STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013818	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 08/02/2023, Surveyors conducted a verification visit at Touchstone of Mayville. 20 deficiencies were identified. Multiple 2nd, 3rd, and 4th repeat deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census 7	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview the provider did not investigate 2 injuries of unknown origin. Findings include: On 08/02/2023, Surveyor reviewed Resident 6's facility record. A report titled "Final Report" written by the orthopedic clinic on 05/23/2023, documented Resident 6 sustained a fracture of the left femur. The record indicated it was most likely an injury that occurred during an attempted transfer. Resident 6's thigh was visibly swollen	N 161		

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

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N 161	Continued From page 1 and tender and his/her appetite was poor. An additional report titled "Radiology Report" documented on 03/16/2023, Resident 6 had x-rays taken that showed a fracture of Resident 6's femoral neck. On 08/02/2023 at approximately 11:27 AM, Surveyor interviewed Assistant Administrator N who stated s/he did not investigate Resident 6's broken bones. Assistant Administrator N stated s/he did not have any information or investigations into how the fractures occurred but understood the requirement of investigating injuries of unknown origin.	N 161		
N 188	83.13(3)(a) Posting license, deficiencies, revocations The CBRF shall post all of the following: CBRF license, any statement of deficiency, notice of revocation and any other notice of enforcement action as required under s. DHS 83.14(2)(h). This Rule is not met as evidenced by: Based on observation and interview the provider did not post statement of deficiency # I87Y13 dated 03/29/2023, issued on 05/24/2023. Findings include: On 08/02/2023 at approximately 9:14 AM, Surveyor toured the facility. Surveyor did not observe statement of deficiency # I87Y13 posted at the facility. Statement of deficiency # I87Y13 was issued to the provider on 05/24/2023. On 08/02/2023 at approximately 12:43 PM, Surveyor asked Assistant Administrator N if	N 188		

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N 188	Continued From page 2 statement of deficiency # I87Y13 was posted anywhere at the facility. Assistant Administrator N stated the statement of deficiency was not posted because Licensee U did not notify him/her there was another statement of deficiency and just received a copy of the statement of deficiency on 08/02/2023.	N 188		
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 interview and record review Licensee U did not ensure the community based residential facility and its operation complied with all laws governing the community based residential facility. This is a recite from SOD # I87Y12 dated 10/04/2022. From 04/13/2021 thru 08/02/2023, Touchstone of Mayville has had 86 deficiencies issued. Of the 86 deficiencies there were multiple 2nd, 3rd, and 4th recites. The provider has had 4 substantiated complaints. Findings include: SOD # I87Y13 On 08/02/2023, Surveyors conducted a verification visit for SOD # I87Y13 dated	N 196		

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N 196	Continued From page 3
	03/29/2023. As a result 20 deficiencies were identified. The following deficiencies were identified:
	
	83.12(3)(a) Investigate Injuries of Unknown Source.
	83.13(3)(a) Posting License, Deficiencies, Revocations.
	83.13(1) Employee Record Maintained and Current
	83.14(2)(a) Licensee Ensures Facility Complies with Laws. (Recite SOD # I87Y12 dated 10/04/2022.)
	83.17(1) Licensee Conduct Caregiver Background Check. (3rd Recite SOD # I87Y11 Dated 05/24/2022, SOD # I87Y12 Dated 10/04/2022.)
	83.17(2)(a) Employees Screened for Communicable Disease. (Recite from SOD I87Y11 dated 05/24/2022.)
	83.35(1)(c) Listed Areas for Assessments.
	83.35(2) Temporary Service Plan.
	83.35(3)(c) Implement, Follow The Individual Service Plan. (3rd Recite from SOD I87Y12 dated 10/04/2022 and SOD # I87Y13 dated 03/29/2023.)
	83.35(3)(d) Service Plans Updated Annually or on Changes. (4th Recite from SOD # I87Y11 dated 05/24/2022, SOD # I87Y12 Dated 10/04/2022, SOD # I87Y13 dated 03/29/2023.)
	83.35(4) Resident Satisfaction Evaluation.
	83.35(5)(b) Annual Evaluation of Evacuation Limits. (3rd Recite from SOD # I87Y11 dated 05/24/2022, SOD# I87Y12 dated 10/04/2022.)
	83.37(2)(d) Documentation of Medication Administration.
	83.37(3)(c) Medication Storage: Locked Cabinet. (3rd Recite from SOD # I87Y12 dated 10/04/2022, and SOD # I87Y13 dated 03/29/2023.)
		N 196		

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N 196	Continued From page 4
	83.38(1)(c) Leisure Time Activities. (Recite from SOD # I87Y12 dated 10/04/2022.)
	83.42(1) Resident Record Maintained. (Recite from SOD # I87Y12 dated 10/04/2022.)
	83.43(1) Environment Safe, Clean, and Comfortable. (4th Recite from SOD # I87Y11 dated 05/24/2022, SOD # I87Y12 dated 10/04/2022, SOD # I87Y13 dated 03/29/2023.)
	83.44(1)(c) Clothes Dryers Enclosed and Vented.
	83.45(3) Toxic Substances. (4th Recite from SOD # VGK911 dated 04/13/2021, SOD # I87Y11 dated 05/24/2022, I87Y12 dated 10/04/2022.)
	83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways. (Recite from SOD # I87Y13 dated 03/29/2023.)
	
	On 08/02/2023 at approximately 12:43 PM, Surveyor shared findings with Assistant Administrator N. Assistant Administrator N stated s/he was not aware there was another statement of deficiency issued. Assistant Administrator N stated Licensee U had just sent the statement of deficiency to him/her that day.
	
