

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 10/20/2020, the Department conducted a complaint investigation, self-report investigation, and verification visit at Tender Reflections. Data was collected through 12/02/2020. Nine of 17 complaints were substantiated. Deficiencies identified in the following Statement of Deficiencies (SODs) were reviewed to determine if compliance was achieved: ~ DJ2W11, dated 05/20/2020. One of 1 violation was uncorrected. ~ NWQY11, dated 02/11/2020. Two of 2 violations were uncorrected. ~ SLYV11, dated 12/10/2019. One of 2 violations was uncorrected. ~ 0O5811, dated 09/04/2019. Four of 10 violations were uncorrected. ~ OI9K11, dated 04/18/2019. Two of 4 violations were uncorrected. ~ 7H6111, dated 03/27/2019. Two of 3 violations were uncorrected. ~ OQ3H11, dated 01/14/2019. Six of 15 violations were uncorrected. ~ 8L9G11, dated 11/27/2018. Two of 5 violations were uncorrected. ~ 7XEN13, dated 10/09/2018. One of 1 violation was uncorrected. Eighteen violations were identified. Twelve of 18 violations were repeat deficiencies identified in the following SODs: ~ DJ2W11, dated 05/20/2020 ~ NWQY11, dated 02/11/2020 ~ SLYV11, dated 12/10/2019 ~ 0O5811, dated 09/04/2019 ~ OI9K11, dated 04/18/2019	{N 000}		

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

TITLE

(X6) DATE

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{N 000}	Continued From page 1 ~ 7H6111, dated 03/26/2019 ~ OQ3H11, dated 01/14/2019 ~ 8L9G11, dated 11/27/2018 ~ 7XEN13, dated 10/09/2018 ~ 7XEN12, dated 04/16/2018 ~ 7XEN11, dated 10/18/2017 Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 30	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Department was notified within 3 business days after Resident 1 had a fall with injury that resulted in emergency room treatment and hospitalization on 08/17/2020, and a fall with injury the resulted in emergency room treatment on 10/13/2020. Repeat violation. See statement of deficiency (SOD) 7XEN12, dated 04/16/2018. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally	N 165		

Wisconsin Department of Health Services

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N 165	Continued From page 2 disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. On 10/20/2020, the Department received a self-report from the provider indicating Resident 1 had a fall with injury on 10/13/2020. The report indicated Resident 1 was taken to the emergency room (ER) and "It was determined [Resident 1] had a sub dural [sic] hematoma. An x-ray of [his/her] shoulder did not confirm a suspected acromial fracture, but the physician did document it as a suspected fracture." Resident 1 returned to the facility on 10/13/2020. The report was sent to the Department on 10/20/2020, 5 business days after the incident occurred. On 10/26/2020 and 11/05/2020, Surveyor reviewed Resident 1's file. Resident 1 was admitted to the provider on 08/03/2020. His/her file contained an incident report dated 08/15/2020 at 9:22 PM that read, in part: "Writer had went into resident room to put [his/her] laundry away when i [sic] hear yelling for help. i [sic] did not see [him/her] at first just seen [sic] [his/her] walker laying on the floor and than [sic] i [sic] heard [him/her] yell help again from the bathroom i [sic] ran into the bathroom and seen [sic] resident [Resident 1] laying on the floor yelling help. i [sic] called for another staff to help me assist [him/her] to get up from the floor, [sic] i [sic] noticed that [s/he] was bleeding from some where [sic] i [sic] did a body inspection and seen [sic] that [s/he] had scraped [his/her] elbow. writer [sic] and staff got [him/her] to sit in [his/her] recliner staff [sic] performed range of motion. staff [sic] seen that [s/he] had also hit [his/her] head on the right side of [his/her] forehead [his/her] left knee is also red a [sic] slight cut on [his/her] right thumb and resident stated that [his/her] back also hurts."	N 165		

Wisconsin Department of Health Services

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N 165	Continued From page 3 Resident 1's observation notes indicated s/he was sent to the hospital on the morning of 08/17/2020 due to "a bleed in [his/her] brain." Resident 1 returned to the facility on 09/19/2020. Resident 1's hospital discharge instructions dated 08/19/2020 read, in part: "Reason for Admission: fall Discharge Diagnosis: acute traumatic subdural hematoma..." What causes a subdural hematoma? A subdural hematoma happens when a blood vessel between the layers of the covering of the brain gets torn or ruptured. A blood vessel can be torn or ruptured when there is a blow to the head or if the head moves back and forth forcefully. Some of the most common causes are: - falls..." On 11/12/2020 at 3 PM, Surveyor interviewed the management team which included Regional Director (RD) A, Regional Support (RS) K, Compliance Officer (CO) J, and Operations L. Surveyor asked if the provider submitted a self-report to the Department related to Resident 1's 08/17/2020 hospitalization. RS K stated they believed Resident 1's brain bleed was of natural origin and not related to the fall. RS K stated s/he would send documentation to support this reasoning. On 11/12/2020, the provider sent Surveyor Resident 1's hospital summary which identified Resident 1's final diagnosis (dated 08/19/2020) as "acute traumatic subdural hematoma with compression," and the physician's initial impression (dated 08/17/2020) as "subdural hematoma likely from fall sustained on Saturday night."	N 165		

Wisconsin Department of Health Services

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N 165	Continued From page 4 On 11/13/2020, Surveyor received an email from RS K that included a copy of an email sent by former Assistant Director R at 10:15 AM on 08/17/2020 that read, in part: "[Resident 1] will be getting hospitalized...Doctor stated that the bleed is not from the fall, or trauma related. [S/he] stated that [s/he] thinks the bleed caused resident to fall and may be a part of why resident has become weaker and unsteady on [his/her] feet." The email did not have any supporting documentation or information on who the doctor was. The provider did not ensure the Department was notified within 3 business days after Resident 1 had a fall in August 2020 that resulted in hospitalization and a fall on 10/13/2020 that resulted in emergency room treatment.	N 165			
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's and Resident 17's legal representatives and physicians were immediately notified of Resident 1's and Resident 17's incidents and injuries.	N 169			

Wisconsin Department of Health Services

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N 169	Continued From page 5 Repeat violation. See statement of deficiencies (SOD) 7XEN12, dated 04/16/2018 and OI9K11, dated 04/18/2019. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. RESIDENT 1: On 10/26/2020, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/03/2020. Resident 1's file included 13 incident reports. Of the 13 documented incidents, 3 indicated activated Power of Attorney (POA) B was notified and 2 indicated Resident 1's physician was notified. The following is a summary of the incident reports: 08/15/2020 - Unwitnessed fall in Resident 1's bedroom. Injuries included a bleeding scrape on his/her elbow, bump on the right side of his/her forehead, cut and reddened area on his/her left knee. Resident 1 reported back pain. POA B was notified; Resident 1's physician was not. 08/20/2020 - Resident 1 had a near fall and was lowered to the ground. No injuries. Neither Resident 1's physician nor POA were notified. 08/23/2020 - Unwitnessed fall in Resident 1's bedroom with injury (scrape on elbow). No notifications were made.	N 169		

Wisconsin Department of Health Services

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N 169	Continued From page 6 08/24/2020 - Unwitnessed fall in Resident 1's bathroom with injury ("shallow cut on right forearm"). No notifications were made. 08/27/2020 - Staff found Resident 1 sitting on the floor in front of his/her recliner. No notifications were made. 08/28/2020 - Witnessed fall in hallway. No notifications were made. 09/06/2020 - Unwitnessed fall in the bathroom. Resident 1 was found lying on his/her left side. Resident 1 stated his/her low back hurt. No notifications were made. 09/30/2020 - Unwitnessed fall in Resident 1's bedroom. Resident 1 hit his/her head and was sent to the ER (emergency room) for evaluation. POA B and Resident 1's physician were notified. 10/10/2020 - Resident 1 was involved in a resident to resident altercation. No notifications were made. 10/13/2020 - Unwitnessed fall in Resident 1's bedroom with injury (golf ball sized bump on left forehead, bleeding "gash" on finger, abrasions on left and right side of head). Resident 1 was sent to the ER for evaluation. No notifications were made. 10/14/2020 - Witnessed fall in the common area. A physical therapist observed Resident 1 attempt to self-transfer from his/her wheelchair to the couch and the couch moved. Resident 1 fell to the floor. No notifications were made. 10/14/2020 - Resident 1 was involved in a	N 169		

Wisconsin Department of Health Services

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N 169	Continued From page 7 resident to resident altercation. No notifications were made. 10/17/2020 - Unwitnessed fall with injury in Resident 1's room. Resident 1 had a bleeding abrasion on his/her right elbow and injuries to his/her left side and back of his head. Resident 1 was sent to the ER for evaluation. POA B and Resident 1's physician were notified. On 10/27/2020, Surveyor interviewed Regional Director (RD) A. RD A stated s/he was new to his/her position as of September and s/he was aware that incident reports did not consistently indicate notifications to legal representatives and physicians. RD A stated s/he believed the notifications occurred, but staff were failing to go back into the incident report to document the notification. RD A stated physicians were typically notified via fax which would be retained in the resident record; if physicians were notified via phone, it would be documented in the resident's observation notes. RD A reviewed Resident 1's record for any record of notifications related to the above incidents and provided Surveyor 2 documents: an observation note from 10/19/2020 indicating all parties were notified of the incident on 10/17/2020 and a fax to Resident 1's physician dated 09/30/2020, notifying him/her of the fall on 09/30/2020. On 11/04/2020 at 3:09 PM, Surveyor interviewed POA B. POA B stated Resident 1 returned to the facility on 11/03/2020 on hospice care. POA B was generally satisfied with Resident 1's care at the facility and stated s/he felt that the facility was keeping him/her informed of any incidents, injuries or changes in condition. POA B stated his/her only concern was that Resident 1 was	N 169			

Wisconsin Department of Health Services

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N 169	Continued From page 8 falling. Surveyor asked POA B how many times Resident 1 fell at the facility and POA B stated, "I'm thinking 4." POA B stated Resident 1 had 3 falls that resulted in ER evaluation and 1 fall occurred because a couch moved as Resident 1 was sitting (see incident on 10/14/2020 above). POA B was not aware of any resident altercations involving Resident 1. The provider's policy titled Resident Falls Policy Procedure - Operations read, in part: "It is the intent of this policy to ensure resident safety by assessing for fall risk, having interventions in place to prevent falls, ensuring that staff respond appropriately when a fall occurs, and reviewing and modifying fall-prevention interventions as needed after a fall occurs..." 11. Staff will update the residents' legal representative and Hospice provider (if applicable) regarding the incident, resident status, and immediate interventions implemented to prevent further occurrences. 12. The Administrator or Management Designee will update the practitioner (via fax) and resident's case management agency (if applicable) via a phone call regarding the incident, resident status, and immediate interventions implemented to prevent further occurrences." The provider did not ensure Resident 1's legal representative and physician were notified of Resident 1's incidents or injuries. POA B was notified of 4 out of 13 incidents and Resident 1's physician was notified of 2 out of 13 incidents. RESIDENT 17: On 07/29/2020, the provider submitted a	N 169		

Wisconsin Department of Health Services

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N 169	Continued From page 9 self-report to the Department about Resident 17's fractured arm diagnosed on 07/24/2020 at the ER. The provider's investigation found that the fractured arm was most likely a result of a fall on 07/21/2020; Resident 17 fell against a counter top in the common area. This self-report indicated a bruise was found on Resident 17's arm on 7/22/2020 after the 7/21/2020 fall. The self-report indicated Resident 17's complaints of pain began on 07/24/2020, 3 days after the fall. There is no information in the observation notes about this initial fall and bruised arm. On 10/28/2020 at 3:21 p.m., Surveyor interviewed Resident 17's Activated Power of Attorney (APOA) U about notification of the fall and injury. APOA U stated it was his/her understanding when s/he received the call from the provider on the evening of 07/24/2020 that the fall happened earlier in the day and Resident 17 was going to the hospital now. APOA U stated s/he was told no one had seen Resident 17 fall and they found the resident on the floor. APOA U stated s/he was not notified of the fall three days prior. According to the fall report for the 7/21/2020 fall (revised on 10/6/2020), Resident 17's Primary Care Provider (PCP) was not notified of the fall. On 11/23/2020, the Department received a complaint alleging Resident 17 drank another resident's juice which contained medications. The complainant indicated staff left the resident's medication and juice mixture unsupervised and Resident 17 drank it. On 12/01/2020, Surveyor reviewed a medication deviation report dated 11/23/2020 at 9 AM which read, in part: "[Resident 17] drank [Resident 10's] juice that had Risperidone 1mg and Ferrous	N 169		

Wisconsin Department of Health Services

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N 169	Continued From page 10 Sulfate 300mg mixed in it. The cup was left sitting by [Resident 10] at dining room table for res (resident) to drink. [Resident 17] walked by, grabbed cup and drank all contents ...Verbal direction to staff: Instructed staff to never leave med unattended w/res (with resident) and that med should be prepared in med room, not the kitchen." On 12/1/2020 at 3:26 PM, Surveyor interviewed APOA U about Resident 17 receiving another resident's medications. APOA U stated s/he had been called by the resident's managed care organization. APOA U stated s/he had no details as the provider had not called to notify him/her or Resident 17's daughter/son. On 12/02/2020 at 3:54 PM, Regional Support (RS) K confirmed the provider did not contact APOA U after Resident 17 ingested Resident 10's medications on 11/23/2020. Cross references: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee did not ensure that the provider and its operation were compliant with all laws governing a community based residential	N 196		

