STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014758	A. BUILDING: _____ B. WING _____	R-C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERY MEMORY CARE	**215 BIRCH STREET WEST AMERY, WI 54001**

(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 06/08/2022, the Department conducted a self-report investigation, complaint investigation, verification visit, and standard survey at Amery Memory Care. Data was collected through 06/15/2022. One of 2 complaints was substantiated. Five violations were identified. Three of 5 violations were repeat deficiencies. See Statement of Deficiencies (SOD) T19F11, dated 10/29/2020; ZFFP11, dated 03/13/2019; and BGEG12, dated 08/24/2018. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 48	{N 000}		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on interview and record review, the	N 230		

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

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provider did not ensure staffing agency staff completed orientation training prior to working on the floor.

This is repeat violation. See Statement of Deficiencies (SOD) T19F11, dated 10/29/2020.

Findings include:

The provider is licensed to care for 77 residents within the client groups advanced aged and irreversible dementia/Alzheimer's disease.

On 06/08/2022 at 5:20 PM, Surveyor interviewed Life Enrichment Coordinator (LEC) B. LEC B stated Caregiver C, Caregiver D, and Resident Care Coordinator (RCC) 3 E were the scheduled staff. LEC B said RCC3 E was a permanent facility staff and the only medication passer on this night; Caregiver C and Caregiver D were agency staff.

At approximately 6:00 PM, Surveyor interviewed Caregiver C. Caregiver C stated s/he was a certified nurse aide (CNA). Caregiver C stated s/he was contracted approximately 3 weeks ago to work at the facility 4 days a week from 10:00 AM to 10:00 PM. Caregiver C stated s/he did not receive training and was "thrown right on the floor." Caregiver C said one of the caregivers wrote him/her a cheat sheet so Caregiver C knew what to do.

At 6:08 PM, Surveyor interviewed Caregiver D. Caregiver D stated s/he was a CNA. Caregiver D stated s/he had worked at the facility approximately 5 times in the past 3 years. Caregiver D stated s/he last worked at the facility 1 month prior. Caregiver D stated s/he did not receive training prior to working the floor.

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N 230	Continued From page 2 Caregiver D said s/he did not know the provider's emergency policies, door codes, or resident names. Caregiver D said s/he had access to the provider's electronic charting program, but s/he did not know how to use it or where to access things like care plans. Caregiver D stated s/he worked off a cheat sheet to know what to do. Surveyor reviewed employee training records. Records for Caregiver C and Caregiver D did not include evidence of training on abuse and neglect, the provider's residents' needs, the provider's emergency plans and general policies, or recognizing and responding to changes in condition. At 9:26 PM, Surveyor interviewed Administrator A. Administrator A stated the provider did not provide education or training to agency staff. Administrator A stated the staff that worked alongside the agency staff show them around on their first day, but there was no documentation of this. Administrator A stated there was no system, such as a checklist, for experienced caregivers to work off when showing the new agency staff around.	N 230		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure staff were provided in numbers to meet resident needs. The provider did not provide at least 2 staff at all times	N 396		

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when residents required 2-assist and the provider did not ensure a sufficient number of staff to meet resident medication, supervision, or fall-prevention needs.

This is repeat violation. See Statement of Deficiencies (SOD) T19F11, dated 10/29/2020 and ZFFP11, dated 03/13/2019.

Findings include:

The provider is licensed to care for 77 residents within the client groups advanced aged and irreversible dementia/Alzheimer's disease. The facility is divided into 4 areas: A, B, C, and D quads. Each quad has a dining room, living room with exits to the outside, and 15 resident units.

On 05/26/2022, the Department received a self-report from the provider indicating Resident 2 eloped on 05/21/2022. The report stated staff received a phone call at approximately 5:25 PM from the sheriff's department asking if Resident 2 lived at the facility. Police reported they found Resident 2 walking in the park across the street from the facility.

On 06/08/2022 at 5:18 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 eloped this evening and police recently returned him/her to the facility.

At 5:20 PM, Surveyor interviewed Life Enrichment Coordinator (LEC) B. LEC B stated there were 3 caregivers working the floor that night (1 medication passer and 2 caregivers) and 3 life enrichment (LE) staff assisting with feeding. LEC B stated LE staff did not assist with cares or medications. LEC B stated 2 of the 3 caregivers were not permanent employees at the facility;