	On 08/03/2023, Surveyor reviewed Department records and reviewed the following:
	
	SOD I87Y12
	
	On 03/29/2023, a verification visit was conducted for SOD I87Y12 dated 10/03/2022. The following 8 deficiencies were identified in SOD # I87Y13 dated 03/29/2023.
	83.17(2)(a) Employees Screened for Communicable Disease
	83.35(3)(b) Service Plan Development: Parties involved
	83.35(3)(d) Service Plans Updated Annually or on Changes
	83.37(3)(c) Medication Storage: Locked Cabinet
		N 196		

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N 196	Continued From page 5 83.43(1) Environment Safe, Clean, and Comfortable 83.46(1)(f) Combustibles 83.48(1)(b) Smoke and Heat Detectors per NFPA 72 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways On 05/24/2023, The Department sent a notice and order letter via Electronic statement of deficiency to Touchstone of Mayville. The letter had the following Department orders: 1. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee shall comply with the requirements specified by Wis. Admin. Code § DHS 83.35(3)(d). That is, the CBRF shall develop a comprehensive individual service plan, and update when there is a change in needs, abilities or condition, and at least annually based on an assessment. The licensee will develop (or review/revise) written procedures and staff training (as appropriate) to address: - An up to date, written, comprehensive assessment of all current residents, in all areas required by Wis. Admin. Code § DHS 83.35(1)(c). The assessments shall address potential safety risks associated with resident health conditions (e.g. skin injuries, choking, aggression, elopement, falls or other safety risks.), special diets, assistive devices and behaviors, and include the least restrictive measures necessary to meet the resident's needs. -The timely development, completion, and revision of Individualized Service Plan (ISP) with specific individualized interventions. -The ISP review process shall include input from	N 196		

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N 196	Continued From page 6 the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or legal representative shall sign the ISP acknowledging their involvement in, understanding of, and agreement with the ISP. - All staff responsible for providing services to residents will review the resident ' s individualized service plan and will provide services in accordance with the plan. A copy of the procedures required by Order # 1 will be maintained at the facility and made available to department representatives upon request. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. SOD # I87Y11 On 10/03/2022, Surveyors conducted a verification visit for SOD # I87Y11 and standard survey at Touchstone of Mayville. Seventeen deficiencies were identified (including this deficiency) The following deficiencies were identified: 83.14(2)(a) Licensee Conduct Caregiver Background Checks (2nd Recite) 83.20(2)(a)-(d) Department-Approved Training Courses (Recite) 83.21(1)-(3) All Employee Training (Recite) 83.25 Continuing Education 83.29(2) Admission Agreement Include Services, Changes (Recite) 83.32(2)(b) Post Resident Rights, Grievance Procedure 83.35(3)(c) Implement, Follow The Individual Service Plan	N 196		

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N 196	Continued From page 7 83.35(5)(b) Annual Evaluation of Evacuation Drills (Recite) 83.37(3)(c) Medication Storage: Locked Cabinet 83.38(1)(c) Leisure Time Activities 83.42(1) Resident Record Maintained 83.43(1) Environment Safe, Clean, And Homelike (Recite) 83.45(3) Toxic Substances (2nd Recite) 83.46(1)(f) Combustibles 83.47(2)(d) Fire Drills 83.47(2)(e) Other Evacuation Drills On 02/10/2023, the Department issued a notice and order letter via Electronic statement of deficiency. The order stated the following: ORDER NOT TO ADMIT NEW OR ADDITIONAL RESIDENTS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Touchstone of Mayville NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency I87Y12 are corrected, compliance is verified by the Department, and this Order is rescinded in writing. 1. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee shall comply with the requirements specified by Wis. Admin. Code § DHS 83.14(2)(a) and ensure that the CBRF and its operation comply with this chapter and with all other laws governing the CBRF and its operation. That is, the licensee shall comply with department orders issued with Statement of Deficiency (SOD) I87Y11 on July 21, 2022, and will:	N 196		

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N 196	Continued From page 8 a) Develop (or review/revise) a written procedure to address caregiver misconduct to include recognizing, investigating, documenting, and reporting allegations of abuse, neglect, misappropriation of property, and injuries of unknown origin. The procedure will address requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code chs. DHS 13 and 83. The procedure will incorporate steps to ensure that residents are protected while a determination on the matter of caregiver misconduct is pending during an investigation. Links to reporting regulations and resource materials can be found at: https://www.dhs.wisconsin.gov/caregiver/complaints.htm b) Provide all managers and resident care staff (as appropriate) with inservice training regarding the written procedure on caregiver misconduct. The training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. c) Retroactively, with available information, document a complete investigation report of the alleged incidents of caregiver misconduct described in SOD I87Y11. The investigation will conform to requirements and guidelines specified by Wis. Admin. Code chs. DHS 13 and 83, and The Wisconsin Caregiver Program Manual. d) WITHIN 14 DAYS of receipt of this notice, the provider will submit a copy of the investigation report to the Department's Office of Caregiver Quality for department review. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the	N 196		

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N 196	Continued From page 9 licensee shall provide the legal representative and the case manager (if any) for each current resident with a copy of Statement of Deficiency I87Y12 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request. Additionally, WITHIN 45 DAYS of receipt of this notice, the licensee shall hold a care conference for Resident 6, their legal representative and case manager (if any), for the purpose of reviewing the resident's individual service plan (ISP). The ISP will address individualized services and interventions to meet Resident 6 ' s assessed needs in the areas of mobility, transfers and personal cares, at a minimum. The licensee will obtain a statement of agreement with the plan, dated and signed by all persons involved in developing the plan. All staff responsible for providing services will review Resident 6's ISP and will provide services in accordance with the plan. The No New Admit Order was Lifted on 04/03/2023. Non Compliance with Department Orders On 07/21/2022, The department sent a notice and order letter via electronic mail to Licensee U. The following special orders were sent with SOD # I87Y11 in the notice and order letter from the Department:	N 196		