Wisconsin Department of Health Services

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N 196	Continued From page 11 facility. This had the potential to affect 30 of the 30 residents that resided at the facility. This is a repeat violation. See statement of deficiencies (SOD) 005811, dated 09/04/2019; OQ3H11, dated 01/14/2019; and 7XEN12, dated 04/16/2018. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, terminally ill. The provider was licensed in 2014. Between 2018 and 2020, the Department conducted 10 complaint investigation surveys, each resulting in at least 1 substantiated complaint. The following is a summary of their compliance history over the last 2 years: ~ SOD 7XEN12, dated 04/16/2018. Four of 4 complaints were substantiated. Eighteen deficiencies were identified. ~ SOD 7XEN13, dated 10/09/2018. Two of 2 complaints were substantiated. One deficiency was identified. ~ SOD 8L9G11, dated 11/27/2018. One complaint was substantiated. Four deficiencies were identified. ~ SOD OQ3H11, dated 01/14/2019. Four of 4 complaints were substantiated. Fifteen deficiencies were identified. ~ SOD 7H6111, dated 03/26/2019. Two of 3 complaints were substantiated. Four deficiencies were identified. ~ SOD OI9K11, dated 04/18/2019. One complaint was substantiated. Five deficiencies were identified.	N 196			

Wisconsin Department of Health Services

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N 196	Continued From page 12 ~ SOD 005811, dated 09/04/2019. One complaint was substantiated. Ten deficiencies were identified. ~ SOD SLYV11, dated 12/10/2019. One of 2 complaints was substantiated. Two deficiencies were identified. ~ SOD NWQY11, dated 02/11/2020. One complaint was substantiated. Two deficiencies were identified. ~ SOD DJ2W11, dated 05/20/2020. One complaint was substantiated. One deficiency was identified. This survey was in response to the Department's receipt of 17 complaints and 7 facility self-reports. Deficiencies identified in the provider's 9 most recent surveys were also reviewed to ensure compliance was achieved. Eighteen violations were identified. Thirteen of 18 violations were repeat violations. The following is a summary of the issues identified throughout the course of the survey: ~ Incidents involving emergency room treatment or hospitalization were not reported to the Department timely. ~ Legal representatives and physicians were not notified when residents experienced an incident, injury or change. ~ Staff did not complete minimum training. ~ The provider did not maintain accurate records of employee training. ~ Residents did not receive medications as prescribed by their physician. ~ Residents were not safeguarded from environmental hazards. ~ The provider did not assess residents when they experienced a change in condition. ~ The provider did not update resident service plans when residents' needs changed.	N 196			

