycemia in diabetes, 1998-2022, https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631 (retrieval date - March 3, 2023).)</p> <p>On 02/14/2023, Surveyor reviewed Surveyor Resident 9's medical documentation and identified the following:</p> <ul style="list-style-type: none"> - On 01/27/2023 at 8:27 a.m., facility received fax from Endocrinologist N indicating new insulin scale updated 12/29/2022: Lantus 16 units once daily. Humalog shortly before a meal. Based on blood sugar before meal. Hold if not eating. Breakfast, lunch and dinner scale: < 80 hold, 80-100 3 units, 100-150 4 units, 151-200 6 units, 201-250 8 units, 251-300 10 units, over 300 12 units. - On 01/27/2023 at 10:30 a.m., facility received fax from Pharmacy Technician (PT) CC reading, "Please fax updated MAR with changes made on 12/29/22 for both Lantus Solstar and Humalog Kwikpen 100 unit/ML (milliliters) to 414-235-8173. Thank you." - On 01/27/2023 at 10:31 a.m., facility received fax from Pharmacy Technician (PT) DD reading, "Facility is saying they didn't get a MAR for the current Humalog dosing. Please reprint and send a MAR for the Humalog and the current lantus 	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 49</p> <p>[sic] on it to the facility. (If they didn't get the Humalog I doubt they have the lantus [sic] MAR as both we changed on the same day). Please make sure this is sent today."</p> <p>- On 02/16/2023 at 11:45 a.m., Surveyor interviewed Endocrinologist N who stated, "I'm glad you called. I sent an angry note to this facility a while ago." Endocrinologist N recalled meeting Resident 9 in August of 2022. S/He described a review of Resident 9's glucometer showed not testing consistently. S/He observed in his/her notes that some days no testing was done for Resident 9 at all. Endocrinologist N reviewed notes and told Surveyor that on 08/12/2022, 01/20/2023, and 02/02/2023 Resident 9 had an emergency room visit for high blood sugars.</p> <p>- On 02/16/2023 at 1:55 p.m., Surveyor interviewed Primary Physician (PMD) S, who confirmed their office received a lot of calls due to high blood sugars. PMD S stated there was no way the sugar should go up if the caregivers were following the insulin regimen. PMD S informed Surveyor back in August of 2022, the facility called almost every day. [Resident 9] had very erratic blood sugars.</p> <p>- On 02/22/2023 at 10:30 a.m., Surveyor interviewed Family Care Registered Nurse (FC RN) Z, who confirmed s/he started with Resident 9 on 06/01/2022. S/He confirmed Resident 9 had several ER (emergency room) visits for hyperglycemia. In Resident 9's chart, s/he noted four emergency room visits on 06/04/2022, 06/29/2022, 08/12/2022 and 01/20/2023. FC RN Z described when the Managed Care Organization (MCO) would go to the facility, they would find the MARs incorrect. The sliding scale was off because the staff was not following the</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 50</p> <p>directions correctly. The MCO staff found themselves educating the staff on how to document in the MARs. FC RN Z recalled the new sliding scale blood sugar order that was issued at the end of December 2022 finally noted at the end of January of 2023. FC RN Z explained that three high priority placement referrals have been created to remove Resident 9 from facility due to staff's lack of knowledge and understanding.</p> <p>Record Review</p> <ul style="list-style-type: none"> - DOO O provided copy of Family Care provider concern, dated 05/11/2022. Resident 9's Family Care Registered Nurse (FC RN) T submitted provider concern stating Resident 9 was given wrong insulin. FC RN T was notified by Home Care RN O (HC RN) O that member was given 16u (units) of Lantus on 5/11 for the morning when it should have been Humalog. - HC RN O forwarded his/her documentation on Resident 9 via email to Surveyor, dated 05/16/2022. HC RN O wrote, "[Resident 9] is scheduled to receive 12 units lantus [sic] at 8 am however staff gave 10 units lantus [sic] on 5/14 at 8am, 8 units lantus [sic] on 5/15 at 8 am. Staff has been signing in MAR that they've been giving 12 units. HC RN O asked Lead Caregiver P (LC P), what happens to staff when med errors occur. LC P stated, "I'm going to start writing them up." HC