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N 196	Continued From page 10 SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Touchstone of Mayville: 1. A written procedure to address recognizing, investigating, documenting, and reporting allegations of abuse, neglect, misappropriation of property, and injuries of unknown origin. The procedure will address requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code chs. DHS 13 and 83. The procedure will incorporate steps to ensure that residents are protected while a determination on the matter of caregiver misconduct is pending during an investigation. Links to reporting regulations and resource materials can be found at: https://www.dhs.wisconsin.gov/caregiver/complaints.htm - Retroactively, with available information, document a complete investigation report of the alleged incidents of caregiver misconduct described in Statement of Deficiency (SOD) #I87Y11. The investigation will conform to requirements and guidelines specified by Wis. Admin. Codes ch. DHS 13, ch. DHS 83 and The Wisconsin Caregiver Program Manual. - WITHIN 14 DAYS of receipt of this notice, the provider will submit a copy of the investigation report to the Department's Office of Caregiver Quality for department review. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the provider's written procedures required by Order #1. - Training will be documented in employee files	N 196		

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N 196	Continued From page 11	N 196		

and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.
- A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request.

On 10/03/2022, Surveyors conducted a verification visit for SOD # I87Y11 dated 05/24/2022.

On 10/03/2022 at 10:45 AM, Surveyors requested a copy of any abuse, neglect, or misappropriation investigations, referrals to the Office of Caregiver Quality, a copy of in-service training regarding the providers written policies, and a copy of the procedures for abuse, neglect and misappropriation. Assistant Administrator N stated there was not any investigations of abuse, neglect, or misappropriation that were completed. Assistant Administrator N stated LPN-A was supposed to take care of the investigation then called LPN-A on the phone and verified there was not a report filed with the Office of Caregiver Quality or an investigation conducted. Assistant Administrator N stated there was not documentation of training regarding the provider's written procedures. Assistant Administrator N gave Surveyors a copy of the facility policy for Abuse and Neglect.
Assistant Administrator N stated there were allegations that Caregiver T was leaving residents soiled during the third shift and 1st shift staff had notified management this was occurring but there was not an investigation into the allegations and that Caregiver T had terminated their employment on 09/30/2022.

On 10/03/2022, Surveyors reviewed the facilities

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N 196	Continued From page 12 policy on abuse, neglect and misappropriation. The policy that was given to Surveyors did not address how residents would be protected during an active investigation. On 10/03/2022, Surveyors requested Caregiver T's facility file including disciplinary actions. There were no disciplinary actions regarding leaving residents soiled in Caregiver T's facility file. SOD # I87Y11. On 10/03/2022, Surveyors conducted a verification visit for SOD # I87Y11 and standard survey at Touchstone of Mayville. Seventeen deficiencies were identified (including this deficiency) The following deficiencies were identified: 83.14(2)(a) Licensee Conduct Caregiver Background Checks (2nd Recite) 83.20(2)(a)-(d) Department-Approved Training Courses (Recite) 83.21(1)-(3) All Employee Training (Recite) 83.25 Continuing Education 83.29(2) Admission Agreement Include Services, Changes (Recite) 83.32(2)(b) Post Resident Rights, Grievance Procedure 83.35(3)(c) Implement, Follow The Individual Service Plan 83.35(5)(b) Annual Evaluation of Evacuation Drills (Recite) 83.37(3)(c) Medication Storage: Locked Cabinet 83.38(1)(c) Leisure Time Activities 83.42(1) Resident Record Maintained 83.43(1) Environment Safe, Clean, And Homelike (Recite)	N 196		

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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 83.45(3) Toxic Substances (2nd Recite) 83.46(1)(f) Combustibles 83.47(2)(d) Fire Drills 83.47(2)(e) Other Evacuation Drills Example of noncompliance. On 10/04/2022, Surveyors reviewed Department records for Touchstone of Mayville. Records were reviewed to determine if any violations were repeat violations. The following was reviewed: The provider had two other surveys dated 05/24/2022 and 04/13/2022. The Surveys had a total of 3 complaints of which were substantiated, and 23 deficiencies were issued total from two surveys. Both surveys were issued a Notice and Order letter from the Department to include an order to comply and special orders. SOD # I87Y11 dated 05/24/2022- The Department conducted two complaint investigations; complaints were substantiated. The following 20 deficiencies were identified: 1.) 83.12(2)(a) Caregiver: Investigating Abuse & Neglect 2.) 83.12(4)(b) Reporting When Law Enforcement Is Called 3.) 83.17(1) Licensee Conduct Caregiver Background Check 4.) 83.17(2)(a) Employees Screened For Communicable Disease 5.) 83.18(1) Employee Records Maintained and Current 6.) 83.19 Orientation 7.) 83.20(2)(a)-(d) Department-Approved Training Courses 8.) 83.12(1)-(3) All Employee Training 9.) 83.28(4)(a) Resident Health Screening and	N 196		

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N 196	Continued From page 14 Documentation 10.) 83.29(2) Admission Agreement Include Services, Changes 11.) 83.32(2)(a) Explanation Of Rights, Grievance Procedure 12.) 83.32(2)(b) Post Resident Rights, Grievance Procedure 13.) 83.32(3)(d) Rights of Residents: Free From Mistreatment 14.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 15.) 83.35(5)(b) Annual Evaluation Of Evacuation Limits 16.) 83.37(2)(e) Other Administration Given Or Delegated By RN 17.) 83.43(1) Environment Safe, Clean, And Comfortable 18.) 83.45(3) Toxic Substances 19.) 50.065(2)(bb) Determine Final Disposition Of Charge 20.) 50.09(1)(f)3 Privacy Health Care SOD # VGK911 SOD # VGK911 dated 04/13/2021- The Department conducted a complaint investigation and standard survey, complaint was substantiated. The following 3 deficiencies were identified: 1.) 83.12(2)(a) Caregiver: Investigating Abuse & Neglect 2.) 83.39(1) Infection Control Program 3.) 83.45(3) Toxic Substances Summary The provider has not held compliance with numerous orders given by the Department. From 04/13/2021 thru 08/02/2023, Touchstone of	N 196		