Wisconsin Department of Health Services

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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 196	Continued From page 13 ~ The provider did not provide supervision to meet the needs of residents. ~ The provider did not provide leisure time activities to meet resident needs. ~ The provider did not provide prompt and adequate services to residents. ~ The provider did not provide medication administration services to meet resident needs. ~ The provider did not provide behavior management services to meet resident needs. ~ Staff did not practice hand washing procedures in accordance with standards of practice. ~ The provider did not maintain all flooring in good repair. The Department received multiple complaints alleging the provider was falsifying, omitting or altering records. This concern was substantiated. On 11/05/2020 at 11:30 AM, Surveyor interviewed Resident Care Provider (RCP) G. Surveyor asked RCP G if s/he was ever instructed to change information or to exclude information from electronic charting. RCP G referred to a specific incident involving a resident to resident altercation on 10/10/2020 involving Resident 6 and Resident 13. RCP G informed Surveyor that on 10/10/2020, RCP G witnessed Resident 13 grab Resident 6's wrist and shake his/her arm and Resident 6's whole body was moving. RCP G planned to write an incident report regarding the resident to resident altercation and RCP G stated that Regional Director (RD) A told RCP G s/he did not need to complete an incident report because the incident was handled immediately. RCP G filled out an incident report and put the initials of the resident's involved (Resident 6 and Resident 13). RCP G stated that if Resident 13's initials weren't in the incident report, someone changed/edited the documentation. RCP G also	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 196	Continued From page 14 recalled RD A wanted RCP G to minimize the seriousness of the incident between Resident 13 and Resident 6 on 10/10/2020. RCP G stated, "I wrote what I saw and I asked RD A if s/he wanted me to lie and RD A told me to write what you need to write in the incident report." On 10/10/2020 at 1:39 PM, an incident report was initialized by RCP G about a resident to resident altercation. A resident had grabbed Resident 6's wrist and was shaking Resident 6's arm to the point that Resident 6 "was screaming for help and crying." The report did not identify the aggressor. On 11/05/2020 at 1:53 PM, Surveyor interviewed RCP G about the incident and the report. RCP G stated that once staff completed their portion of the report they were unable to edit it. The report was then reviewed by management. RCP G indicated s/he always put the initials of all residents involved in the incident in the report. RCP G stated, "How are we supposed to know who we should be watching if no one knows who it was?" RCP G stated that when the report was submitted, it included Resident 13's initials. RCP G indicated the 2 directors, several nurses, and the owners have the ability to edit the reports. On 11/5/2020, Surveyor reviewed the facility's submitted incident reports and there were none for this incident involving Resident 13 on 10/10/2020. On 11/12/2020 at 1:21 PM, Surveyor interviewed RCP G. RCP G stated s/he was certain s/he created an incident report identifying Resident 13 as the aggressor. RCP G indicated concern that this report was deleted without his/her knowledge. On 11/05/2020 at 3:41 PM, Surveyor interviewed	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 196	Continued From page 15 Resident Care Coordinator (RCC) E. RCC E stated s/he was told by his/her directors to exclude information from his/her charting and reports on more than one occasion. RCC E stated s/he was directed not to write things like "no supplies" or "neglect." RCC E stated s/he ran out of supplies before (soap) and needed to purchase items on his/her own, so s/he documented this in observation notes. RCC E stated, "They will delete our comments and put it in their own words." Surveyor asked if s/he ever questioned his/her directors about this and RCC E stated they told him/her they changed things that were inappropriate because "State will look at it wrong." RCC E stated s/he has found some of his/her comments were deleted completely. On 11/11/2020 at 3:17 PM, Surveyor interviewed Assistant Director (AD) I. Surveyor asked AD I if s/he was aware of anyone changing staff charting. AD I stated, "Yes. I know exactly what you mean...I've watched upper management change things in ECP (electronic charting)...They say we don't want to get in trouble for what you wrote." AD I stated, "I've had staff write specifics with resident initials and it was changed to 'unknown resident' or 'female resident.'" AD I discussed 2 examples when Regional Support (RS) K altered AD I's documentation. AD I stated that on 10/19/2020, Resident 13 was choking Resident 18. Staff intervened, removed Resident 13's hands from around Resident 18's throat and separated the residents. AD I stated RS K told him/her that AD I's charting was wrong, so s/he changed it. AD I stated RS K morphed his/her observation note and incident report in a way that minimized the situation and removed the specifics of how staff intervened. AD I stated, "[RS K] didn't like that it said 'hands removed.'"	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 196	Continued From page 16 AD I stated that about 1 month ago, s/he created an incident report on an injury of unknown origin for Resident 21. AD I stated s/he made the incident report so detailed that s/he was going to use it in staff training. AD I stated s/he went back to print it out and it was deleted. AD I stated s/he asked RD A about it but RD A shrugged it off. AD I stated s/he believes the incident report was deleted because they should have investigated the injury of unknown origin. On 11/12/2020 at 3 PM, Surveyor interviewed RD A, RS K, Compliance Officer (CO) J, and Operations L. Surveyor asked if management ever changed, edited, altered or removed staff documentation. RS K stated, "We ask staff to change it." RS K admitted s/he had altered staff documentation if staff "put their perspective and not just the facts." Surveyor asked if incident reports were ever deleted and RS K stated they were not. Surveyor explained that records must be maintained and should not be altered or removed; if changes or edits were needed, then an addendum or "late entry" could be added. RS K and CO J stated they understood. In the current complaint investigation and survey, seventeen new violations were found in addition to this violation, as follows: DHS 83.12(4)(c) Reporting Incidents With Serious Injury DHS 83.12(5)(a) Notification: Incident, Injury, Changes DHS 83.20(2)(a)-(d) Department-Approved Training Courses DHS 83.21(1)-(3) All Employee Training DHS 83.22(1)-(4) Task Specific Training DHS 83.26(1) Documentation of Required Employee Training	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 196	Continued From page 17 DHS 83.32(3)(h) Rights of Residents: Receive Medication DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment DHS 83.32(3)(n) Rights of Residents: Safe Environment DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes DHS 83.38(1)(b) Supervision DHS 83.38(1)(c) Leisure Time Activities DHS 83.38(1)(h) Medication Administration DHS 83.38(1)(i) Behavior Management DHS 83.39(3) Hand Washing DHS 83.44(2)(c) Interior Floors, Walls And Ceilings The licensee did not ensure that the provider and its operation were compliant with all laws governing a community based residential facility. This had the potential to affect 30 of the 30 residents that resided at the facility.	N 196		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety.	N 239		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 239	Continued From page 18 First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident Care Coordinator (RCC) C completed a Department-approved fire safety and first aid and choking course within 90 days of hire. Repeat violations. See statement of deficiencies (SOD) OQ3H11, dated 01/14/2019; and 7XEN11, dated 10/18/2017. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. The Department received multiple complaints regarding staff training. On 10/27/2020, Regional Support (RS) K stated Compliance Officer (CO) J was the provider's Department-approved trainer for all of the	N 239		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 239	Continued From page 19 required Department-approved courses. On 10/27/2020, Surveyor reviewed staff records. Some records were not complete or were not able to be found, so Regional Director (RD) A and Regional Support (RS) K stated they would send Surveyor additional documentation that was kept off site. Additional staff training documentation was sent to Surveyor on 10/28/2020, 11/05/2020, 11/10/2020, 11/12/2020, and 11/13/2020 for review. RCC C was hired on 08/11/2020. RCC C's training records did not include evidence that s/he completed Department-approved fire safety and first aid and choking courses. On 11/12/2020 (93 days since RCC C was hired), Surveyor reviewed the Wisconsin Community-Based Care and Treatment Training Registry. RCC C's training record on the Registry did not indicate s/he completed fire safety or first aid and choking. On 11/12/2020 at 3 PM, Surveyor interviewed RD A, RS K, Compliance Officer (CO) J and Operations L. Surveyor asked CO J if RCC C completed fire safety or first aid and choking. CO J stated RCC C would receive the training tomorrow. The provider did not ensure Resident Care Coordinator (RCC) C completed a Department-approved fire safety and first aid and choking course within 90 days of hire. Cross reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 239		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 243	Continued From page 20	N 243		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. HFS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. HFS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF 's complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be	N 243		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 243	Continued From page 21 completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 6 of 6 staff sampled received training on all of their licensed client groups. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. The Department received multiple complaints regarding staff training. On 10/27/2020, Surveyor reviewed staff records. Some records were not complete or were not able to be found. Regional Director (RD) A and Regional Support (RS) K stated they would send Surveyor additional documentation that was kept off-site. Additional staff training documentation was sent to Surveyor on 10/28/2020, 11/05/2020, 11/10/2020, 11/12/2020, and 11/13/2020 for review. Resident Care Provider (RCP) G was hired on 7/24/2020. RCC G's file contained an Orientation Agenda indicating s/he completed a 1 hour training on 07/19/2020. The training was titled, "About Our Residents - Client Group Specific DHS 83.21(2) Normal Aging, Characteristics of	N 243			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 243	Continued From page 22 Aging. Resident Group: Physical, Social, Mental, and Spiritual needs." RCP M was hired on 03/18/2019. RCP M's file contained an Orientation Agenda indicating s/he completed the 1 hour About Our Residents training referenced above on 03/18/2019. Resident Care Coordinator (RCC) E was hired on 08/20/2019. RCC E's file contained an Orientation Agenda indicating s/he completed the 1 hour About Our Residents training referenced above on 08/09/2019. RCC C was hired on 08/11/2020. RCC C's file contained an Orientation Agenda indicating s/he completed the 1 hour About Our Residents training referenced above on 08/01/2020. RCP N was hired on 02/04/2020. RCP N's file contained an Orientation Agenda indicating s/he completed the 1 hour About Our Residents training referenced above on 01/29/2020. RCP O was hired on 07/30/2020. RCP O's file contained an Orientation Agenda indicating s/he completed the 1 hour About Our Residents training referenced above on 07/27/2020. On 10/27/2020, RS K described the provider's new hire training program as a mix of self-study (done prior to the date of hire and at the prospective employee's leisure) and on-site training (a scheduled orientation day with the facility director). The Orientation Agenda served as the employee's proof of training completion for the required DHS 83 training topics. RS K stated new employees started "on the job training" (i.e. scheduled to work with a mentor) after their Orientation Agenda was complete. RS K	N 243		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 243	Continued From page 23 confirmed client group training occurred prior to "on the job training." RS K stated RD A could provide the materials and curriculum used for the provider's client group training. On 10/27/2020, RD A provided Surveyor the new hire training manual for review. The manual did not contain training materials for client group training. RD A stated s/he did not believe employees received client group training prior to "on the job training." RD A stated, "They tell us they hire experienced people." On 11/05/2020 at 3:41 PM, Surveyor interviewed RCC E about his/her training experience. RCC E stated there was no initial training and that s/he learned his/her job on his/her own; "It took me months to learn the residents." Surveyor asked if s/he received the self-study materials and if s/he completed an onsite orientation day prior to working on the floor. RCC E stated s/he never watched the videos (i.e. self-study materials) and orientation day consisted of new hire paperwork and reviewing employment policies. RCC E stated any training s/he received from the facility was provided in a read and sign format. Surveyor asked if RCC E completed training related to mental illness, dementia, traumatic brain injuries, advanced age, developmental disabilities, or terminal illness; RCC E stated s/he believed s/he received training on advanced age, but nothing related to any of the other client groups. On 11/11/2020 at 3:17 PM, Surveyor interviewed Assistant Director (AD) I (hired 09/14/2020). AD I confirmed it was his/her responsibility to complete the onsite orientation with new employees. AD I stated s/he did not provide training on the licensed client groups. AD I stated new employees received dementia training through	N 243			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 243	Continued From page 24 the videos they receive prior to onsite orientation (i.e. self-study). Surveyor asked if new employees got training on mental illness, traumatic brain injuries, advanced age, developmental disabilities or terminal illness. AD I stated they did not because the facility was a memory care facility; "I think that's why they don't offer other training for other client groups." On 11/11/2020 and 11/16/2020, Surveyor reviewed the provider's self-study materials. The materials did not include training on the physical, social and mental health needs of the following client groups: emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, or terminally ill. The materials included information on dementia/Alzheimer's and advanced aged. On 11/12/2020 at 3 PM, Surveyor interviewed RD A, RS K, Compliance Officer (CO) J and Operations L. CO J confirmed that the provider's initial training program did not include training on the physical, social and mental health needs of the following client groups: emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, or terminally ill. Surveyor asked how the provider ensured staff completed the self-study materials prior to onsite orientation. CO J stated the provider recently revised their training program (changes implemented 11/06/2020) because they could not tell if staff completed the self-study portion. CO J stated the new training program tracked staff progress and staff were not able to fast forward training videos. The provider did not ensure 6 of 6 staff sampled received training on all of their licensed client	N 243		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 243	Continued From page 25 groups.	N 243			
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident 's needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.	N 247			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 247	Continued From page 26 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 6 of 6 staff completed task specific training prior to providing personal care services to residents or assuming the responsibility of monitoring resident vitals. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. The Department received multiple complaints regarding staff training. On 10/27/2020, Surveyor reviewed staff records. Some records were not complete or were not able to be found, so Regional Director (RD) A and Regional Support (RS) K stated they would send Surveyor additional documentation that was kept off site. Additional staff training documentation was sent to Surveyor on 10/28/2020. On 10/27/2020 at 10:25 AM, Surveyor interviewed Resident Care Coordinator (RCC) C. RCC C indicated s/he had to learn the job as s/he went. RCC C stated s/he believed newer employees were getting "actual training." On 11/04/2020 at 1:18 PM, Surveyor interviewed former employee RCC Q (hired 08/11/2020).	N 247		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 247	Continued From page 27 RCC Q stated s/he did not receive training on the floor (i.e. on the job training). RCC Q stated that on the day s/he completed orientation, s/he was asked to fill in on the floor. RCC Q stated s/he reported to the facility, found Resident Care Provider (RCP) M and introduced her/himself. RCC Q stated, "[RCP M] looked at me and said, 'I'm not training you, so you better know what you are doing.'" RCC Q stated that during orientation, Assistant Director (AD) R told RCC Q and the other new employees that they would be trained on resident cares during on the job training On 11/5/2020 at 7:51 AM, Surveyor interviewed former employee Community Director (CD) H. CD H stated s/he was concerned about the training of the floor staff, specifically related to obtaining vital signs. CD H stated that in May 2020, a floor staff called CD H with concerns that one of the resident's blood pressure (b/p) was low. CD H stated s/he was "floored" when the staff member said the resident was standing and staff had taken the b/p on his/her finger. CD H found out this staff member believed the pulse oximeter measured b/p. A pulse oximeter is a device clipped on a person's finger to read the oxygen saturation and the pulse of a resident, not b/p. On 11/05/2020 at 10:47 AM and 3:41 PM, Surveyor interviewed RCC E about his/her training experience. RCC E stated there was no initial training and that s/he learned his/her job on his/her own; "It took me months to learn the residents." RCC E stated a previous coworker helped him/her learn how to do specific things as they came up, such as which straps to use on the mechanical lifts, how to do range of motion, and how to take vitals. RCC E stated s/he was taught how to take vitals about 6 month ago, about 8 months into his/her employment.	N 247		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 247	Continued From page 28 RCC E stated that on the day of his/her first medication pass, s/he shadowed Assistant Director (AD) R for about 1 hour, then AD R "just handed over the keys to complete the pass by myself." RCC E stated AD R told him/her to come to AD R with any questions. RCC E stated s/he did not know anything about the residents or their medications. On 11/05/2020, Surveyor interviewed RD A and RS K. RS K explained that when a new employee completed orientation, they were placed on the floor with an experienced caregiver. This was considered "on the job training." RS K stated the experienced caregiver provided training on provisions of care and documented the training on the Resident Care Provider Training Progress Record (RCPTP). RS K stated the new employee was not considered fully trained until their RCPTP was complete. Surveyor informed RS K that none of the staff files reviewed contained this document. RD A agreed to send Surveyor a blank copy of the RCPTP and RS K stated s/he would continue to look for completed RCPTP for the 6 staff sampled. RS K stated medication passers (RCC) were responsible for obtaining vitals on residents and reporting the concerns to management. Surveyor asked RS K when RCCs were trained on obtaining vital signs. RS K stated RCCs got the information on videos provided prior to the scheduled orientation day (i.e. self-study training) and again during their on the floor medication training. RS K stated the on the floor medication training was documented on a Medication Training Proficiency (MTP) checklist. Surveyor informed RS K that none of the staff files reviewed contained a MTP. RD A agreed to send	N 247		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 247	Continued From page 29 Surveyor a blank copy of the MTP and RS K stated s/he would continue to look for completed MTP for the 2 RCCs sampled. On 11/11/2020 and 11/16/2020, Surveyor reviewed the provider's self-study materials provided to new employees prior to onsite orientation. The materials did not include information on obtaining vitals. On 11/11/2020, Surveyor interviewed Assistant Director (AD) I (hired 09/14/2020). AD I stated s/he was responsible for training new employees during their on-site orientation. AD I was also responsible for the staff schedule. AD I stated s/he believed the training program was "lacking" and that upper management "expect us to throw staff out there...they just say, 'It's on the job training.'" AD I stated s/he had tried to schedule extra staff so that new employees could be with an experienced staff member but s/he got in trouble. Surveyor received additional training documentation on 11/05/2020, 11/10/2020, 11/12/2020, and 11/13/2020 for review. The following staff were reviewed: - RCP G, hired on 7/24/2020 - RCP M, hired on 03/18/2019 - RCC E, hired on 08/20/2019 - RCC C, hired on 08/11/2020 - RCP N, hired on 02/04/2020 - RCP O, hired on 07/30/2020 None of these staff files contained documentation indicating they completed training on provisions of care related to the DHS required topics of bathing, dressing, oral hygiene, nail and foot care, toileting/incontinence care, and positioning/body alignment. RCC files did not contain documented	N 247		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 247	Continued From page 30 training on obtaining vitals. The provider did not ensure 6 of 6 staff completed task specific training prior providing personal care services to residents or assuming the responsibility of monitoring resident vitals.	N 247		
