STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019627	A. BUILDING: _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARK DR HOME	140 MARK DR JOHNSON CREEK, WI 53038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 11/28/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Mark Dr Home, an adult family home (AFH) located in Johnson Creek, WI. As a result of the survey, 1 deficiency was identified. The complaint was substantiated. Census: 2	M 000		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's health was monitored with documented changes when s/he experienced changes in medical condition on 09/05/2023 and 10/28/2023. Findings include: On 11/28/2023, Surveyor conducted a complaint investigation into concerns of resident health monitoring. On 11/28/2023, Surveyor reviewed an emergency medical services (EMS) call report dated 10/28/2023. The report indicated that EMS was contacted due to concerns that Resident 1 was experiencing "uncontrolled vomiting." The report	M 448		

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

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documented, "...The caregiver was unable to provide a complete patient history, stating they did not know the patient's last known well time or detailed medical information. The caregiver reported that the patient had been vomiting, but did not know how many times or how much. The caregiver stated that the vomiting had been reported since at last 3 hours prior to calling for EMS. Assessment showed that the patient was experiencing uncontrolled vomiting, and had a small rash/sore along the left side of their chin and cheek where bile and emesis had accumulated. The patient was wearing a diaper that was soiled, and was partially dressed. The patient's skin was pale, dry, and upon contact, an elevated temperature was detected..."

On 11/28/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 09/01/2023 with diagnoses including dysphagia and developmental delay. Within Resident 1's record were 4 medical record reports for 4 different medical visits, including an emergency department visit (11/04/2023) 1 hospitalization (from 09/11/2023 - 09/18/2023), and primary care provider appointments on 09/27/2023 and 11/14/2023. There were no other documents in Resident 1's record that indicated his/her health.

At approximately 9:50 a.m., Surveyor interviewed Licensee A. Surveyor asked for all dates/times that Resident 1 required EMS since 10/01/2023. Licensee A reported that there were 3 total occasions since Resident 1 was admitted: 09/04/2023, 10/28/2023, and 11/05/2023. Licensee A reported that s/he had e-mails where s/he updated Resident 1's guardian and managed care organization (MCO) team about each of the instances. Surveyor reviewed the

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e-mails from Licensee A's laptop and observed the following regarding 2 of the 3 instances:

- E-mail sent on 09/05/2023 (7:04 a.m.): "[Resident 1] started gagging and trying to throw up last night. [S/he] took [his/her] evening meds and stopped throwing up. [S/he] does have a history of that due to acid reflux. However, This[sic] morning, the staff felt that [s/he] was breathing heavy/congested chest and could maybe have some saliva stuck in [him/her] just due to the vomit. [S/he] was taken to the [emergency room] to be checked out..."

- E-mail sent on 10/29/2023 (11:47 p.m.): "[Resident 1] was taken to the [emergency room] over the weekend for vomiting. They had [him/her] stay in for a night and was brought back to the house later today. They didn't prescribe any new meds or made any changes to the tube feeding. [S/he] is back at the house and hasn't had any vomiting since [s/he] was brought back from the hospital."

Surveyor asked if there was any other documentation about Resident 1's change of condition other than the e-mails above. Licensee A replied that the change in condition on 09/05/2023 correlated with the hospital discharge summary in Resident 1's record from 09/18/2023 since Resident 1 had been hospitalized for an extended time, but denied that s/he had any other documentation in the provider's records which had documented the initial change(s) in Resident 1's condition that were observed by staff. Licensee A reported that s/he did not have any other documentation for the EMS visit that occurred around 10/28/2023. Surveyor asked how resident changes of condition were typically handled. Licensee A replied that when staff notice

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a medical change of condition they either call EMS if the change seems urgent or call him/her if it seems non-emergent. Licensee A reported that s/he then reports to staff what/how to monitor or when to have residents sent out for further evaluation. Surveyor asked if any observed changes in residents' health or the recommendation from him/her when providing monitoring guidance to staff was documented. Licensee A replied that after being informed by staff of a resident change in condition s/he typically sends an e-mail to the resident's care team (like in the e-mails above). Surveyor asked if staff had access to the e-mails. Licensee A replied they did not. Surveyor asked if there was anything documented as part of records that staff had access to in order to monitor resident changes in health, such as progress notes or observation notes. Licensee A replied that there was not. Licensee A replied that s/he used to have staff document progress notes but they would typically document things of little relevance and so s/he had them stop. Surveyor then asked specifically about the EMS response for Resident 1 on 10/28/2023. Licensee A reported s/he was out of the country during that time but staff had called him/her with concerns of Resident 1 vomiting. Surveyor asked what time the vomiting started. Licensee A replied that s/he wasn't sure and that s/he would have to look in his/her text messages. After looking at his/her phone, he reported that the text was sent by staff at approximately 9:15 p.m. Licensee A reported that s/he told staff to monitor Resident 1 and that if s/he continued to vomit, call EMS. Licensee A reported that staff had later told him/her that EMS was called on site sometime around midnight. Surveyor asked if any information about Resident 1's onset of vomiting that day, any other assessments completed or observations made by

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M 448	Continued From page 4 staff, or the monitoring guidance s/he instructed staff to provide was documented anywhere. Licensee A replied that nothing further was documented. Surveyor asked if the provider had the report from Resident 1's emergency department visit on 10/28/2023, since s/he did not see it in Resident 1's record. Licensee A confirmed s/he did not have the report and stated s/he would have to request it from the hospital.	M 448		