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N 196	Continued From page 15 Mayville has had 86 deficiencies issued. Of the 86 deficiencies there were multiple 2nd, 3rd, and 4th recites. The provider has had 4 substantiated complaints. The provider has had a No New Admit Order which was lifted on 04/03/2023.	N 196		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview the provider did not complete a caregiver background check which included the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS) for 1 out of 3 employees reviewed.	N 219		

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N 219	Continued From page 16 This is a repeat deficiency from SOD # I87Y11 dated 05/24/2022, and SOD # I87Y12 dated 10/04/2022. Findings include: The complete background check is to include the background information disclosure form (BID), the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS). On 08/02/2023, Surveyor reviewed Caregiver BB's facility record. Caregiver BB was hired 05/31/2023. Caregiver BB did not have record of a DOJ background check or IBIS background check in their employee record. On 08/02/2023 at approximately 11:43 AM, Surveyor interviewed Assistant Administrator N. Assistant Administrator N stated that Licensee U has the information to run the background check and confirmed they did not have a background check completed for Caregiver BB.	N 219		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90	{N 220}		

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{N 220}	Continued From page 17 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis within 90 days before the start of employment for 3 out of 5 staff files reviewed. This is a recite from Statement of Deficiency (SOD) # I87Y11 dated 05/24/2022 and SOD #I87Y13 dated 03/29/2023. Findings include: On 08/02/2023, Surveyor asked Assistant Administrator N to provide the records for clinically apparent communicable disease screens for employees of the facility. Surveyor reviewed the following: Caregiver P's date of hire was 12/19/2022. A review of the file noted no screening for clinically apparent communicable disease including tuberculosis. The file contained no tuberculosis screen or test. Caregiver AA's date of hire was 07/18/2023. A review of the file noted no screening for clinically apparent communicable disease including tuberculosis.	{N 220}		

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{N 220}	Continued From page 18 Caregiver BB's date of hire was 05/31/2023. A review of the file noted to screening for clinically apparent communicable disease including tuberculosis. On 08/02/2023, at 1:47 PM, Surveyors interviewed Assistant Administrator N regarding the screening for clinically apparent disease and tuberculosis. Assistant Administrator N stated s/he was aware of the requirement but has been very involved with other responsibilities at the facility and other locations.	{N 220}		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview the provider did not maintain documentation of training for Caregiver D. Findings include: On 10/04/2022, SOD # I87Y12, the facility was issued a violation for Department approved	N 223		

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N 223	Continued From page 19 training for Caregiver D. On 03/29/2023, SOD I87Y13, The Department approved training for Caregiver D was corrected. On 08/02/2023, Surveyor reviewed Caregiver D's facility file. Caregiver D did not have documentation of training in standard precautions, client group related training, medications, resident rights, prevention and reporting of abuse, neglect, and misappropriation, or fire safety and emergency procedures in 2022. On 08/02/2023 at 11:43 AM, Surveyor shared findings with Assistant Administrator N. Assistant Administrator N stated s/he could not find record of training in 2022 for Caregiver D.	N 223		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including,	N 383		

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N 383	Continued From page 20 choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on record review, observation, and interview the provider did not assess Resident 6 for adaptive equipment being used. Findings include: On 08/02/2023 at approximately 9:14 AM, Surveyor toured the facility. Surveyor observed an adaptive hand splint to help with contraction in Resident 6's room. On 08/02/2023, Surveyors observed Resident 6. Resident 6 has clear mobility limitations. Resident 6 is not able to ambulate, position easily, and has movement restrictions. On 08/02/2023, Surveyor reviewed Resident 6's facility file. Surveyor could not find physicians orders or an assessment for adaptive hand splints. Surveyor reviewed Resident 6's individual service plan that did not mention the use of adaptive hand splints. On 08/02/2023 at approximately 11:27 AM, Surveyor interviewed Assistant Administrator N.	N 383		

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N 383	Continued From page 21 Assistant Administrator N stated s/he was not sure if the adaptive hand splints were to be used or not. Assistant Administrator N stated s/he could not find an order for them and could not find a discontinue order for the adaptative hand splints. Assistant Administrator N stated there is not an order for the adaptive hand splints were not assessed. Assistant Administrator N confirmed Resident 6 has limited mobility concerns.	N 383		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on observation, record review and staff interview, the provider did not prepare and implement a written temporary service plan to meet the immediate needs of Resident 10. Findings include: On 08/02/2023, Surveyor reviewed the record of Resident 10. Resident 10 was admitted to the provider on 07/19/2023 with a diagnoses including hemiplegia left side; hypertension; history of alcohol use and cerebral infarction. The record did not contain a temporary service plan which addressed any immediate needs for Resident 10. The record contained documentation from the	N 385		

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N 385	Continued From page 22	N 385		

previous facility which noted Resident 10 was incontinent; Resident 10 needed assistance in repositioning in bed; limited toilet use; dysphagia; risk for injury due to smoking and a fall risk.

A document completed by Assistant Administrator N, dated 07/19/2023 noted Resident 10 used a wheelchair and walker. Had a history of falls and left sided arm pain and left hip pain.