RN O asked LC P what happens when staff make errors; LC P stated, 'that ends today' and that s/he is going to call [Administrator B]." - DOO O provided copy of Family Care provider concern, dated 06/03/2022. Resident 9's Family Care Case Manager (FC CM) U submitted provider concern stating staff was not 	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 51</p> <p>administering medication as instructed which resulted in member becoming hospitalized. S/He wrote, "[Resident 9] was never given his/her insulin by unidentified caregiver and had to be sent to the hospital due to a high blood sugar level of 412. Staff reported that s/he did not know how to give member insulin. Oncoming [Caregiver] V stepped in to assist." Resident 9 was sent to the hospital and released at 4:30 a.m. on 06/04/2022. According to FC CM U, Resident 9 was ordered to be given 12 units of Lantus and Resident 9 went all day without receiving his/her insulin.</p> <p>- DOO C provided a complete investigation summary of medication error incidents occurring on 05/11/2022, 06/04/2022, and 06/08/2022. Surveyor reviewed investigation summary which acknowledged Resident 9's Primary Care Physician was not notified per physician orders after 05/11/2022 incident, 06/04/2022 incident, or after 06/08/2022 incident.</p> <p>- DOO O provided copy of Family Care provider concern, dated 06/09/2022. Resident 9's Family Care Registered Nurse (FC RN) Z submitted provider concern stating Resident 9's HC RN O noted medication errors. The concern summarized continued medication errors, lack of notification to interdisciplinary staff and professionalism. Facility implemented new insulin medication policy for Resident 9 reading on 06/09/2022: "Daily, between 7:00 a.m. and 3:00 p.m., the staff on duty must fax over the daily glucose login sheet and MAR to corporate." The fax number was provided to ensure staff had the information.</p> <p>- DOO O provided copy of Family Care provider concern, dated 06/15/2022. On 06/08/2022,</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 52</p> <p>Resident 9's HC RN O noted medication errors: On 06/08/2022 at 8:00 a.m.- 4 units instead of 12 units of Lantus given. On 06/08/2022 at 4:00 p.m., incorrect documentation on glucose log (meter reports 393) log reports 320 and then written over that, 300. On 06/08/2022 at 8:00 p.m., Glucose noted 55; staff failed to call Primary Care Physician S and did not follow MAR (Medication Administration Record) to give glucose packet.</p> <p>- On 07/25/2022, Pharmacist EE conducted an annual medication regimen review and documented, "Significant fluctuations in BS (blood sugar) noted MD (physician) following closely."</p> <p>- On 08/01/2022, Resident 9's note in resident communication form identified Resident 9's blood sugar was high at 403, then at 482. Doctor was notified. Lead Caregiver Q spoke with the nurse.</p> <p>- On 08/02/2022, Resident 9's note in resident communication form identified Resident 9's blood sugar continued to elevate. Primary Care Physician (PMD) S notified. Lead Caregiver Q wrote, "Starting on 08/03/2022, Resident 9 will only get 8:00 a.m. Lantus 15 units."</p> <p>- On 08/03/2022, Resident 9's incident report indicated Resident 9's blood sugar was 523 at 8:30 p.m. CG L called (PMD) S's on-call RN. CG L was directed to call 911. After arrival, Resident 9's blood sugar reduced to 381. Resident 9 was not transported to ER.</p> <p>- On 08/12/2022, Resident 9's incident report indicated Resident 9's blood sugar was taken at 7:07 p.m. and registered at 523. CG L contacted doctor's office to inform of blood sugar readings. On call nurse (OC RN) Y instructed CG L to call</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 53</p> <p>911.</p> <p>- On 08/24/2022, Resident 9's note in resident communication form identified Lead Caregiver Q spoke to Resident 9's nurse regarding low blood sugar of 52 and 71. Nurse informed Lead Caregiver Q of change in Resident 9's sliding scale. Lead Caregiver Q wrote, "Resident 9's sliding scale has been changed as of 08/24/2022 < 80 hold, 80-100 1 unit, 101-150 2 units, 151-200 3 units, 201-250 4 units, 251-300 5 units, 301-350 6 units, 351-400 7 units, > 400 call doctor."