N 283	83.26(1) Documentation of required employee training The CBRF shall maintain documentation of all employee training under s. HFS 83.21 and task specific training under s. HFS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 6 of 6 training documentation was complete and accurate. Training documentation did not include the name of instructor or dates the training took place for the following training requirements: resident rights; client-group; recognizing, preventing, managing and responding to challenging behaviors; and dietary. The documented length of training was not accurate. Findings include: The facility is licensed to provide care to 80 residents from the client groups emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, traumatic brain injury, developmentally disabled, terminally ill, and advanced aged.	N 283		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 283	Continued From page 31 The Department received multiple complaints regarding staff training. On 10/27/2020, Regional Support (RS) K described the provider's new hire training program as a mix of self-study (done prior to the date of hire and at the prospective employee's leisure) and onsite training (a scheduled orientation day with the facility director). The Orientation Agenda served as the employee's proof of training completion for the required DHS 83 training topics. On 10/27/2020, Surveyor reviewed staff records. Some records were not complete or were not able to be found, so Regional Director (RD) A and Regional Support (RS) K stated they would send Surveyor additional documentation that was kept off site. Additional staff training documentation was sent to Surveyor on 10/28/2020, 11/05/2020, 11/10/2020, 11/12/2020, and 11/13/2020 for review. Each of the staff files listed below had Orientation Agendas that read, in part: - Abuse, Neglect and Misappropriation training DHS 83.19(2) with Resident Rights DHS 83.21(1); 1.5 hours - Introduction to Challenging Behaviors DHS 83.21(3); 1 hour - About Our Residents - Client Group Specific DHS 83.21(2); 1 hour - Dietary Services DHS 83.22(4); 1 hour The Orientation Agenda included a brief description of each training listed above, but it did not include a name of an instructor or the date each training was completed. The document contained a single date; the date the employee signed to attest his/her training was complete, but	N 283		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 283	Continued From page 32 this date was not necessarily the same day the employee completed each of the training topics listed above. Resident Care Provider (RCP) G was hired on 7/24/2020. RCC G's Orientation Agenda was dated 07/19/2020. RCP M was hired on 03/18/2019. RCP M's Orientation Agenda was dated 03/18/2019. Resident Care Coordinator (RCC) E was hired on 08/20/2019. RCC E's Orientation Agenda was dated 08/09/2019. RCC C was hired on 08/11/2020. RCC C's Orientation Agenda was dated 08/01/2020. RCP N was hired on 02/04/2020. RCP N's Orientation Agenda was dated 01/29/2020. RCP O was hired on 07/30/2020. RCP O's Orientation Agenda was dated 07/27/2020. On 11/11/2020, Surveyor reviewed the provider's self-study materials used for the above listed training topics. The training materials did not contain information related to all of the provider's licensed client groups, as indicated in the Orientation Agenda. Challenging Behaviors was identified on the Agenda as a 1 hour training while the self-study video was 9 1/2 minutes. On 11/12/2020 at 3 PM, Surveyor interviewed RD A, RS K, Compliance Officer (CO) J and Operations L. CO J stated the other 50+ minutes of training was captured during self-study reading materials. CO J agreed to send Surveyor the additional challenging behavior training material.	N 283		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 283	Continued From page 33 On 11/16/2020, Surveyor reviewed the additional challenging behavior training material which consisted of 1 eight-page document, taking less than 10 minutes to read. The provider did not ensure training documentation was complete and accurate. Cross reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0243 DHS 83.21(1)-(3) All Employee Training	N 283		
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 interview and record review, the provider did not ensure that each resident received medication according to the doctor's orders, for 4 of 5 residents. Residents 8, 10, 20 and 9 were not given medications as the medications were not available at the facility prior to running out. Repeat violation. See statement of deficiency (SOD) DJ2W11, dated 05/20/2020; NWQY11, dated 02/11/2020; SLYV11, dated 12/10/2019; OQ3H11, dated 01/14.2019; 8L9G11, dated 11/27/2018; 7XEN13, dated 10/09/2018; and 7XEN12, dated 04/16/2018.	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 352	Continued From page 34 Findings include: The provider is licensed to care for up to 80 residents from the client groups advanced age, developmentally disabled, traumatic brain injury, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness and terminally ill. INTERVIEWS: On 10/27/2020 at 11:09 AM, Surveyor interviewed Resident Care Coordinator (RCC) C about the process to reorder medications and supplies. RCC C noted Resident 2 had run out test strips and RCC C was using Resident 2's last strip. RCC C stated Resident 2 or any other resident should never be out of supplies or medications. RCC C stated the procedure was for staff to hit the reorder button in the electronic medication administration record (MAR). RCC C stated staff were to click on this and then management was to order the medication from the pharmacy. RCC C indicated this procedure did not guarantee medications and supplies were ordered and it appeared previous staff had not hit the button for the test strips. At 1:12 PM, Surveyor interviewed Resident 2. Resident 2 stated s/he has called the pharmacy to reorder medications as staff were not pushing the reorder button. Resident 2 indicated the provider ran out of his/her long-acting insulin 3 times since January 2020. Resident 2 stated s/he had also called the pharmacy for eye drops, hearing aid batteries, insulin and oxygen several times. Resident 2 stated administration said the managed care organization (MCO) had been called as the MCO paid for blood sugar test strips in the past when the insurance company had	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 352	Continued From page 35 previously said it was too soon to reorder. At approximately 1:45 PM, Surveyor interviewed RCC D about the procedure to reorder medications. RCC D stated staff are to use the reorder button, however RCC D stated s/he has had to call the pharmacy him/herself as the "office" had not reordered the medication. On 11/05/2020 at 8:51 AM, Surveyor interviewed RCC D. RCC D stated s/he was aware of a time when Resident 10 has been out of risperidone, as it has not been reordered in time. RCC D stated that this happened several days in October. RCC D indicated that if the MAR had the word "OTHER" in it, which meant the drug was not available and the notation section of the MAR would provide the details. On 11/05/2020 at 10:47 AM, Surveyor interviewed RCC E. RCC E stated most often creams and eye drops were missing. RCC E stated "just last week" Resident 20 was missing all but 2 medications and 2 weeks ago Resident 9 was missing eye drops. RCC E stated Resident 2 was always missing long-acting insulin and usually Resident 2 would call for refills if the provider ran out. On 11/12/2020 at 3:00 PM, Surveyor interviewed Regional Director (RD) A, Compliance Officer (CO) J, Regional Support (RS) K, and Operations Vice President (OVP) L about the omissions. CO J explained the omissions are considered medication errors and in September a new audit of the medication pass was initiated. The staff stated a new process was put in place in which at 9:00 AM and 9:00PM the management is to report to how the medication pass went and if there were concerns about missing meds or order	N 352			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 36 changes. RECORD REVIEW: Example 1: The October MAR for Resident 8 indicated that from 10/22/2020 to 10/26/2020 the provider was out of Resident's Multaq (an antiarrhythmic heart medication). There was no evidence of a call to Resident 8's Primary Care Provider (PCP), MCO, or legal representative. The MAR stated the medication was "on order," reordered on 10/23/2020, but not given until 10/27/2020. The provider's new process of twice daily audits recognized the medication was out and needed a new script from the physician, however this was not resolved until 4 days later. Example 2: The October MAR for Resident 10 indicated on the evening of 10/19/20 through the morning of 10/22/2020 the provider was out of Resident 10's anti-psychotic medication, risperidone. There was no evidence of a call to Resident 10's physician or legal representative. There was no evidence in the audits this shortage was reviewed to determine why the medication was not given. Example 3: The October MAR for Resident 20 indicated that on 10/24/2020 and 10/25/2020 the provider did not administer all but 2 medications. Resident 20 did not receive low dose aspirin as a blood thinner, atorvastatin for high cholesterol, Losartan to treat high blood pressure, and vitamin D. There was no evidence of notification to the PCP, legal representative, and MCO in Resident 20's file. Resident 20 received his/hers medications from the Veterans Administration (VA). There was no evidence in the audits the procedure to reorder	N 352		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 352	Continued From page 37 from the VA was examined. Example 4: The October MAR for Resident 9 indicated on the morning of 10/27/2020 Resident 9 was not given his/hers anti-inflammatory eye drops. There is no evidence in the audits this omission was addressed. SUMMARY: Residents 8, 10, 20 and 9 were not given medications as the medications were not available at the facility prior to running out. The omissions were not reviewed and analyzed for a root cause and systemic factors such as insurance complications, the provider's processes to reorder, and staff forgetting to reorder in time. The provider's latest change in procedure began on 9/26/2020 to correct these omissions due to a medication not being reordered on time. These omissions were not consistently reported to the physician, legal representative/family member and MCO. A discussion was not started with the physician to suggest a substitute medication or discuss with staff possible effects the omission would have on the resident. There was no discussion with the resident, legal representative or MCO to explore ways to get the medication or find an alternative way to pay. In these instances there was no evidence of a call to update them about not being able to supply the medication. The medication omissions included heart medication, antipsychotic medication, blood pressure medication, eye drops, and a vitamin.	N 352			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 352	Continued From page 38	N 352		
N 353	Cross references: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment when Resident 1 had a fall with injury on 08/15/2020. Findings include: On 10/26/2020, Surveyor reviewed Resident 1's record. The provider sent Surveyor additional documentation throughout the survey. Resident 1 was admitted to the facility on 08/03/2020. Resident 1's file indicated Resident 1 had 10 falls between 08/15/2020 and 10/17/2020, resulting in 2 emergency room visits and at least 2 hospitalizations. Resident 1's preadmission assessment did not indicate Resident 1 was on anticoagulation therapy; however, Resident 1's hospital discharge summary indicated Resident 1 was taking Eliquis (an anticoagulant that was prescribed to Resident 1 on 05/13/2020) at the time of the fall on	N 353		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 353	Continued From page 39 08/15/2020. Resident 1's medication administration record (MAR) confirmed Resident 1 was administered Eliquis at the facility. Resident 1's individual service plan (ISP) did not indicate Resident 1 was on anticoagulation therapy which increased his/her risk for internal bleeding. Resident 1's 08/15/2020 incident report read in part: ""Writer had went into resident room to put [his/her] laundry away when i [sic] hear yelling for help. i [sic] did not see [him/her] at first just seen [sic] [his/her] walker laying on the floor and than [sic] i [sic] heard [him/her] yell help again from the bathroom i [sic] ran into the bathroom and seen [sic] resident [Resident 1] laying on the floor yelling help. i [sic] called for another staff to help me assist [him/her] to get up from the flloor, [sic] i [sic] noticed that [s/he] was bleeding from some where [sic] i [sic]did a body inspection and seen [sic] that [s/he] had scraped [his/her] elbow. writer [sic] and staff got [him/her] to sit in [his/her] recliner staff [sic] performed range of motion. staff [sic] seen that [s/he] had also hit [his/her] head on the right side of [his/her] forehead [his/her] left knee is also red a [sic] slight cut on [his/her] right thumb and resident stated that [his/her] back also hurts." Resident 1's observation note dated 08/15/2020 at 9 PM read, "Resident had an unwitnessed fall this evening. Writer contacted residents poa [power of attorney] immediately and reported to [him/her] the injury to the elbow and the bump on the head. POA stated that if vitals were in range, and baseline was normal to keep resident within the facility and monitor throughout the night. If any changes occurred in mental or physical status send the resident out and contact [him/her]."	N 353		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 353	Continued From page 40 Resident 1's ISP was changed on 08/15/2020 to include hourly checks for 24 hours in response to the fall. Staff instructions included: "Evaluate the questions. report [sic] any YES responses immediately. If there are any changes in mental or physical status notify admin and poa [power of attorney] immediately and have resident sent out to er." Questions included: Headache: (yes/no) Bleeding, Bumps, or Bruising?: (yes/no) Extreme Fatigue or Lethargy: (yes/no) Nausea or Vomiting?: (yes/no) A/O [alert/orientation] Per Usual?: (yes/no) Speech Clear (per usual)?: (yes/no) Able to Move Extremities Per Usual? (yes/no) Staff began fall monitoring at 9:46 PM, at this point the answers to the questions above were as follows: Headache: No Bleeding, Bumps, or Bruising?: Yes Extreme Fatigue or Lethargy: No Nausea or Vomiting?: No A/O [alert/orientation] Per Usual?: No Speech Clear (per usual)?: No Able to Move Extremities Per Usual?: No Over the next 24 hours (last fall monitoring documented at 8:34 PM on 8/16/2020), staff's responses to these questions changed multiple times, suggesting Resident 1 experienced changes in condition throughout the 24-hour post fall monitoring period. Resident 1's vital history indicated Resident 1's pain level at 9:21 PM on 08/16/2020 (approximately 24 hours after the fall) was 10 with 15 being the highest pain rating. This was Resident 1's first recorded pain level at the	N 353		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 353	Continued From page 41 facility. Based on the pre-admission assessment documentation, Resident 1 experienced some pain at baseline (pain of 1.5 out of 3 for "years") and an observation note dated 08/16/2020 indicated Resident 1 was not complaining of any pain as of 5:15 AM (approximately 8 hours after the fall). All of this suggests Resident 1 experienced a change in condition after the fall. Resident 1's file did not include evidence that Resident 1's physician was notified of the fall or at any point during the 24-hour fall monitoring. Resident 1's observation notes read, in part: 08/17/2020, 9:45 AM (nearly 37 hours after the fall) - "Writer walked into residents room to give [him/her] medication. Resident didn't want to take them staff [sic] got resident to take [his/her] meds and to drink [his/her] water. Resident when asked if [s/he] was ok [s/he] [sic] appeared to be sleeping and not alert. Resident did not want to stand up, resident [sic] would not squeeze writers hand. Resident's left side appeared to be droopy and resident was drooling. Writer went to go get another staff member, staff member did vitals, vitals [sic] appeared to be normal. Writer and staff member went to director and all decided to call EMS and family members and got resident sent out." Resident 1's hospital discharge summary dated 08/19/2020 indicated Resident 1 was diagnosed with subdural hematoma. Discharge instructions included: discontinuation of Eliquis, a change in diet (normal to dysphasia diet), a change in transfer assistance (independent to 1 assist with transfers), a change in dressing assistance (independent to needing assistance), a change in incontinence (no incontinence to "total incontinence") and implementation of fall	N 353		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 353	Continued From page 42 precautions. As of 10/27/2020, Resident 1's file included 2 assessments dated 09/22/2020 and 10/04/2020, suggesting the provider did not reassess Resident 1 when Resident 1 returned from the hospital. Resident 1's ISP was updated on 08/19/2020 to include changes to his/her diet. The ISP was not changed to reflect Resident 1's changes or needs until 08/27/2020. Between 08/19/2020 and 08/27/2020, Resident 1 had 1 near fall (lowered to the ground on 08/20/2020); and 3 unwitnessed falls on 08/23/2020, 08/24/2020, and 08/27/2020. On 11/05/2020 at 11:52 AM, Surveyor interviewed Regional Director (RD) A and Regional Support (RS) K. RD A stated staff did not consistently alert the directors when incidents or changes in condition occurred. RD A also stated the assistant directors were responsible for monitoring resident charting on a daily basis and follow up as necessary. RS K stated, "We expect the assistant director or director to notify us...we also constantly review charting." RD A stated the assistant director, regional director, or any of the upper management team could complete assessments and update the ISP. On 11/11/2020 at 3:17 PM, Surveyor interviewed Assistant Director (AD) I. Surveyor asked AD I who was responsible for monitoring resident fall monitoring charting. AD I stated the regional director should be reviewing this charting and following up as appropriate. AD I stated the assistant director or the regional director was responsible for doing post-fall assessments. AD I	N 353		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 353	Continued From page 43 stated the only assessment process s/he had been trained on was the pre-admission assessment. AD I stated s/he tried everything s/he could with 4 staff to prevent Resident 1's falls, but it was not enough. AD I stated s/he tried to get alarms for Resident 1, but "Upper management shot it down." AD I stated s/he implemented hourly checks since s/he was hired (AD I was hired on 09/15/2020). On 11/12/2020 at 3 PM, Surveyor interviewed RD A, RS K, Compliance Officer (CO) J and Operations L. Surveyor asked if staff were educated on the risks of anticoagulation therapy. RS K stated s/he did not know for sure, but it should have been addressed in Resident 1's ISP. Surveyor discussed concern that Resident 1 was on Eliquis at the time of his/her fall on 08/15/2020 and staff noted changes in his/her condition during their hourly post-fall monitoring. RS K stated the director should have been alerted to the noted changes, and the director should have reviewed the charting the next day. Surveyor asked if Resident 1's physician was notified of the fall on 08/15/2020. RS K stated s/he would review his/her file again. (As of 11/17/2020, Surveyor did not receive evidence that Resident 1's physician was notified of the fall on 08/15/2020.) The provider did not ensure Resident 1 received prompt and adequate treatment. Resident 1 was taking Eliquis and had a fall on 08/15/2020 resulting in a head injury. Resident 1's physician was not notified of the fall. The provider implemented post-fall monitoring and directed staff to send Resident 1 to the ER with any changes in condition. Staff noted changes in condition within the 24-hour post-fall monitoring period, but did not notify the director and did not send Resident 1 to the ER. Resident 1 was	N 353		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 353	Continued From page 44 hospitalized on 08/17/2020 with a subdural hematoma and returned to the facility on 08/19/2020 with changes in condition. The provider failed to assess Resident 1 after this fall and implement fall interventions. Resident 1 had 5 more falls between 08/23/2020 and 09/22/2020 and a hospitalization on 08/30/2020 before the provider assessed Resident 1. The provider did not maintain documentation of Resident 1's 08/30/2020 hospitalization. Resident 1 had 4 more falls between 09/30/2020 and 10/17/2020. The provider did not assess Resident 1's risks or provide interventions to prevent Resident 1's falls. Cross references: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 353		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by:	N 358		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 358	Continued From page 45 Based interview and record review, the provider did not ensure each resident was safe from environmental hazards. Resident 8 was entrapped between the mattress and a bed rail. The provider reapplied the device after the incident without an assessment of possible injury, assessment of need, and exploration of possible safer alternatives. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. On 11/4/2020, Surveyor reviewed Resident 8's record. Resident 8 was admitted on 2/26/2018. Resident 8's diagnoses include a past stroke with paralysis on the left side along with an irregular heart rate. Resident 8's Individual Service Plan (ISP) indicated s/he needed staff assistance for repositioning and moving in bed and can help staff in doing so. "[Resident 8] is able to help with mobility but needs staff to effective[ly] reposition." In addition, Resident 8 has a "loop rail" to help him/her be independent. On 05/21/2020 at 12:15 PM, Community Director (CD) H recorded in Resident 8's observation notes, "Writer was informed by NOC (nocturnal/night) staff that resident was found wedged between [his/her] mattress and bed cane. Writer interviewed resident who acknowledged the fact but unknown to reliability. Writer found bed rail not secured to bed and bar was placed beneath box spring. Placement was adjusted."	