Resident 10 was observed by Surveyor at 9:15 AM and 12:55 PM. Resident 10 had uncombed hair and an accumulation of facial hair. On 08/02/2023, at 12:55 PM, Resident 10 stated to Surveyor that s/he tries to be as independent as possible but is not able to shave at this time as s/he needed an electric shaver. Resident 10 pointed to a walker in the room and stated it was not his/hers but that s/he wanted to use the walker but only if they removed the wheels and placed rubber tips on the walker as s/he is very much afraid of falling. Resident 10 pointed to the wheelchair and stated the chair gets uncomfortable if s/he sits in it too long. Resident 10 stated s/he likes to go outside to smoke and has difficultly opening the door to the outside.

On 08/02/2023, Surveyor interviewed Assistant Administrator N regarding the temporary service plan for Resident 10. Surveyor asked if the facility had developed a temporary service plan which addressed Resident 10's needs. Assistant Administrator N stated s/he has not yet done so and has talked with Resident 10 to obtain some information but is still waiting on information from LPN-A who completed the pre-admission assessment. Surveyor asked if Assistant Administrator N had requested the information from LPN-A. Assistant Administrator N stated yes but is waiting for this information.

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{N 388}	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review and staff interview, the provider did not implement the individual service plan for 2 out of 4 residents reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) #I87Y12, dated 10/04/2022 and SOD #I87Y13, dated 03/29/2023. Findings include: Example 1 - Resident 9 On 08/02/2023, Surveyor observed Resident 9 in bed at 9:39 AM. At approximately 10:15 AM, Caregiver BB entered Resident 9's room and closed the door to the room. Shortly afterwards, Surveyor observed Resident 9 seated in the wheelchair in the dining room. Resident 9 was served a breakfast burrito. Surveyor reviewed Resident 9's record. Resident 9 was admitted to the facility on 10/04/2022 with a diagnoses including quadriplegia due to spinal cord injury. On 08/02/2023, at 11:16 AM, Surveyor observed Resident 9 dressed and in the dining room. Surveyor asked Caregiver BB to describe how Resident 9 was transferred from the bed to chair. Caregiver BB stated when Resident 9 is positioned sitting on the edge of the bed, Caregiver BB will stand in front of the resident,	{N 388}		

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{N 388}	Continued From page 24	{N 388}		

position residents feet toward caregivers feet, and bear hug to a standing position, bracing the residents feet so they do not slide. They then pivot to the wheelchair. Caregiver BB stated this transfer is done with Caregiver BB independently and no other caregivers assist. Caregiver BB then explained how Resident 9 is assisted to the bathroom with Caregiver BB transferring Resident 9 to the toileting and Resident 9 holding onto the grab bar in the bathroom.

A review of the individual service plan dated 10/30/2022 with an update on 02/21/2023 noted the following:
Toileting: "One assist with toileting with EZ stand."
Ambulation: "Needs one assist with EZ stand for all transfers."

On 08/03/2023, at 8:00 AM, Surveyor interviewed Assistant Administrator N regarding Resident 9's individual service and Caregiver BB's description of transfers. Assistant Administrator N stated staff are to use the EZ lift if only one caregiver is assisting. No caregiver should transfer Resident 9 alone. Resident 9 can be transferred without the lift but only if 2 caregivers are present. Assistant Administrator N stated staff should be following the ISP and use the lift if transferring independently. Surveyor explained that the individual service plan was not implemented and is not clear on how 2 staff can transfer Resident 9.

Example 2 - Resident 6.

On 08/02/2023 at approximately 9:14 AM, Surveyor observed Resident 6 sitting by the television in the living room.

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{N 388}	Continued From page 25 On 08/02/2023, Surveyor reviewed Resident 6's facility record. Resident 6's individual service plan dated 11/18/2022, states Resident 6 is on a 2 hour toileting schedule. On 08/02/2023 at approximately 11:41 AM, Surveyor noted Resident 6 had not been taken out of the living room and had not been toileted in over two hours. On 08/02/2023 at approximately 11:43 AM, Surveyor shared findings with Assistant Administrator N. Assistant Administrator N stated s/he was not aware Resident 6 had not been toileted per individual service plan.	{N 388}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of 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 review the individual service plan for 2 out of 4 residents reviewed.	{N 389}		

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{N 389}	Continued From page 26 Resident 4's individual service plan annually. The provider did not update Resident 9's individual service plan with a change of services. This is a repeat deficiency. See Statement of Deficiency (SOD) # I87Y11, dated 04/07/2022, SOD # I87Y12 dated 10/04/2022. and SOD #I87Y13, dated 03/29/2023. Findings include: On 08/02/2023, Surveyor reviewed Resident 4 and Resident 9's records and noted the following: Example 1 - Resident 4 Resident 4 was admitted to the facility on 08/01/2016. Resident 4's individual service plan was dated 03/31/2022. On 08/02/2023 at approximately 11:43 AM, Surveyor asked Assistant Administrator N if there was an updated individual service plan for Resident 4. Assistant Administrator N stated the most recent individual service plan would be located in the binder that Surveyor was reviewing. Example 2 - Resident 9 On 08/02/2023, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the facility on 10/04/2022 with a diagnoses including quadriplegia due to spinal cord injury. On 08/02/2023, at 11:16 AM, Surveyor observed Resident 9 dressed and in the dining room visiting with Family Member CC. Family Member CC stated therapy just stopped working with Resident 9 but that Resident 9 still needed some	{N 389}		

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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 389}	Continued From page 27 adjusting on the right leg brace and right hand brace. Family Member CC stated s/he did not know if therapy had any further instructions or notes on how staff should follow up with Resident 9 but that they had old notes and exercises s/he does with Resident 9 about 2 times per week. A review of Resident 9's individual service plan dated 10/30/2022 with an update on 02/21/2023 noted no therapy services identified. No exercise program nor documentation of involvement in services or recommendations for services. On 08/02/2023, at 1:57 PM, Surveyor interviewed Assistant Administrator N regarding Resident 9's needs and recommendations from therapy for working with Resident 9. Surveyor asked if therapy involvement was documented on the individual service plan and if they had progress notes or recommendations from therapy. Assistant Administrator N stated therapy just discontinued services last week and s/he did not know. Assistant Administrator N stated the therapist does not leave notes or recommendations for staff or Resident 9.	{N 389}		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and interview the	N 392		