</p> <p>- On 08/25/2022, Resident 9's incident report indicated Resident 9's blood sugar was taken at 5:00 p.m. and registered at 60. Lead Caregiver Q contacted doctor's office to inform of blood sugar readings. At 5:15 p.m., Resident 9's blood sugar registered at 56 and 5:30 p.m., his/her blood sugar registered at 58. On call nurse (OC RN) X instructed Lead Caregiver Q to call 911 and to give PRN (as needed) glucose. Upon arrival of ambulance, Resident 9's blood sugar was rechecked and registered at 92. Resident 9 was not transported to emergency room.</p> <p>- On 02/03/2023, Resident 9's incident report indicated Resident 9's blood sugar was taken at 5:00 p.m. and registered above 500. CG L contacted doctor's office to inform of blood sugar readings. Doctor advised CG L to call 911. Resident was taken to ER.</p> <p>Interviews</p> <p>On 02/14/2023 at 11:28 a.m., CG M explained, "The instructions were to call the endocrinologist nurse when the blood sugar was over 500. The endocrinologist said stop calling them first and</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	<p>Continued From page 54</p> <p>call 911. This may be on the MARs. The sliding scale is also there."</p> <p>On 02/14/2023 at 1:40 p.m., Surveyor interviewed CG M who stated, "On 12/29/2022, [Endocrinologist] N faxed blood sugar update. I don't think it ever reached the management. No changes were made until the end of January. They went a whole month without being updated." CG M recalled L Lead Caregiver Q's last day was 12/28/2022. Lead Caregiver R started at facility on 01/01/2023 and never knew about Resident 9's blood sugar changes. "No one was here to catch the change." Surveyor asked CG L if s/he had nurse delegation training through the facility. CG L replied, "Yes, I know what I'm doing."</p> <p>On 02/14/2023 at 11:20 a.m., Director of Operations (DOO) C stated, "[Resident 9]'s original blood sugar incident was at the end of May 2022. [Resident 9] was hospitalized and treated." On 02/14/2023 at 11:45 a.m., DOO C stated, "[Resident] 9's ISP mentions diet however it is just ancillary. It only mentions his diabetes. There is no protocol information on staff administering insulin."</p> <p>DOO C told Surveyor none of the staff had RN delegation. By the end of May 2022 all the staff received delegation. "We kept having turnover. I don't know if [Administrator B] kept up with the RN delegations." DOO C described, "Three more incidents happened in June. We had new staff but didn't have the delegation again. The family care nurse looked through the glucometer and noted one number and then the log displayed a different number. I believe there was possibly another hospitalization in June."</p> <p>On 03/01/2023, at 1:14 p.m., during the exit</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/01/2023
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N 431	Continued From page 55 conference, DOO C confirmed that Former Administrator B was not monitoring Resident 9's physician orders, MARs or blood sugars. DOO C stated, "[Resident 9's] blood sugars were like a roller-coaster of really not having the right protocols in place." Cross Reference N0352 83.32(3)(h) Rights of Residents: Receive Medications	N 431		
{N 447}	83.41(1)(c) Dishwashing Dishwashing. 1. Whether washed by hand or mechanical means, all equipment and utensils shall be cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Residential dishwashers may be used in kitchens serving 20 or fewer residents. Kitchens serving 21 or more residents shall have a commercial type dishwasher for washing and sanitizing equipment and utensils in accordance with standard practices described in the Wisconsin food code. 2. A 3-compartment sink for washing, rinsing and sanitizing utensils, with drain boards at each end is required for all large facilities with a central kitchen. Washing, rinsing and sanitizing procedures shall be in accordance with standard practices described in the Wisconsin food code. In addition, a single compartment sink or overhead spray wash located adjacent to the soiled drain board is required for pre-washing. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure dishes, equipment and utensils washed by hand were cleaned using separate steps for pre-washing, washing, rinsing, and	{N 447}		