N 358		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 358	Continued From page 46 On 11/5/2020 at 7:51 AM, Surveyor interviewed CD H stated s/he did not recall who had told [him/her] of the incident. CD H stated s/he went to the room and the bed cane was bent away from the mattress, so s/he put it back where it should be. CD H stated s/he then reviewed the ISP and found it was not on the plan and asked Assistant Director (AD) R what should be done. CD H then added it to the ISP and removed the intervention of a pillow in bed. Surveyor asked CD H if follow-up interventions and reports were completed related to this incident. CD H stated s/he did not follow up about the appropriateness of the cane as this was the day s/he quit. On 11/12/2020 at 3:00 PM, Surveyor interviewed Regional Director (RD) A, Compliance Officer (CO) J, Regional Support (RS) K, and Operations L. RS K stated a situation in which a resident was wedged between the bed cane and the mattress would be handled first by dislodging the resident, assess for injury, and removing the bar and finding a different mode. RS K stated this would be considered an incident. Staff would then take that track and find out why it happened and file an incident report. After the incident with Resident 8, the facility did not remove the hazard but placed it back on unsecured. There was no assessment noted on the ISP or observation notes to determine if the bed cane was to be on. The device was put back even when staff discovered it was not in the ISP. The use of the bed cane and not securing the bed cane created an unsafe environment for Resident 8.	N 358		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 381	Continued From page 47	N 381		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was assessed when his/her needs, condition and abilities changed. Repeat violation. See statement of deficiencies (SOD) OI9K11, dated 04/18/2019 and 7H6111, dated 03/26/2019. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. On 10/26/2020, Surveyor reviewed Resident 1's file. Additional documentation was collected through 11/12/2020.	N 381		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 381	Continued From page 48 Resident 1 was admitted to the facility on 08/03/2020. Diagnoses included vascular dementia, atrial fibrillation, congestive heart failure, coronary artery disease, hypertension and chronic kidney disease. A pre-admission assessment was completed on 07/22/2020. This assessment summarized Resident 1 as: - Independent with ambulation, transfers, and bed mobility. - Used a wheeled walker. - Independent with toileting (no incontinence), but needing assistance with peri care. - On a general diet and not needing any nutritional/meal assistance. - Had general joint pain. - Required partial assistance with dressing; specifically, needing cues and help with buttons. - Required verbal cues with oral care daily. - Required assistance with shaving (set up and cueing). Resident 1's pre-admission assessment did not indicate Resident 1 was taking a prescribed anticoagulant, a medication that increases the risk of internal bleeding. According to Resident 1's history and physical dated 07/22/2020, which was reviewed as part of the pre-admission assessment, Resident 1 was prescribed Apixaban (Eliquis) 2.5 mg daily. This risk was not included in Resident 1's pre-admission assessment or Resident 1's care plan. Resident 1's file indicated Resident 1 had 10 falls between 08/15/2020 and 10/17/2020, resulting in 2 emergency room visits and at least 2 hospitalizations. Resident 1's first fall at the facility (08/15/2020)	N 381			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 381	Continued From page 49 resulted in a subdural hematoma and hospitalization from 08/17/2020 through 08/19/2020. Discharge instructions included: discontinuation of Eliquis, a change in diet (dysphasia diet), a change in transfer assistance (1 assist with transfers), a change in dressing assistance ("has to be dressed"), a change in incontinence ("total incontinence"), need for shower/bathing assistance, and implementation of fall precautions. Resident 1's file contained 2 assessments, dated 09/22/2020 and 10/04/2020. The first assessment did not include documentation that Resident 1's risk for falls was assessed. The assessment documentation was not filled out completely and contained contradicting information, indicating all required assessment areas were not evaluated. The first documented fall risk assessment was completed on 10/04/2020. On 11/05/2020 at 11:52 AM, Surveyor interviewed Regional Director (RD) A and Regional Support (RS) K. RD A stated staff did not consistently alert the directors when incidents or changes in condition occurred. RD A also stated the assistant directors were responsible for monitoring resident charting on a daily basis and follow up as necessary. RS K stated, "We expect the assistant director or director to notify us...we also constantly review charting." RD A stated the assistant director, regional director, or any of the upper management team could complete assessments, but assessments occurring as a result of a change in condition were the assistant director's responsibility. On 11/11/2020 at 3:17 PM, Surveyor interviewed Assistant Director (AD) I. Surveyor asked AD I who was responsible for monitoring resident fall	N 381		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 381	Continued From page 50 charting. AD I stated the regional director should be reviewing this charting and following up as appropriate. AD I stated the assistant director or the regional director was responsible for doing post-fall assessments. AD I stated the only assessment process s/he had been trained on was the pre-admission assessment. On 11/12/2020 at 3:00 PM, Surveyor interviewed RD A, RS K, Compliance Officer (CO) J and Operations L. RS K and RD A confirmed Resident 1 was assessed 3 times at the facility - on 09/22/2020, 10/04/2020, and 11/04/2020. Surveyor asked if there was a reason why Resident 1 was not assessed upon changes in condition, such as after s/he returned from his/her hospitalization on 08/19/2020. RS K stated, "No. There is no reason." Surveyor asked if the provider had a system to ensure assessments were completed. RS K stated RD A was responsible to ensure assessments were done at appropriate intervals and complete. RS K stated that prior to RD A taking on this responsibility (RD A was hired on 09/14/2020), upper management was responsible for auditing resident assessments. RS K stated a member from the upper management team would have been at the facility at least weekly to review files; management pulled a couple files each week to review. The provider did not ensure Resident 1 was assessed when his/her needs, condition and abilities changed. Cross references: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 381		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 389	Continued From page 51	N 389		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident 's needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was updated when Resident 1's needs changed and Resident 1's legal representative did not sign Resident 1's ISP, acknowledging their involvement in, understanding of, and agreement with the plan. Repeat violation. See statement of deficiencies (SOD) NWQY11, dated 02/11/2020; 0O5811, dated 09/04/2019; OQ3H11, dated 01/14/2019; 8L9G11, dated 11/27/2018; and 7XEN12, dated 04/16/2018. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally	N 389		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 389	Continued From page 52 disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. On 10/26/2020, Surveyor reviewed Resident 1's file. Additional documentation was collected through 11/12/2020. Resident 1 was admitted to the facility on 08/03/2020. Diagnoses included vascular dementia, atrial fibrillation, congestive heart failure, coronary artery disease, hypertension and chronic kidney disease. Resident 1 had an activated healthcare power of attorney (POA). A pre-admission assessment was completed on 07/22/2020. This assessment summarized Resident 1 as: - Independent with ambulation, transfers, and bed mobility. - Used a wheeled walker. - Independent with toileting (no incontinence), but needing assistance with peri care. - On a general diet and not needing any nutritional/meal assistance. - Had general joint pain. - Required partial assistance with dressing; specifically, needing cues and help with buttons. - Required verbal cues with oral care daily. - Required assistance with shaving (set up and cueing). On 08/15/2020, Resident 1 had a fall that resulted in a subdural hematoma and hospitalization from 08/17/2020 through 08/19/2020. Discharge instructions included: discontinuation of Eliquis, a change in diet (dysphasia diet), a change in transfer assistance (1 assist with transfers), a change in dressing assistance ("has to be dressed"), a change in incontinence ("total	N 389		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 389	Continued From page 53 incontinence"), need for shower/bathing assistance, and implementation of fall precautions. A Fall Risk Intervention Tool was completed on 10/04/2020. The Tool had 2 columns with a list of selections in each column. The columns read, in part: "Risk Factor...Check all the [sic] apply & address in ISP" and "Interventions...Check all that apply; an intervention must be in place if a risk factor is identified." The following risk factors and interventions were selected on the assessment: - Resident is prescribed PRN and/or Psychotropics - Observe resident for side effects including unsteady gait, confusion, anxiety. - Low/Poor vision and hearing - Staff assist with cleaning of glasses at least daily. Increase lighting including nightlight. Post signs on room door/bathroom for identification. Encourage resident to wear assistive aids. - Resident has limited mobility with or without assistive devices - Correct environmental issues including bed and assistive device height. Remind resident of safe practices frequently. Monitor resident and encourage to be in common areas whenever possible. - Incontinence - Administer medications as prescribed. Encourage activity. Encourage fluids. Staff assist with hygiene. Take vitals monthly/weekly and as needed and report abnormal results to MD. Ensure incontinence products are applied as needed. Encourage daily exercise program. Resident 1's file included a physician order dated 10/05/2020 that read, in part: "Please upgrade [Resident 1] to thin liquids. [S/he] tolerated thin liquid trial and demonstrates appropriate safety for permanent upgrade."	N 389		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 389	Continued From page 54 Resident 1 had 9 falls between 08/20/2020 and 10/17/2020, resulting in 2 emergency room visits and at least 1 hospitalization from 10/18/2020 through 11/03/2020. Documentation from Resident 1's 10/18/2020 hospitalization indicated his/her baseline condition at admission included needing assistance with all activities of daily living and mobility, 1 assist with transfers and wheeled walker, and swallowing difficulties. Resident 1's ISP, printed 10/22/2020, indicated Resident 1 required the following: - "Mechanical soft diet and nectar thickened liquids only...Prepare foods according to diet, observe while eating." - "PERSONAL CARES AM...Daily@ AM...Oral Care: [blank] Grooming: [blank] Hygiene: [blank] Dressing: [blank] Other: [blank]...NARRATIVE OF CARES NEEDED." (Sections not filled out completely) - "PERSONAL CARES HS...Daily@ HS...Oral Care: [blank] Grooming: [blank] Hygiene: [blank] Dressing: [blank] Other: [blank]." (Sections not filled out completely) - Bathing - "verbal cues and encouragement as needed...monitor for changes in independence." - "Assistance with clean up and hygiene after voiding or bowel movement. Requires cues to use own bathroom and may require assistance with changing incontinence products." - Fall interventions: "Resident is not a good fit for a pendent at this time. Resident will be monitored regularly after any incident for at least 72 hours. Resident will be checked on, toileted, and have cares done by staff members during purposeful rounds every day and night. Hourly rounds to be completed for safety checks." Resident 1's ISP was inconsistent with Resident	N 389		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 389	Continued From page 55 1's condition and discharge instructions dated 08/19/2020 and 10/18/2020 related to bathing. The ISP did not include the type of personal care needed in the morning or evening. Fall interventions included on the 10/04/2020 assessment were not transferred to the ISP. Resident 1's ISP was not consistent with his/her prescribed diet on 10/05/2020. Resident 1's ISP was not signed by POA B. On 10/27/2020, Regional Director (RD) A confirmed Resident 1's file did not contain evidence that POA B was given a copy or agreed to the services outlined in Resident 1's ISP and Resident 1's ISP was not signed by POA B. On 11/12/2020 at 3 PM, Surveyor interviewed RD A, Regional Support (RS) K, Compliance Officer (CO) J and Operations L. CO J stated ISPs were created on the date of admission and added to throughout the first 30 days. CO J stated at 30 days, a resident's ISP was considered comprehensive. RS K stated that when the ISP was complete, the provider should schedule a care conference with the resident and/or their legal representative to discuss the service plan and get the legal representative's signature. RS K stated the provider did not request a signature from Resident 1's POA. RS K stated Resident 1 returned to the facility on 11/03/2020 on hospice care, so "we are using [his/her] hospice care plan." Surveyor explained the provider was still required to maintain an ISP; RS K stated s/he understood. Surveyor asked what interventions were in place to prevent falls. RS K stated Resident 1 was given a high-back wheelchair, was encouraged to stay in the common area during awake hours, and s/he was working with physical therapy.	N 389		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 389	Continued From page 56 Surveyor discussed concern that these interventions were not included in his/her ISP. RD A confirmed s/he assessed Resident 1's fall risk on 10/04/2020 and did not put the interventions in his/her ISP. Surveyor asked who was responsible for creating and maintaining ISPs. RS K stated the assistant directors and community director were. RS K stated RD A was responsible for auditing resident ISPs to ensure accuracy and completion. The provider did not ensure Resident 1's ISP was updated when Resident 1's needs changed and Resident 1's legal representative did not sign Resident 1's ISP, acknowledging their involvement in, understanding of, and agreement with the plan. Cross references: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 389			
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review, observation and	N 426			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 426	Continued From page 57 interview, the provider did not ensure supervision appropriate to meet residents' needs. Resident 14 was assessed to be an elopement risk and successfully eloped from the facility multiple times. Resident 16 was observed exiting the occupied portion of the facility to the unoccupied and unsupervised portion of the facility without staff knowledge. Resident 6's whereabouts were unknown for at least 2 hours; Resident 6 was found soiled in a locked room with a partially clothed Resident 13. Repeat violation. See statement of deficiencies (SOD) 005811, dated 09/04/2019; and OQ3H11, dated 01/14/2019. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced age, irreversible dementia/Alzheimer's, and terminally ill. RESIDENT 14: This investigation was prompted by 2 self-reports to the Department that Resident 14 eloped on 03/01/2020 and was returned by the family/police on the same day. Resident 14 eloped on 06/09/2020 and was returned by the police on the same day. On 10/27/2020, Surveyor reviewed Resident 14's record. Resident 14 was admitted to the facility on 02/26/2020 with diagnoses that included, in part: anxiousness and vascular dementia without behavioral disturbance. According to Resident	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 426	Continued From page 58 14's records, Resident 14's Health Care Power of Attorney (HCPOA) was activated. A pre-admission assessment was completed by the facility on 02/25/2020. According to the pre-admission assessment, it was noted under the heading Exit Seeking Behavior (pg. 1 of 6), "...when frustrated with [daughter/son], [Resident 14] would walk out (and) was (a) product of (a) silver alert." The pre-admission assessment also noted under the heading Capacity for Self-Determination (pg. 4 of 6) that Resident 14 was "unable to make good decisions but can direct cares and make choices." Under the heading Exit Seeking Behavior (pg. 5 of 6), Resident 14 has a history of elopement or exit seeking behavior and s/he was highly mobile and likes to walk. According to Resident 14's Individual Service Plan (ISP) (dated: initial date unknown, ISP updated on 03/01/2020 and 06/09/2020), "Resident 14 has demonstrated or verbalized the intent to elope." According to Resident 14's ISP (Risk-Elopement), the provider put the following interventions in place upon admission: staff are expected to perform routine, purposeful resident rounds to continuously surveil the resident population for needs outside of the ISP, offer fluids, offer assistance with using the restroom, offer coffee, talk to [Resident 14], offer a snack. The ISP interventions were updated on 03/01/2020 to include: [Resident 14] needs to be within care staff eye sight at all times for the remainder of evening due to elopement. As noted in the provider's comprehensive assessment dated 04/01/2020, Resident 14 was "always asking when [s/he] can leave." According to the facility's observation notes dated	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 426	Continued From page 59 03/01/2020 to 10/21/2020, Resident 14 eloped from the facility on 03/01/2020, at approximately 3:30 PM. Resident 14 walked away from the facility and ended up getting a ride to Resident 14's child's home. In an attempt to return Resident 14 to the facility, Resident 14's daughter reported that Resident 14 kept getting out of Resident 14's daughter's car at the stoplights because Resident 14 wanted a cigarette and Resident 14's daughter did not have a cigarette. The police were called and Resident 14 was returned to the facility safely by the police. Resident had apparently eloped from the facility at approximately 3:30 PM when a visitor left the facility. Per records, the elopement was not witnessed by staff. According to weather.com, the weather in Wausau, WI on 03/01/2020 had a high of 46 degrees and a low of 23 degrees. Observation notes dated 05/12/2020 indicated Resident 14 was observed outside the facility unattended when a service provider left the building. Community Director (CD) H observed Resident 14 outside and escorted Resident 14 back into the facility. On 06/09/2020, staff discovered Resident 14 was not in the facility at 7:45 PM on 06/09/2020. Staff searched for Resident 14 and contacted local law enforcement. It was discovered Resident 14 had eloped and wandered by the Wausau Police Department around 7:45 PM. The Wausau Police Department is approximately 5 miles away from the facility. Police had observed Resident 14 walking by the police station. Resident 14 approached an officer and stated that s/he was homeless and needed help. An officer returned Resident 14 to the facility at 8:30 PM. According to weather.com the weather in Wausau, WI on 06/09/2020 had a high of 84 degrees and a low of	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 426	Continued From page 60 63 degrees. According to facility records, Resident 14 released the locking mechanism on a window in an unoccupied room and pushed the screen out and eloped through the window. Prior to Resident 14's elopement on 03/01/2020, the provider noted in the ISP - staff are expected to perform routine, purposeful resident rounds to continuously surveil the resident population for needs outside of the ISP. After Resident 14 eloped on 03/01/2020, Resident 14's ISP was updated - "[Resident 14] needs to be within care staff eye sight at all times for the remainder of evening due to elopement. All non-staff member key fobs were deactivated due to safety concerns with [Resident 14] following behind as visitors leave." After Resident 14 eloped on 06/09/2020, Resident 14's ISP was updated to reflect - "[Resident 14] disengaged the locking mechanism in the window and pushed out the screen. Temporary intervention: Care Team to complete ongoing supervision through evening of 06/09/2020 until maintenance has completed replacement of tamper proof screw to windows on 06/10/2020. Update 06/10/2020: all windows have been checked and tamper proof screw placed in window(s) throughout facility. Discontinue direct supervision but continue to monitor and check on [Resident 14]. [Resident 14] is a high elopement risk. Marathon County police have also placed an alert in system that s/he is a high elopement risk and that s/he lives at Tender Reflections." On 11/02/2020 at 3:41 PM, Surveyor interviewed Resident Care Coordinator (RCC) E. RCC E stated s/he frequently worked at the facility with a total of 3 caregiving staff and care staff were responsible for all resident cares, supervision, activities, cleaning, laundry, dishes, and	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 426	Continued From page 61 assistance with meals/dietary issues. RCC E stated it was difficult to complete all of his/her daily tasks and provide adequate supervision to residents. RCC E discussed incidents s/he believed occurred because of a lack of supervision. These incidents involved residents getting into physical altercations, residents choking on food, missing residents, and residents that successfully eloped from the facility. According to RCC E, residents would go down the unused halls and try to escape out the back doors. RCC E also stated, "[Resident 14] ran out of the facility and hitched a ride to [his/her] Power of Attorney's door." RCC E reported this happened 2 or 3 times. RESIDENT 16: On 10/27/20, at approximately 1:45 PM, Surveyors observed Resident 16 pass through the doors of an unoccupied wing of the facility (Wing D). Resident 16 can only ambulate by using his/her feet to move the wheelchair forward. Resident 16's Individual Service Plan (ISP) states that Resident 16 is a wander risk and needs some supervision. The facility is built as a quad and on the day of the survey only Wing A and Wing B contained residents and staff. Resident 16 went down the hall of Wing D in a wheelchair to the exit doors of Wing D then turned around and entered one of the unoccupied rooms before returning to Wing B. At no time did any alarms sound to alert staff that Resident 16 had left Wing B to go to the unsupervised Wing D. At approximately 2:00 PM, Surveyor discussed this concern with Resident Care Provider (RCP) G. RCP G indicated that several residents on	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 