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N 392	Continued From page 28 provider did not provide each resident and the resident's legal representative the opportunity to complete an evaluation of the resident's level of satisfaction with the CBRF's services for 2 out of 2 residents reviewed. Resident 4 and Resident 6 or their legal representatives the opportunity to complete an annual evaluation of the resident's level of satisfaction with the facility's services. Findings include: On 08/02/2023, Surveyor reviewed Resident 4's and Resident 6's facility file. Resident 4 was admitted to the facility on 08/01/2016. Resident 4 did not have a resident satisfaction survey for 2022. Resident 6 was admitted to the facility on 11/18/2020. Resident 6 did not have a resident satisfaction survey for 2022. On 08/02/2023 at approximately 10:43 AM, Surveyor shared findings with Assistant Administrator N who confirmed the most recent satisfaction surveys should have been in the resident's facility file. Assistant Administrator N stated the residents do not have a more recent satisfaction survey.	N 392		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm.	N 394		

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N 394	Continued From page 29 This Rule is not met as evidenced by: Based on record review and interview the provider did not evaluate Resident 6 for their mental or physical capability to respond to a fire alarm at least annually. This is a repeat deficiency. See Statement of Deficiency (SOD) # I87Y11 dated 05/24/2022, and SOD # I87Y12 dated 10/04/2022. Findings include: On 08/02/2023, Surveyor reviewed Resident 6's facility file. Resident 6 was admitted to the facility on 11/18/2020. Resident 6 had an evacuation assessment dated 12/05/2020. On 08/02/2023 at approximately 11:43 AM, Surveyor shared findings with Assistant Administrator N who confirmed that the evacuation assessments that were in the resident's file were the most recent evacuation assessments the facility had completed.	N 394		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the	N 415		

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N 415	Continued From page 30 resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and staff interview the provider did not ensure when staff administered residents medication, the person administering the medication documented administration in the residents record the name, dosage, date and time of medication taken and initialed the medication administration record for 3 out of 5 residents reviewed. Findings include: On 08/02/2023, Surveyor reviewed the record of Resident 9. Resident 9 had the following physician orders: Carbamazepine 100 MG- one tablet four times per day. A review of the medication administration for the month of July 2023 noted staff did not document the administration of the medication on 7/29/2023 at 8 AM and 12:00 PM. Carbamazepine 200 MG- one tablet four times per day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM and 12:00 PM. Famotidine 20 MG one tablet twice a day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.	N 415		

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N 415	Continued From page 31	N 415		

Fluoxetine 60 MG one tablet a day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Metoclopramide 5 MG one tablet by mouth twice a day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Omeprazole 40 MG one daily. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Polyethylene Glycol- Dissolve 17 Grams in 8 ounces of liquid and drink. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Senna-Time 8.6 MG- two tablets twice day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/28/2023 at 8:00 PM and 07/29/2023 at 8:00 AM.

Therems-M one tablet per day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Vitamin D-3 one capsule by mouth daily. A

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N 415	Continued From page 32	N 415		

review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Example 2- Resident 10

On 08/02/2023, Surveyor reviewed the record of Resident 10. Resident 10 was admitted to the provider on 07/19/2023. Resident 10 had the following physician orders:

Acetaminophen 500 MG two tablets twice per day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Aspirin Low 81 MG one tablet day. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Duloxetine 20 MG one capsule by mouth daily. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Folic Acid 1000 MCG tab take one tablet by mouth daily. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM.

Lisinopril 20 MG one tablet daily. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at

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N 415	Continued From page 33 8:00 AM. Tamsulosin 0.4 MG take 1/2 tablet by mouth every morning after breakfast. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM. Vitamin B-1 100 MG one tablet by mouth daily. A review of the medication administration record for the month of July 2023 noted staff did not document the administration of the medication on 07/29/2023 at 8:00 AM. Example 3 Resident 6 On 08/02/2023, Surveyor reviewed Resident 6's facility file. The following was reviewed. July 2023 Medication administration record indicated there were 5 doses of medication that were not documented as administered. June 2023 medication administration record indicates there were 15 doses of medication that were not documented as administered. On 08/02/2023, Surveyors interviewed Assistant Administrator N regarding the medication administration records. Assistant Administrator N stated staff should have documented at the time of administration the medications, time and initial each dose. If a medication was refuse, that would have been documented. If the resident was out of the building, it should have been documented. Assistant Administrator N stated s/he had spoken to staff many times about this and it continues to be a problem.	N 415		

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{N 419}	Continued From page 34	{N 419}		
{N 419}	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not keep all medicine cabinets locked and the key available only to personnel identified by the CBRF when the door to the medication storage area was left unlocked and unattended in several observable instances during the survey process. As a result, medications were not secured. This is a repeat deficiency. See Statement of Deficiency (SOD) #I87Y12, dated 10/04/2022 and SOD #I87Y13 dated 03/29/2023. Finding include: The provider is licensed to serve clients with traumatic brain injury, developmentally disabled, physically disabled, advanced aged and irreversible dementia/Alzheimer's. The home is a Class CNA (non-ambulatory) facility with a capacity to serve 8 adults. On 08/02/2023, at 9:15 AM, Surveyors entered the facility to conduct a verification visit. Surveyors observed 2 residents seated in the dining room. The medication room was directly around the corner from the kitchen and dining room. The door to the medication room was open and not secure. The medication cart was observed inside the medication room. The medication cart was not locked. Surveyor opened the drawers on the medication cart. The	{N 419}		

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{N 419}	Continued From page 35	{N 419}		

cart contained a 30 day supply of medications for the month of August 2023. The cart contained the medications for 7 residents of the home. Surveyor observed the refrigerator in the room. The door of the refrigerator was not secured. Stored inside the refrigerator was insulin labeled for Resident 2. Caregiver BB was observed in the kitchen then entered the living room at 9:15 AM. The door to the medication room remained open with the medications left unsecured.