Wisconsin Department of Health Services

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NAME OF PROVIDER OR SUPPLIER FINCH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 FINCH LN GREENDALE, WI 53129
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{N 447}	<p>Continued From page 56</p> <p>sanitizing.</p> <p>This deficiency is being cited for a third time. See SOD 44E011, dated 04/25/2022, and SOD 44E012, dated 09/14/2022.</p> <p>Findings include:</p> <p>On 02/14/2023 at approximately 1:10 p.m., Surveyor observed Caregiver M wash dishes by hand in the kitchen sink. The facility had a working dishwasher, but Caregiver M stated there were just a few dishes and decided to wash them by hand. There were 2 separate sink compartments. Caregiver M had soapy water in the left sink. Surveyor observed a utensils, plates, and drinking cups in the dish rack.</p> <p>On 02/14/2023, at approximately 3:00 p.m., Surveyor interviewed Caregiver M. Caregiver M stated s/he washes the dishes in soapy, bleach water, rinses and places the dishes in a rack to air dry. Surveyor asked if Caregiver M used any sanitizer. Caregiver M stated s/he was familiar with the separate steps for pre-washing, washing, rinsing and sanitizing but s/he just used bleach.</p> <p>On 02/14/2023, at approximately 3:05 p.m., Director of Operations (DOO) C informed Surveyor that s/he provided disposable test strips, sink dividers as well as posters outlining how to wash dishes properly to former Administrator B. DOO C stated the staff had been told to use the dishwasher even if there are just a few dishes.</p>	{N 447}		
{N 531}	<p>83.47(4)(a) Fire extinguishers: type and inspection.</p> <p>At least one portable dry chemical fire</p>	{N 531}		

Wisconsin Department of Health Services

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{N 531}	<p>Continued From page 57</p> <p>extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of inspection.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 3 fire extinguishers was maintained in readily usable condition and inspected by a qualified professional annually for the year 2022. The basement fire extinguisher was gone from the mounting bracket during the time of survey.</p> <p>This deficiency is being cited for a third time. See SOD 44E011, dated 04/25/2022, and SOD 44E012, dated 09/14/2022.</p> <p>Findings include:</p> <p>The provider is licensed as a class CNA (non-ambulatory), Community Based Residential Facility (CBRF) to provide care for 8 residents that have been diagnosed with intellectual disabilities, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's or advanced age.</p> <p>On 02/14/2023 at approximately 3:19 p.m., Surveyor toured facility with Director of Operations (DOO) C and observed 2 fire extinguishers on the main level, both were inspected 03/01/2022.</p> <p>Surveyor toured the basement with DOO C and</p>	{N 531}		

Wisconsin Department of Health Services

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{N 531}	Continued From page 58 observed there was not an extinguisher in the bracket located at the base of the stairs. On 02/14/2023 at approximately 3:19 p.m., Surveyor interviewed DOO C, who stated s/he did not know where the fire extinguisher was and how long it had been gone.	{N 531}		
{N 554}	83.48(6)(e) Integrated heat detector in laundry room. CBRFs shall have at least one heat detector integrated with the smoke detection system at all of the following locations or in accordance with the heat detector manufacturer ' s specifications: Laundry room. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the facility had at least one heat detector integrated with the smoke detection system located in the laundry room on the main level. This requirement is being cited for the third time. See SOD 44E011, dated 04/25/2022 and SOD 44E012, dated 09/14/2022. Findings include: On 02/14/2023 at approximately 11:00 a.m., Surveyor reviewed the Notice and Order letter for Finch House dated 11/03/2022. The letter read, "Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure interconnected heat detectors are installed in all required locations. The licensee's corrective actions will include the installation of any needed upgrades to the integrated smoke	{N 554}		

Wisconsin Department of Health Services

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{N 554}	<p>Continued From page 59</p> <p>and heat detection system in order to meet the requirements specified by Wis. Admin. Code § DHS 83.48(6). The licensee shall obtain approval from the department before installing a smoke and heat detection system. WITHIN 30 DAYS of receipt of this notice, the licensee shall submit plans for review of any needed upgrades to the integrated smoke and heat detection system to the Office of Plan Review and Inspection (OPRI)."</p> <p>On 02/14/2023 at approximately 11:06 a.m., Surveyor observed the laundry area. The laundry area was located on the main level of the home between the kitchen and side exit. Surveyor observed a smoke detector on the ceiling instead of the required heat detector.</p> <p>On 02/14/2023 at approximately 11:10 a.m., Surveyor interviewed Director of Operations (DOO) C who stated s/he was working on taking care of this but never "quite got to it." DOO C stated s/he was aware of the plans needed to be submitted to the Office of Plan Review and Inspection for approval prior to installation of a heat detector; however, nothing had been submitted. Surveyor informed DOO C this was repeat deficiency.</p>	{N 554}		