426	Continued From page 62 both of the units would exit through the doors to C and D wing and that staff are usually not aware of this and sometimes residents are not located until the 2 hour resident check. RCP G stated Resident 16 is known to wander and is labeled as a wander risk on Resident 16's Individual Service Plan. RCP G stated that Resident 16 is to be supervised if Resident 16 leaves Wing B. RCP G stated Resident 16 went through those doors (to Wing D) "a lot." Surveyor asked RCP G if s/he was aware that Resident 16 left the wing for approximately 15 minutes. RCP G said "no, "there are not any alarms on the doors leading from Wing B to Wing D." RCP G stated there are alarms on the egress doors on Wing D. RCP G stated it was his/her understanding that the doors from Wing B to Wing D were supposed to be locked. Surveyor asked RCP G to demonstrate the egress door on Wing D. RCP G activated the egress and an alarm sounded on Wing D. Surveyor asked where else the alarm sounded and RCP G stated it sounded at the front door panel. Surveyor and RCP G left Wing D while the alarm was still sounding and entered Wing B where the alarm was barely audible. RCP G and surveyor proceeded to the front door panel. The alarm was not sounding at the front door panel. RCP G stated to surveyor that the alarm should be sounding. Surveyor asked how any staff would know if a resident passed through the doors from Wing B to Wing D. RCP G stated they would not know but the resident(s) would be located during a 2 hour check of all residents. RCP G then located Regional RN (RRN) S. RRN S came to the front panel and observed there was no alarm sounding. RRN S stated the alarm only activates on Wing D. Surveyor asked if staff would know a resident exited Wing A or Wing B to	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 426	Continued From page 63 go to Wing C or Wing D if no alarm sounded. RRN S replied the alarm would be heard. Surveyor stated to RCP G that Resident 16 went through the door to Wing D unsupervised and without knowledge of staff at approximately 1:45 P.M. Surveyor stated RCP G and Surveyor just set off the alarm at the egress doors on Wing D and the alarm was still sounding but barely audible. Surveyor discussed with RRN S that no staff at that point of the alarm being set off, responded to the Wing D alarm. Surveyor also stated to RRN S that a resident could exit the egress door on Wing D without staff knowing, and with colder weather coming, could be at risk of exposure. The alarm was deactivated on Wing D. At no time did any staff react to the alarm set off at the egress door on Wing D. Surveyor then went through the doors of Wing A to Wing C. No alarm sounded. Surveyor pushed on the egress door on Wing C and it immediately opened without the egress alarm sounding. Surveyor discussed this concern during interview with Regional Director (RD) A. RD A wrote down the concern. At approximately 2:30 PM, RRN S reported that the egress alarm on Wing C had been "fixed." At approximately 2:40 PM, Surveyor discussed with RD A if the egress door on Wing C could have been propped open by staff and if that was an area where staff smoked. RD A stated that was where the garbage was taken out and the door may not have fully closed when the garbage was last taken out. Surveyor asked if there should be alarms located at the doors leading to Wing C and Wing D or if the doors should be locked. RD A said it is something that could be looked into.	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 426	Continued From page 64 The facility is a memory care facility with residents who do need supervision. There are unsupervised hallways leading to unsecured exits that resident use. Staff have no way of monitoring when residents leave the occupied areas of the facility. On the day of the survey one of the egress doors on an unoccupied unsupervised side of the building was not functioning properly. The other egress alarm on Wing D was barely audible on Wing B and no staff came to see why the alarm on Wing D was activated. RESIDENT 6: On 8/24/2020 at 12:15 AM, Staff T documented in Resident 6's observation notes, "Resident was missing when B shift started. Resident found with [a resident of the opposite sex] in C wing with the door locked. Resident has been sitting in a soiled depend for a long period of time, to the point of poop being dried ALL over [his/her] bottom." On 11/4/2020 at 3:27 PM, Surveyor interviewed Staff T about the observation note. Staff T stated it was the first night shift s/he had ever done. The facility staffs with 12 hour shifts beginning at 10:00 AM and 10:00 PM. Staff T recalled 2 staff from the day shift talking about Resident 6 as they were coming into the break room. Staff T remembered one of them asking the other if s/he had helped Resident 6 to bed and s/he said they hadn't. Staff T saw them both shrug. Staff T stated s/he only remembered that later when they could not find Resident 6. Staff T stated a bed check was done at approximately 10:30 PM and Resident 6 was not found. Between 1 and 2 hours later, Staff T stated s/he went back for a 2nd time to look in C and D wing. In C wing, the unoccupied wing, there was a locked room door. Staff T unlocked the door and found Resident 6	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 426	Continued From page 65 and Resident 13 half asleep in the room. Resident 13 was on the couch in a t-shirt and boxer shorts and Resident 6 was fully dressed and in a wheelchair. The lock was such that a person could leave the room. Staff T stated 2 coworkers took Resident 6 to get a shower and Resident 6 had dried feces front and back. Staff T indicated s/he did not try to find out what happened and how it had happened and was more concerned about Resident 6's dried feces. Staff T stated Assistant Director (AD) R was informed of the situation the next morning. Staff T indicated no management staff asked any questions and Staff T never received any feedback from any investigation about how they got into the room or why. Staff T also stated the doors to the C and D wings were never locked and felt residents were going back there periodically as Staff T has been asked to clean the bathrooms in those unoccupied units and the bathroom were quite dirty. Staff T stated s/he heard "a rumor thing" that Resident 13 had "done something sexual but a long time ago." Staff T indicated s/he did not know any details. Surveyor asked if Resident 6 was in distress, Staff T stated Resident 6 did not appear upset. Review of the clinical records of Resident 13 indicated s/he has a power of attorney (POA) that was activated. This indicates two physicians have deemed the person incompetent to make decisions about their health and well-being. Resident 13's diagnoses include dementia. Resident 13 has had several instances of physical and verbal altercations with both male and female residents. See citation 83.38(1)(i)	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 426	Continued From page 66 Behavior Management. Resident 13's individual service plan (ISP) notes this issue of "verbally and physically assaultive to other resident's at the home." The ISP indicates that loud noises and loud voices appear to trigger this behavior. Resident 6 also will pick up others belongings and believe they are his/hers and will not allow anyone to take them. Staff are to intervene with distraction of a soda, popcorn, movies on his/her DVD player, walks, calls to family, and tasks and talking of his/her past creative work life. Resident 6 has Alzheimer's disease and also an activated POA. Resident 6's ISP notes s/he can understand and communicate needs, continues to do some simple activities of daily living with only set up, however is dependent on staff for dressing. Resident 6 still makes his/her own decisions about food and how to spend his/her time. Resident 6 is very friendly and enjoys hugs. SUMMARY: The provider did not ensure supervision appropriate to meet residents' needs. Resident 14 was assessed to be an elopement risk and successfully eloped from the facility multiple times. Resident 16 was observed exiting the used portion of the facility to the unoccupied or unsupervised portions of the facility without staff knowledge. Resident 6's whereabouts were unknown for at least 2 hours. Resident 6 was found soiled in a locked room with a partially clothed Resident 13. Cross reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 426		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 427	Continued From page 67	N 427		
N 427	83.38(1)(c) Leisure time activities. 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. HFS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a daily activity program to meet the interests and capabilities of the residents. Repeat violation. See statement of deficiency (SOD) OQ3H11, dated 01/14/2019. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. The facility has a 3rd party therapy service located in the building. The therapy service provides outpatient physical, occupational, and	N 427		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 427	Continued From page 68 speech therapy services to the general public and facility residents. On 10/27/2020, Surveyor interviewed Therapist V. Therapist V stated that any activity listed as "Genesis" on the activity calendar was a therapy service s/he provided to his/her clients. Therapist V stated that if other residents wanted to join in on the therapy activities, s/he let them, but s/he did not provide any other activities at the facility. On 10/27/2020, Surveyor observed a monthly activity calendar, dated October 2020, posted on the wall in a common area (Living Room/Day Room) at the facility. The activity calendar had different activities listed throughout the day/month. The following activities were specifically scheduled for 10/27/2020: 10 AM Hand Care and Music with Genesis 11 AM Painting 2 PM Carmel [sic] Apples 3 PM Men's Club 4 PM Ice Cream Social On 10/27/2020 at 10:00 AM, Surveyor interviewed Resident 2. Surveyor asked Resident 2 if activities were consistently conducted at the facility. Resident 2 reported, "We very seldom have activities." Surveyor asked Resident 2 if s/he liked to participate in activities. Resident 2 indicated that s/he liked bingo, music and visiting with the animals from the animal shelter. While on site during the AM hours, Surveyor did not see activities being performed as scheduled. On 10/27/2020 at 12:55 PM Surveyor interviewed Cook (C) P. Surveyor asked C P if s/he had caramel apples for the scheduled activity at 2:00 PM. C P responded, "Nobody told me, you may	N 427		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 427	Continued From page 69 have to talk to management. There are no caramel apples for the day - how are the residents going to eat them?" On 11/02/2020 at 2:30 PM, Surveyor interviewed Resident Care Coordinator (RCC) D. RCC D reported that an RCC's responsibilities include passing medications, providing care, cleaning/housekeeping and doing activities with the residents. RCC D admitted there is not enough time to get all the work done. RCC D reported that sometimes there was no time to do activities or get all the clearing/housekeeping done. On 11/05/2020 at 11:30 AM, Surveyor interviewed Resident Care Provider (RCP) G. RCP G stated, "Activities are not being done consistently. The only activity that gets completed is the activity with Physical Therapy at 10:00 AM." On 11/05/2020 at 3:41 PM, Surveyor interviewed RCC E. RCC E stated caregivers were responsible for leading activities. Surveyor asked if activities were done and RCC E replied, "Nope. Never." On 11/11/2020 at 3:17 PM, Surveyor interviewed Assistant Director (AD) I. AD I stated s/he was responsible for scheduling staff. S/he stated s/he was directed to schedule 4 staff per shift, and when s/he tried to schedule more, s/he got in trouble. AD I stated that 4 staff were not enough to complete all of their responsibilities plus get to the extra tasks from upper management such as shampooing the carpets and mattresses and sanitizing the facility. AD I stated, "I tried to explain we can't. There is not time." AD I stated staff were good about prioritizing their responsibilities but activities and deep cleaning	N 427		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 427	Continued From page 70 often were "pushed off." In regards to activities, AD I stated, "It's frustrating that we are expected to do these...management gets mad at me or [Regional Director (RD) A] if they aren't done." The provider did not arrange services adequate to meet the needs of the residents in all of the following areas: leisure time activities. The provider did not ensure there was a daily activity program to meet the interests and capabilities of the residents.	N 427		
N 432	83.38(1)(h) Medication administration. 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. HFS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the provider did not ensure medication administration services were provided in a way that met residents' needs. Residents that needed eye drops were not given medications using the recommended administration technique and timing, impacting the dosage of the medicated eye drops. Resident Care Coordinator (RCC) C gave Resident 5 three different eye drops in his/her left eye in rapid succession.	N 432		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 432	Continued From page 71 Resident 10's medications were hidden in juice and staff did not supervise Resident 10 take the medication, impacting Resident 10's right to refuse medication and creating a condition where the provide could not accurately monitor Resident 10's medication intake. On 11/23/2020, Resident 10's unsupervised medications were consumed by Resident 17. Repeat violation. See statement of deficiency (SOD) 005811, dated 09/04/2019. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, terminally ill. EXAMPLE 1: The standards of practice regarding the wait time between different eye drops is to wait at least 3 minutes and as long as 10 minutes. The timeframe outlined in the American Academy of Ophthalmologists' guidance at https://www.aao.org/eye-health/treatments/how-to-put-in-eye-drops reads in part: "If you need to take more than one type of eye drop at the same time, wait three to five minutes between the different kinds of medication." The United States Pharmacists' publication at https://www.uspharmacist.com/article/how-to-use-eye-drops-properly reads in part: "If another drop of eye medication is needed, wait at least 5 to 10 minutes before administering the second eye drop so the first drop will not be washed out of the eye. The small pouch formed by the lower lid will	N 432		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 432	Continued From page 72 only hold one drop at a time, and extra drops will either flow into the tear duct (and out of the eye) or down the face." On 10/27/2020 at 11:44 AM, Surveyor observed RCC C give Resident 5 three different eye drops into the left eye. The drops were ofloxacin 0.3% (an antibiotic), prednisolone 1% (a steroid), and diclofenac 0.1% (a non-steroidal anti-inflammatory). All 3 drops were given in less than 1 minute. On 11/12/2020 at 3:00 PM, Surveyor interviewed Compliance Officer (CO) J about several policies and procedures, how staff are trained to give eye drops, and the timeframe to wait between multiple types of eye drops. CO J stated staff were trained in the Medication Administration class to wait 5 minutes between eye drops. On 10/27/2020 at 10:25 AM, Surveyor interviewed RCC C. RCC C indicated the training at the facility to pass medication did not meet his/her expectations and s/he had to learn the job as s/he went. RCC C stated current employees were getting "actual training." RCC C stated training took place in less than a day and was with a staff member for the first medication pass and that staff member was fired. RCC C's continued his/her first medication pass alone. RCC C stated it was very stressful. The provider did not ensure and evaluate RCC C's ability to pass medications. The facility has an evaluation tool in place titled Medication Training Proficiency. Included in the task check list is a return demonstration that read in part, "Demonstrated ability to prepare and assist with eye drops." This evaluation tool was not completed for RCC C.	N 432		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 432	Continued From page 73 EXAMPLE 2: Prior to 10/20/2020, the Department received a complaint indicating staff were crushing a resident's medication without an order, placing the medication in juice and serving the juice to the resident. The resident wandered from the table and another resident drank the juice which included psychotropic medication. The complainant indicated the provider failed to report the medication error and notify the residents' physicians. On 11/23/2020, the Department received a complaint alleging Resident 17 drank another resident's juice which contained medications. The complainant indicated staff left the resident's medication and juice mixture unsupervised and Resident 17 drank it. On 12/01/2020, Surveyor reviewed a medication deviation report dated 11/23/2020 at 9 AM which read in part: "[Resident 17] drank [Resident 10's] juice that had Risperidone 1mg and Ferrous Sulfate 300mg mixed in it. The cup was left sitting by [Resident 10] at dining room table for res (resident) to drink. [Resident 17] walked by, grabbed cup and drank all contents ...Verbal direction to staff: Instructed staff to never leave med unattended w/res (with resident) and that med should be prepared in med room, not the kitchen." Resident 17's primary care practitioner (PCP) was updated when the error was discovered. The PCP was told Resident 17 vital signs were good and did not appear to have any effects or negative side effects from the anti-psychotic medication. The PCP told staff to give Resident 17 his/hers prescribed medications now and	N 432		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 432	Continued From page 74 monitor for an adverse reaction and call if Resident 17 had a change in condition. No call was needed. Surveyor reviewed Resident 10's file. Resident 10 was admitted on 12/29/2017. Diagnoses included dementia, paranoid schizophrenia, type 2 diabetes, and mixed hyperlipidemia. Resident 10 had an activated healthcare power of attorney. Resident 10's individual service plan (ISP) read in part: "Receives assistance from staff to administer medication. Method of taking medication: crushed with applesauce, pudding, or ice-cream. Resident has a history of refusing [his/her] medications almost daily stating they're "poison." [Resident 10's] MD has requested [s/he] be notified monthly on medication refusals due to frequency of refusal." Resident 10's medication administration record (MAR) indicated RCC X administered Resident 10's medication the morning of 11/23/2020. On 12/01/2020 at 4:45 PM and 12/02/2020 at 1:41 PM, Surveyor interviewed RCC X (hired 10/05/2020). RCC X stated s/he was trained by RCC E and previous Assistant Director (AD) R to dissolve Resident 10's medications in juice, give Resident 10 the juice, and leave. RCC E stated s/he questioned this practice, but s/he was assured Resident 10 would not drink the juice if s/he was watched. RCC X stated this was how all medication passers (RCCs) were administering Resident 10 his/her medication, and it had been this way since s/he started. RCC X stated after the incident on 11/23/2020, management began retraining all RCCs on medication administration. On 12/01/2020 at 4:22 PM and 12/02/2020 at	N 432		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 432	Continued From page 75 1:50 PM, Surveyor interviewed RCC Y (hired 09/24/2020). RCC Y stated s/he was trained to provide Resident 10's medication to him/her in juice and walk away. RCC Y stated s/he did not tell Resident 10 that the juice had medication in it, and most of the time, RCC Y would bring the juice to Resident 10's room. RCC Y confirmed all RCCs were taught to administer Resident 10's medications this way, but the provider started retraining all RCCs after the incident on 11/23/2020. On 12/02/2020, Surveyor asked Regional Support (RS) K and Regional Director (RD) A via email to explain the medication administration practice described by RCC X and Y. RS K replied via email that read in part: "I nor [RD A] were aware prior to this incident that staff were not informing [Resident 10] that [his/her] medications were in [his/her] juice nor supervising [Resident 10] when [s/he] consumed [his/her] medications. Per our policy staff are expected to follow the 6 rights of medication administration. Following this incident the Director was instructed to remove the med passer responsible for this incident from passing medications until our RN provided education on the correct expectations of medication administration. This was completed and our RN allowed the med passer to resume passing medications. We immediately informed medication passers that this practice cannot occur. We also scheduled mandatory training for all med passers regarding the 6 rights of medication administration as well as reestablishing the requirement that residents are informed of medication that is present in any additional substance. We have also discontinued the practice of allowing med passers to train the expectations of medication administration. This	N 432		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 432	Continued From page 76 is now done by [RD A] to ensure training is occurring which meets all requirements." SUMMARY: The provider did not ensure medication administration services were provided in a way that met residents' needs. Residents that needed eye drops were not given medications using the recommended administration technique and timing, impacting the dosage of the medicated eye drops. Resident 10's medications were hidden in juice and staff did not supervise Resident 10 take the medication, impacting Resident 10's right to refuse medication and creating a condition where the provider could not accurately monitor Resident 10's medication compliance. Cross references: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0247 DHS 83.22(1)-(4) Task Specific Training	N 432			