Stored in the medication cart were the daily medications for 7 residents of the facility including the following:

Resident 10 had physician orders dated 07/19/2023 for the following: Acetaminophen 500 MG; Aspirin Low 81 MG; Atorvastatin 40 MG; Divalproex 125 MG; Duloxetine 20 MG; Folic Acid 1000 MCG; Lisinopril 20 MG; Melatonin 3 MG; Mirtazapine 7.5 MG; Omeprazole 20 MG; Senexon-S 8.6-50 MG; Tamsulosin 0.4 MG; Trazodone 50 MG and Vitamin B-1 100 MG.

Resident 9 had physician orders for Carbamazepine 100 MG; Famotidine 20 MG; Fluoxetine 60 MG; Gabapentin 600 MG; Metoclopramide 5 MG; Olanzapine 15 MG; Omeprazole 40 MG; Polyethylene Glycol; Senna-Time 8.6 MG; Therems-M and Vitamin D3.

On 08/02/2023, at 1:47 PM, Surveyors interviewed Assistant Administrator N regarding the medication room not being secured and the medication cart that was not secured. Assistant Administrator N stated that staff know the door should be closed and locked at all times.

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N 427	Continued From page 36	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. 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: 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 interviews the CBRF did not provide or arrange for a daily activity program to meet the interests of the residents. The provider did not develop and post the activity schedule in an area available to residents. This a repeat deficiency. See Statement of Deficiency (SOD) #I87Y12, dated 10/04/2022. Findings include: On 08/02/2023, at 9:15 AM, Surveyors entered the facility to conduct a verification visit to SOD #I87Y13, dated 03/29/2023. Surveyors observed 2 residents seated in the dining room finishing breakfast. At approximately 10 AM, Resident 6 was brought into the family room and placed by the television. Surveyor did not hear staff ask Resident 6 what Resident 6 wanted to watch on television. Resident 6 was positioned by the	N 427		

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portable crib in which a baby was observed laying in. The baby was watching/listening to a children's program while Resident 6 watched television.

Resident 6 remained in front of the television until approximately 12:04 PM when staff assisted Resident 6 to the dining room.

Resident 9 was observed in the dining room from approximately 10:30 AM to 1:57 PM.

Resident 10 would propel his/her wheelchair between Resident 10's room, the dining room and outside for smoking.

At approximately 12:04 PM, the noon meal was served to the residents. Several other residents came out of their rooms or from outside after smoking, for lunch. After lunch, Resident 2 was observed in the front craft area working on crafts independently.

At 12:55 PM, Surveyor interviewed Resident 10 regarding activities. Resident 10 stated that at his/her previous facility, they had many activities to do and keep you busy. Resident 10 stated there is not much to do at this place. Resident 10 stated s/he did not want to complain but would like more to do such as cards.

At 1:29 PM, Surveyor interviewed Resident 4. Resident 4 stated they were going to a Brewer Game in a few weeks and Resident 4 enjoys doing crafts in his/her room. Resident 4 stated there is not much to do but s/he keeps self-busy. Resident 4 stated the parent of a resident does organize bingo and exercise group but staff really do not organize activities. Resident 4 s/he keeps self-busy and goes out with family members at

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N 427	Continued From page 38 times. From 9:15 AM to 1:57 PM Surveyors did not observe any activities. Surveyors did not observe any activity calendar. At 1:57 PM, Surveyors interviewed Assistant Administrator N regarding activities. Assistant Administrator N stated the calendar was not posted as s/he is working on it. Surveyors expressed on the concern that no activities were observed on the day of survey. Assistant Administrator N did not respond.	N 427		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of	N 454		

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N 454	Continued From page 39 sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.	N 454		

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This Rule is not met as evidenced by:
Based on record review and staff interview, the provider did not maintain a resident record for 2 out of 4 residents reviewed.

The provider did not maintain the pre-admission assessment for Resident 10. The provider did not maintain documentation of rehabilitation services for Resident 9.

This a repeat deficiency. See Statement of Deficiency (SOD) #I87Y12 dated 10/04/2022.

Findings include:

Example 1- Resident 10

Surveyor reviewed Resident 10's record on 08/02/2023. Resident 10 was admitted to the provider on 07/19/2023 with a diagnosis including cerebral infarction, hemiplegia left side, hypertension and history of alcohol use. Resident 10 had a history of smoking.

Review of the record noted no pre-admission assessment or assessment identifying Resident 10's needs.