N 433	83.38(1)(i) Behavior management. 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. HFS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services to manage the	N 433			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 77 behaviors of Resident 12, 13, and 15 that were harmful to themselves and others. Repeat violation. See statement of deficiency (SOD) 7H6111, dated 03/26/2019. Findings include: This provider is licensed to serve up to 80 residents in the client groups developmentally disabled, traumatic brain injury, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and terminally ill. The Department received multiple complaints regarding residents with violent and or aggressive behavior toward other residents and staff. On 10/27/2020, Surveyors conducted several complaint investigations at the facility. Several residents listed on the complaints were reported to have violent and or aggressive behaviors. EXAMPLE 1: Resident 15 was admitted to the facility on 10/24/2019 and was discharged on 06/24/2020. Resident 15 has a diagnosis of dementia with Lewy Body Syndrome. Resident 15's Individual Service Plan stated that Resident 15 only needed some supervision. Between the dates of 02/19/2020 and 05/31/2020, Resident 15 had 16 incident reports regarding wandering, behavior issues, and aggression toward staff and other residents. The reports are summarized as follows:	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 433	Continued From page 78 02/19/2020-Resident followed guest out the front door...it took 3 staff to get the resident back into the building. 03/11/2020-Resident became very upset with another resident in a wheelchair. Resident was yelling and slapped resident on his/her hand then on the head. 03/20/2020-Resident was hitting another resident across the back with a cane. 03/21/2020-Resident struck another resident with his/her fist in the face. Resident walked up to the other resident and kicked him/her in the head. 03/22/2020-Resident struck another resident across the head/face very hard. 04/04/2020-Staff observed resident in a physical altercation with another resident. 04/14/2020-Resident went into another resident's room and after yelling resident kicked the other resident in the leg. 04/20/2020-Resident followed staff into medication room. Resident became upset when asked to leave. Resident then got into an altercation with another resident. Resident was yelling and spitting and cursing at other resident and tried to kick other resident. 04/24/2020-Resident was offered ice cream if resident would allow staff to shower. Resident refused pulled off his/her pants pushed staff by the wrist and pushed staff onto the bed and spit at staff's face. Another staff arrived to assist and the resident began hitting that staff.	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 433	Continued From page 79 04/24/2020, approximately 2 hours after first incident, Resident was on top of staff pulling and twisting staff's arm. Staff asked resident to let the other staff go. Resident then started kicking staff. Resident left the room, threw some clothing protectors on the floor and then tried hitting another staff. 04/28/2020-Resident was combative with another resident, striking the other resident in the head several times. Both residents were redirected. Minutes later resident attacked the other resident again. Medications were given with little to no effect at all. 05/09/2020-Resident punched another resident in the face after dinner. 05/10/2020-Staff heard resident yelling... resident stated resident 15 hit him/her in the head and right arm. 05/25/2020-Staff saw resident go up to another resident and hit that resident in the face. Staff heard yelling and then saw resident hit another resident in the face. Resident took off shirt and hit staff with his/her shirt and then hands. Staff called for other staff assistance. Resident hit that staff. Staff went to call Director while other staff was still trying to calm resident down. Director told staff to send him/her out. Resident was sent to hospital. 05/28/2020-Resident was slamming other resident's door. Staff tried to calm resident down. Resident slapped staff in the arm. 05/31/2020-A resident reported Resident 15 was spitting on him/her and Resident 15 slammed his/her shoe on the desk. Resident was seen	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 433	Continued From page 80 pacing the hall with a shoe in his/her hand. EMS was called. EMS and police arrived. Resident 15 started to scream at EMS (emergency medical service) and police. Resident 15 was transported to ER by EMS. EXAMPLE 2: Resident 13 is a 68 year-old resident with a diagnosis of dementia. Resident 13 was admitted to the facility on 06/25/2020. Surveyor reviewed Resident 13's medical records and found the following information in staff charting, task administration records (TAR), and incident reports: 08/08/2020 - "[Resident 13] took [sic] another resident's breakfast. When staff told [him/her] [he/she] needed to give it back [Resident 13] picked [sic] the pancakes, and fork up and threw them across the room. Staff tried to get Resident to [his/her] room to calm down. Resident became extremely hostile. Resident went down D wing hall way [sic], Staff explained D wing was under construction and [he/she] could not go down there. Resident responded with '[Expletive] come here and ill [sic] bash your head through this glass.' Staff told resident [he/she] should not talk like that. Resident kept screaming down D hallway, and then started banging on the door. Staff tried to redirect Resident. Redirection did not work, Resident then went down a wing right for the door and started beating on it until the alarm went off, [sic] when staff tried to get [Resident 13] to [his/her] room [Resident 13] picked up a chair and tried to throw it at staff...." 09/02/2020 - "Staff was in the dining area with all residents assisting with meals and drinks, [another resident] was upset and was being loud, that agitated [Resident 13] and [he/she] got up	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 433	Continued From page 81 from [his/her] table and walked do [sic]where [the other resident] was sitting and smacked [him/her] in the face." 09/11/2020 - "Writer was hearing yelling coming from the dining area, writer observed resident and p.t. and another staff member trying to stop resident from taking a dining room cart and pushing it into other residents as well as walls and glass doors. Writer was able to redirect however only a few minutes later resident stated [sic] to get angry at writer and tried to strike writer and was calling writer names. A staff tried to redirect and was [sic] unsuccessful. Writer did stay by resident's side most of the morning for the safety of other residents as well as other staff. 09/22/2020 - "[Resident 13] walked up behind [Resident 16] and began pulling and twisting [his/her] hair." 10/01/2020 - "Resident was in another [male/female] resident's room. Resident was undressed in other resident's room making comments regarding [him/her] [sic] genitalia when staff entered room to remove trash. Resident was redirected to put [his/her] clothing back on. Staff had to ask [him/her] twice to have [him/her] to put [his/her] clothing back on...." 10/09/2020 - "[Resident 13] pushed other [sic] very hard. Staff tried to get [him/her] down to [his/her] room, resident refused. Staff stated that it was not okay to put [his/her] hands on a [man/woman]." 10/09/2020 - 6:30 PM - "Resident was very agitated today, would not accept redirection, only seemed to make [him/her] more agitated. Was yelling at/going after other residents all day."	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 82 10/10/2020 - "[Resident 13] and a [male/female] resident were seen in the start of the B wing hallway. [Resident 13] had a hold on [male/female] resident's wrist and was shaking [his/her] arm up and down hard. [Male/Female] resident was screaming for help and crying. by [sic] the time staff had made it to them [Resident 13] had walked away." 10/10/2020 - "[Resident 13] was in a verbal argument with a [male/female] resident when [he/she] lunged at [male/female] resident whipping [his/her] jacket around and towards [male/female] resident. [He/she] made contact at least twice striking [male/female] resident with [his/her] jacket. [Male/Female] retaliated and kicked [Resident 13] in the knee." 10/11/2020 - 5:45 PM - "Resident took another resident's plate of food and dumped it onto the resident and on the floor." 10/12/2020 - 5:24 PM - "[Resident 13] was pushing [Resident 16] in [his/her] wheelchair and [he/she] tried to grab something of [sic] the table and [Resident 13] grabbed [his/her] arm and yanked it for (sic) [him/her] what [he/she] grabbed off the table". 10/14/2020 - "Staff had turned down B wing hallway and had noticed that [Resident 13] was holding on [Resident 1's] wheel chair [sic] and [Resident 13] had started to yell at resident and than [sic] put [his/her] hand over [Resident 19's] mouth so [he/she] could not talk..." 10/17/2020 - "Writer was entering dinning [sic] area when I had seen [sic] [Resident 13] screaming at [Resident 19] and than [sic] push	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 83 [Resident 19] into the couch." 10/18/2020 - 9:58 AM - "Resident was yelling at staff, and grabbing at staff, trying to hit other resident with door, threatening to hurt others." 10/19/2020 - "[Resident 13] was walking down A wing towards the common area. [Resident 13] was yelling so staff went to look at what was happening. As staff was turning the corner, [Resident 13] was walking up behind [male/female] resident and put [his/her] hands on [his/her] throat, yelling and shaking [him/her]. 2 staff members ran over and approached resident. Staff members immediately intervened and [Resident 13] let go.....Resident then began following staff members that intervened yelling at them. Staff members called assistant director for direction. Instructions were given to call the police." Resident 13's physical aggression and propensity to take others clothes and belongings threatened Resident 13's health and safety as other residents aggressed on Resident 13 after Resident 13 aggressed or took belongings. The surveyor interviewed Caregiver M on 10/27/2020 at approximately 10:30 AM, who attributed lost clothing to the fact that Resident 13 was always taking others things and the fact that staff did not have adequate time to do all of their duties (the laundry, showers, meals, cleaning etc.) and provide adequate supervision to prevent Resident 13 from taking other residents' things. Resident Care Provider M also stated Resident 13 would become upset if staff attempted to take other residents' things away from him/her. The ISP stated, discussing Resident 13's work and offering pen and paper may work to distract	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 84 Resident 13, as well as offering a movie or food, but Caregiver M stated these approaches did not consistently work. Resident 13's (ISP) stated staff were also to attempt to distract Resident 13 when it appeared a physical altercation may or had occurred. These were the same approaches used to deal with Resident 13 taking other residents' things. There were few proactive approaches and they were not consistently effective. Staff M stated staff did not have the time to monitor Resident 13 at all times to prevent behaviors. EXAMPLE 3: Resident 12 was admitted to the facility on 03/15/2020. Resident 12 has a diagnosis of dementia. 03/20/2020 - 7:45 PM - "Resident was in an altercation with another resident and resident has chased after the other resident multiple times making threats to [him/her] and was using [his/her] cane for violence." 03/25/2020 - 7:30 PM - "Resident was motioning up and down on [his/her] private area near another resident at 7:30pm [sic]." 05/09/2020 - 6:00 AM - "Staff was doing cares for another resident and heard [Resident 12] down in the a wing living area staff checked outside the door and see [sic] that [Resident 12] had [his/her] hand on another residents [sic] private area on top of clothing..." 05/10/2020 - 5:00 PM - "writer observed resident exposing [him/herself] and touching another resident underneath [his/her] shirt and trying to pull [his/her] hand towards [his/her] [groin area]. Writer yelled to resident and ran over to remove	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 85 other resident from the area as [he/she] was crying and saying "NO NO NO!" Writer told resident that this behavior was not acceptable and will not be tolerated. Resident laughed and said, "I'll do what I do, I get away with it anyway." 05/10/2020 - 7:30 PM - "Resident has been kicking other residents under the dining tables during meal times. Resident has been redirected and [he/she] laughs about it." 05/21/2020 - 11:33 AM - "Housemate reported resident slapped [him/her] in the back of the head....Resident states [he/she] hit this resident because [he/she] didn't like [him/her]." 07/03/2020 - 6:56 AM - "[Resident 11] was seen walking down towards care staff. Resident had blood dripping down [his/her] forehead. When care staff asked what happened resident stated, "This [guy/girl] [Resident 12] hit me in the head with a cane." 09/06/2020 - 9:30 AM - "Care staff went in to resident's room to look for missing keys. While staff was in residents room staff found another residents glasses, 2 cigarettes, and another residents movies." 09/23/2020 - 10:01 PM - "Resident went up to another resident and hit [him/her] with [his/her] cane..." 09/26/2020 - 7:45 AM - "writer found the master key to the employee access only rooms in between resident's mattress and box spring....we need to be checking often for our keys in [his/her] room. This has happened multiple times." 10/11/2020 - 03:55 PM - "writer was standing in	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 86 hallway observing a conversation between [Resident 12] and a [male/female] resident. [Resident 12] asked [him/her] if [he/she] wanted to go out tonight to which [he/she] responded yes. [He/She] then began to walk away, [Resident 12] then called for [him/her] to come back. [Resident 12] grabbed [his/her] chin to [Resident 12] [sic] bring [him/her] closer and asked [him/her] if [he/she] was wearing [undergarments], while grabbing [his/her] chest." The surveyor reviewed Resident 12's ISP for behavioral approaches. The ISP stated staff were to redirect and offer activities if it appeared an altercation might be starting. It stated staff were to check on Resident 12 on purposeful rounds and more often if Resident 12 was in the common areas. It stated staff were to provide continuous monitoring. There were no proactive approaches in the ISP to prevent altercations prior to the behaviors beginning. Resident 12 also exhibited inappropriate sexual behaviors. The ISP stated staff were to tell Resident 12 to stop or attempt to distract Resident 12 by asking what he/she was watching on TV or something about what he/she was doing prior to the sexual behaviors. There were no proactive approaches to attempt to prevent the inappropriate sexual behaviors from occurring. INTERVIEWS: On 11/04/2020 at 1:18 PM, Surveyor interviewed Resident Care Coordinator (RCC) Q. RCC Q stated s/he often worked with a total of 3 staff on the floor. RCC Q stated the facility had a lot of behaviors and not enough staff to supervise or referee the residents. RCC Q stated that at least 1 staff was pulled from their duties during medication pass times so the RCCs could pass medications without interruption. RCC Q stated	N 433			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 87 that during the 1-2 hours it took to pass medications, care tasks were not provided to residents because the non-medication passers had to be watching the residents with high behaviors. RCC Q stated s/he did not receive training on preventing, managing, or responding to challenging behaviors. On 11/05/2020 at 11:52 AM, Surveyor interviewed Regional Director (RD) A and Regional Support (RS) K. Surveyor asked how the provider assessed resident behaviors. RS K stated residents behavior patterns were assessed during the pre-admission assessment. The information collected prior to admission was given to Compliance Officer (CO) J and CO J determined if the provider was able to meet the resident's needs. RS K stated CO J reviewed resident ISPs routinely and "may offer suggestions" related to behavior interventions. RS K stated behavior interventions were included on the ISP and staff documented the use of the interventions on the task administration record (TAR) and in observation notes. The provider did not create separate behavior service plans for residents. RS K stated that when residents had behaviors, the directors should contact the resident's physician. RS K stated, "We expect the directors to notify us (upper management) of resident to resident issues...we also constantly review charting." RS K stated upper management, such as RS K, would come to the facility to observe the resident and determine follow up action. RS K stated s/he recently went to the facility in response to a concern about a resident exhibiting sexualized behaviors toward another resident. RS K stated his/her response to the situation was to assign staff 2 trainings related to dementia and sexuality. The trainings were assigned on	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 433	Continued From page 88 10/19/2020 and due on 10/24/2020. On 11/12/2020, RS K confirmed no staff had completed the trainings. On 11/05/2020 at 3:41 PM, Surveyor interviewed Resident Care Coordinator (RCC) E. RCC E stated s/he frequently worked at the facility with a total of 3 caregiving staff and care staff were responsible for all resident cares, supervision, activities, cleaning, laundry, dishes, and assistance with meals/dietary. RCC E stated it was difficult to complete all of his/her daily tasks and provide adequate supervision to residents. RCC E discussed incidents, which s/he believed occurred because of a lack of supervision. These incidents involved residents getting into physical altercations, residents found to be choking on food, missing residents, and residents that successfully eloped from the facility. RCC E stated s/he did not receive training on preventing, managing, or responding to challenging behaviors. SUMMARY: Between February and June 2020, Resident 15 had 16 documented incidents involving physical aggression toward staff and residents. Between August and October 2020, Resident 13 had 15 documented incidents, including stealing, verbal threats and physical aggression toward staff and residents. Between March and October 2020, Resident 12 had 11 documented incidents including sexual assault and physical aggression toward residents. The provider did not equip staff with the tools they needed to manage harmful behaviors when they failed to adequately train their staff on how to prevent, manage, and respond to challenging behaviors. Interventions included on these residents' ISPs were not effective in managing behaviors. The provider did	N 433		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
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N 433	Continued From page 89 not ensure residents' behaviors were not harmful to themselves or others. Cross references: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0243 DHS 83.21(1)-(3) All Employee Training N0426 DHS 83.38(1)(b) Supervision	N 433		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure each staff member washed their hands between residents and when changing gloves. This has the potential to affect all the residents at the provider and is contrary to the Centers of Disease Control and Prevention (CDC) hand hygiene guidelines. Resident Care Coordinator (RCC) C did not sanitize his/her hands before and after changing gloves when: ~Giving oral and topical medications to Resident 3, ~Giving oral medication and doing a blood sugar finger stick to Resident 4, ~Giving eye drops to Resident 5, ~Assisting Resident 2 on the toilet. RCC C also used the same pair of gloves when checking Resident 2's blood sugar with a finger stick, giving Resident 2 eye drops, and then applying an analgesic ointment to Resident 2's knee. RCC C potentially contaminated his/her gloves with blood	N 441		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/02/2020
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N 441	Continued From page 90 and used the same gloves to instill an eye drop in both of Resident 2's eyes. Repeat violation. See statement of deficiency (SOD) 7XEN12, dated 04/16/2018. Findings include: The provider is licensed to care for up to 80 residents from the client groups advanced age, developmentally disabled, traumatic brain injury, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness and terminally ill. According to information found on https://www.cdc.gov/handhygiene/providers/guide/line.html, "The Core Infection Prevention and Control Practices for Safe Delivery on All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC)" includes the following strong recommendations for hand hygiene in healthcare settings: Health care personnel should use alcohol-based hand rub or wash with soap and water for the following clinical indications: ~Immediately before touching a patient ~Before performing an aseptic task or ... handling invasive medical devices ~Before moving from work on a soiled body site to a clean body site on the same patient ~After touching a patient or the patients immediate environment ~After contact with blood, body fluids, or contaminated surfaces ~Immediately after glove removal The provider's Hand Hygiene policy and	N 441		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/02/2020
NAME OF PROVIDER OR SUPPLIER TENDER REFLECTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3404 COMMUNITY CENTER DR WESTON, WI 54476		
(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 441	Continued From page 91 procedure dated 03/19/2020 did not direct staff to wash their hands before and after touching different residents and their environment. The Usage of Gloves policy dated 03/19/2020 directed staff to wash their hands before and after removing gloves. The Transmission Based Precautions policy dated 03/19/2020 stated staff should use standard precautions. The Standard Precautions policy and procedure states staff were to "take precautions for preventing the transmission of infectious agents among residents and staff. Standard precautions assume that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infections agents." On 10/27/2020 at 11:09 AM, Surveyor observed RCC C don gloves in the medication room without sanitizing his/her hands prior. RCC C had touched the door and the keys in his/her pocket and unlocked the cart. RCC C then locked the cart and door and put Resident 3's topical analgesic cream in his/her pocket. RCC C gave Resident 3 oral medications and applied a topical cream. RCC C pulled off one glove in the room and one off in the medication room. RCC C did not sanitize. At 11:23 AM, RCC C repeated the same procedure for Resident 4 when administering an oral medication and checking Resident 4's blood sugar. RCC C took off the gloves in the medication room but did not sanitize his/her hands. At 11:29 AM, RCC C donned gloves in the medication room and gathered the insulin pen, eye drops, and topical ointment and discovered Resident 2 was unprepared to take the	N 441			