On 08/02/2023, at 1:57 PM, Surveyor interviewed Assistant Administrator N regarding the record for Resident 10. Assistant Administrator N stated s/he did not complete the assessment and did not know all Resident 10's needs on admission. Assistant Administrator N stated LPN-A had the information but it was not a part of the record at the facility. Assistant Administrator N stated s/he is aware of the requirement to maintain the record with the information and had requested it

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	0013818	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

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TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 454	Continued From page 41 from LPN-A but as of 08/02/2023 has not received anything. Example 2- Resident 9 Surveyor reviewed Resident 9's record on 08/02/2023. Resident 9 was admitted to the provider on 10/04/2022 with a diagnoses including quadriplegia due to spinal cord injury. Resident 9 had physician orders for physical therapy. The record did not any documented visits of the rehabilitation services Resident 9 received. On 08/02/2023, at 1:57 PM, Surveyor interviewed Assistant Administrator N regarding the record of Resident 9. Assistant Administrator N stated s/he had requested documentation of progress from the physical therapist back in 3/2023 but has not received any additional documents and just learned they are discontinuing services for Resident 9. Surveyor asked about therapy recommendations. Assistant Administrator N stated s/he did not know as they have not received any information from the physical therapist. Assistant Administrator N stated s/he is aware of the requirement to obtain the documentation but has not been able to as of 08/02/2023.	N 454		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the	{N 481}		

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{N 481}	Continued From page 42 intended use of the room. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure a living environment that was safe, clean, and homelike. This a repeat deficiency. See Statement of Deficiency (SOD) # I87Y11 dated 05/24/2023, and SOD # I87Y12 dated 10/04/2022, and SOD # I87Y13 dated 03/29/2023. Findings include: On 08/02/2023 at approximately 9:14 AM, Surveyor toured the facility and observed the following: 1.) Large dark stains on the living room carpeting. 2.) In bathroom 1 there was toothpaste all over the wall and sink. 3.) Bathroom 2 had a toilet riser that had brown specs all over the seat. 4.) Bathroom 3 had a sign that stated out of order. 5.) The vents in the bathrooms and hallways were covered in dust. 6.) The ceiling fan in the living room was covered in a layer of dust. 7.) The kitchen counter was coming a part in multiple places.	{N 481}		

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{N 481}	Continued From page 43 8.) The living room, craft area, and hallways had paper and dirt debris scattered around the floor. 9.) The door frame on the rear fire exit was rotting away exposing two nails that were sticking out approximately 1 inch. 10.) Multiple window frames had dead bug carcasses laying in them. 11.) The fire alarm in the rear hallway was pulling out of the wall and was very loose. 12.) The lighted exit sign marking the rear fire exit was not working and was not lighting up. 13.) The stove in the kitchen appeared dirty. Surveyor opened the stove and found a layer of burnt food on the bottom of the stove. Surveyor then opened the microwave and found food particles all over the inside of the microwave. On 08/02/2023 at approximately 1:07 PM, Surveyor shared findings with Assistant Administrator N. Assistant Administrator N stated s/he was not aware of the fire alarm being pulled out of the wall. Assistant Administrator N also stated the licensee did not share the previous statement of deficiency with him/her and s/he was not aware of the corrections that needed to be made at the facility until the day of the survey. The bathroom has been out of order since at least 03/29/2023. Administrator N stated there was an issue with the plumbing and it hasn't been fixed yet.	{N 481}		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any	N 488		

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N 488	Continued From page 44 clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure the dryer venting was made of rigid material. Findings include: On 08/02/2023 at approximately 9:14 AM, Surveyor toured the facility. Surveyor observed a new dryer in the laundry room that did not have rigid venting. On 08/02/2023 at approximately 12:43 PM, Surveyor interviewed Assistant Administrator N. Assistance Administrator N stated the dryer was new a couple of months ago and when it was installed, the company who installed it must have replaced the original venting. Assistant Administrator N stated s/he would make sure its fixed.	N 488		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview the provider	N 499		

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N 499	Continued From page 45 did not ensure that cleaning compounds and insecticides were stored in a secure area. This a repeat deficiency. See Statement of Deficiency (SOD) # VGK911 dated 04/13/2021, SOD # I87Y11 dated 05/24/2023, and SOD # I87Y12 dated 10/04/2022. Findings include: Touchstone of Mayville is an 8-bed non-ambulatory community based residential facility that can accept residents in the following client groups; advanced aged, developmentally disabled, irreversible dementia/Alzheimer's, physically disabled, and traumatic brain injury. On 08/02/2023 at 9:14 AM, Surveyor toured the facility and observed the following: The laundry room door was propped open. Inside the laundry room there was 7 gallons of bleach, 6 gallons of Windex, 17 bottles of toilet bowl cleaner, 13 cans of pledge cleaner, 1 bottle of resolve, 1 bottle of 409 cleaner, 2 cans of wasp spray, 10 cans of Lysol spray, and 3 gallon jugs of 409 cleaner in the cupboard. In the kitchen under the counter in an unsecured cupboard there was 3 bottles of Clorox cleaner, 1 gallon of bleach, 2 cans of Lysol spray. On 08/02/2023 at approximately 12:43 PM, Surveyor interviewed Assistant Administrator N. Assistant Administrator N stated the laundry room door should have been closed and locked.	N 499		
{N 637}	83.59(1)(g) Proper exit locations, sidewalks, driveways.	{N 637}		

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{N 637}	Continued From page 46 All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure at least 2 exits provided unobstructed travel to the outside. Touchstone of Mayville is an 8 bed, Class CNA non-ambulatory community based residential facility that can accept clients that are physically disabled. This a repeat deficiency. See Statement of Deficiency (SOD) # I87Y13 dated 03/29/2023. Findings include:	{N 637}		

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{N 637}	Continued From page 47 On 08/02/2023, Surveyors toured the facility and observed the front exit of the facility had a steep short incline with a bump on the end of the concrete. Surveyors also noted the rear exit of the facility had a walk way that had weeds growing up through it and cracks in the walkway. On 08/02/2023 at approximately 1:15 PM, Surveyors interviewed Resident 10. Resident 10 stated s/he had a very hard time getting in and out of the facility because of the bump at the end of the porch and the grade of the bump. It is hard to get his/her wheelchair in and out of the facility by him/herself. Resident 10 stated it was also hard to get the wheelchair over the bump to get back onto the porch of the facility. On 08/03/2023 at approximately 10:00 AM, Surveyor shared findings with Assistant Administrator N. Assistant Administrator N stated s/he would look into this concern.	{N 637}		