Wisconsin Department of Health Services

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N 441	Continued From page 92 medications. RCC C removed the gloves in the medication room and again did not sanitize his/her hands. At 11:44 AM, RCC C repeated the procedure in the medication room for Resident 5's eye drops. RCC C did not change gloves until in the medication room and did not sanitize his/hers hands. At 12:11 PM, RCC C repeated the procedure in the medication room to gather medications for Resident 2. RCC C assisted Resident 2 on and off the toilet and physically wiped Resident 2's bottom. RCC C changed gloves but did not sanitize in between. RCC C took Resident 2's blood sugar and gave Resident 2 the insulin pen to self-administer. With the same gloves RCC C gave Resident 2 eye drops and applied an analgesic ointment to his/her knee. RCC C removed the gloves and went to the medication room. RCC C did not sanitize his/her hands. At approximately 1:34 PM, Surveyor interviewed RCC C. RCC C stated staff were supposed to wash their hands "all the time." RCC C stated handwashing was to be done before and after helping each resident. When discussing the observation of Resident 2's toileting and medications RCC C indicated s/he was unsure if handwashing was to be done in between each step, but the order the medications were observed to be given was as s/he always did it. The observation was shared with Regional Director (RD) A on 10/27/2020 at approximately 2:30 PM. On 10/29/2020 at 10:37 AM, Surveyor interviewed RD A and Compliance Officer (CO) J	N 441		

Wisconsin Department of Health Services

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N 441	Continued From page 93 about the education of RCC C related to handwashing and glove changes between residents and between procedures. Staff stated RCC C was educated individually on 10/28/2020. The provider did not ensure each staff member washed their hands in accordance with CDC hand hygiene guidelines.	N 441		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure every interior floor, wall and ceiling were clean and in good repair. Findings include: The Department received several complaints regarding the physical environment of the facility. On 10/27/2020, at approximately 10:30 AM, Surveyor conducted an environmental tour of the facility. During that tour, Surveyor found the following areas of concern: * There was not a transition strip between the dining area and the hallway of B Wing. This left an approximate 1 inch gap in the carpet between the transition area, causing a trip/fall hazard. * The carpet in the hall of B Wing was rippled, causing a trip/fall hazard. * The carpet of the dining room near the windows	N 491		

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N 491	Continued From page 94 facing the courtyard where residents sit had several large and dark stains. * The carpet outside the kitchen door leading into the dining area was rippled, causing a trip/fall concern. * There was not a transition strip between the dining area and the hall that leads to the A Wing laundry. This left an approximate 1 inch gap in the carpet, causing a trip/fall hazard. On 11/12/2020, Surveyor interviewed Operations L and Regional Director (RD) A. Operations L stated s/he oversaw the facility's maintenance program. Staff were responsible for reporting maintenance concerns to Operations L and Operations L scheduled the necessary maintenance. Operations L stated maintenance cleaned the carpets at least every 45 days. RD A stated nighttime staff were responsible to clean the carpets between maintenance cleanings. RD A stated the stains on the carpet would be cleaned and reappear the next day due to frequent spills. Operations L stated the carpet ripples were repaired in April or May 2020. S/he was not aware the ripples had returned. Operations L was not aware of the missing transitions strips, but stated s/he would have the issue addressed. Summary: The facility did not ensure every interior floor, wall and ceiling were clean and in good repair.	N 491		