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N 396	Continued From page 4 they were agency staff. At 5:52 p.m., Caregiver D told RCC3 E that Resident 11 did not receive a supper tray. RCC3 E called on a walkie talkie for someone to bring Resident 11 something to eat. Surveyor observed Resident 11 eating a fruit cup at the dining room table. Surveyor asked RCC3 E if Resident 11 did not receive a meal tray and who's fruit s/he was eating. RCC3 E said s/he had no idea and did take the fruit cup away from Resident 11. At 6:05 p.m., staff gave Resident 11 a supper tray with a cold sandwich and chips on it. At 6:00 PM, Surveyor interviewed Caregiver C. Caregiver C stated the provider generally scheduled 3 staff (1 medication passer and 2 caregivers) on 1st and 2nd shift and 2 staff (1 medication passer and 1 caregiver) for 3rd shift. Caregiver C stated there were times when s/he worked with only 2 staff on 2nd shift. Caregiver C stated there were multiple residents that required assistance from 2 staff for transfers or behaviors. Caregiver C stated falls and elopements were very common. Caregiver C estimated the facility had 4 to 8 falls and 1 to 2 elopements per week. Caregiver C stated 2 or 3 staff could only do so much. At 6:08 PM, Surveyor interviewed Caregiver D. Caregiver D stated the facility did not have enough staff. Caregiver D stated it had been a good night for behaviors and incidents, but there were still 2 residents that did not get a plate at dinner and Resident 1 got out of the facility 2 or 3 times that night. Caregiver D stated, "The last time I worked (approximately 1 month ago), someone called the facility and said there was a resident sitting in [his/her] car. It's crazy here." Caregiver D stated there were not enough staff to	N 396		

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meet resident needs. Caregiver D stated each quad needed at least 1 designated caregiver.

At 8:17 p.m., Surveyor observed a closet door with a numbered lock on it was open a couple inches. Surveyor opened the door and found Resident 12 sleeping on the floor of the storage closet. Surveyor waved over Caregiver C. Caregiver C called a "code yellow" over the walkie talkie. RCC3 E and Caregiver C assisted Resident 12 off the floor. Caregiver C said Resident 12 put him/herself on the floor a lot. Surveyor inquired about the last time staff had their eyes on Resident 12. RCC3 E said s/he last seen Resident 12 at supper. Caregiver C said s/he last saw Resident 12 approximately 1-hour prior.

At 9:05 PM, Caregiver D called "code yellow" over the walkie and asked for assistance in Resident 3's room. At approximately 9:10 PM, Surveyor observed Resident 3 on the floor in his/her room. Caregiver D stated Resident 3 had an unwitnessed fall and Caregiver D was waiting for a second staff to assist Resident 3 off the floor. Resident 3 was moaning in pain, stating his/her backside hurt.

Surveyor reviewed the staff schedule for dates 05/01/2022 through 06/08/2022. The schedule indicated there were 3 staff scheduled from 6:00 AM to 2:30 PM (1st shift), 3 on from 2:00 PM to 10:30 PM (2nd shift), and 2 on from 10:00 PM to 6:30 AM (3rd shift).

Surveyor reviewed the resident roster provided by Administrator A. The roster indicated there were 48 residents at the facility; 13 were considered elopement risks.

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N 396	Continued From page 6 Surveyor reviewed medication error reports for January through March 2022. The provider had 16 individual medication errors and 1 medication pass that resulted in 14 separate medication errors in this timeframe. On 06/13/2022, Surveyor reviewed the provider's falls and elopements between the dates 04/01/2022 and 06/13/2022. The documentation indicated the facility had 58 falls and 7 elopements. Surveyor identified 2 additional elopements in Resident 1's observation notes that were not on the list and Surveyor observed 2 falls on 06/08/2022 that were not on the list provided, suggesting the number of incidents was greater than what was indicated on the documentation provided by Administrator A on 06/13/2022. On 06/15/2022, Surveyor reviewed Resident 12's (resident observed on the floor of the closet on 06/08/2022) task administration record (TAR). This record read, in part: "Resident needs to be checked on every 30 minutes. Staff need to ensure I am safe and if needing assistance." Resident 12's June TAR from 06/01/2022 - 06/14/2022 did not have staff documentation of 30-minute checks on the following dates and times: 06/05/2022 at 5:30 a.m. 06/08/2022 from 10:00 p.m. - 5:30 a.m. on 06/09/2022 06/10/2022 from 2:00 p.m. - 5:30 p.m. 06/11/2022 from 2:00 p.m. - 5:30 p.m. 06/12/2022 from 6:30 p.m. - 5:30 a.m. on 06/13/2022 06/13/2022 from 2:00 p.m. - 9:30 p.m. 06/14/2022 at 5:30 a.m. 06/14/2022 from 10:00 a.m. - 11:30 p.m.	N 396		

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N 396	Continued From page 7 On 06/15/2022 at 8:25 AM, Surveyor interviewed Resident Care Coordinator (RCC) 3 F. RCC3 F stated s/he normally worked 1st shift. RCC3 F stated s/he quit on 06/13/2022 because s/he showed up for his/her shift and there was only 1 other staff working the floor. RCC3 F stated, "They are severely understaffed." Surveyor asked if residents' scheduled cares were being completed. RCC3 F stated there were times when s/he was not able to complete his/her medication pass in time, so residents missed their medications. RCC3 F stated the facility needed at least 2 medication passers and a caregiver on each quad. Surveyor asked if staff were able to provide supervision to residents to prevent falls and elopements. RCC3 F stated, "We weren't staffed to provide supervision. I did the best I could." RCC3 F stated elopements happened almost daily when the weather started to get nice. On 06/15/2022 at approximately 8:30 a.m., Surveyor interviewed Caregiver C on the phone. Surveyor inquired if there was enough staff to get all his/her work done and supervise all the residents. S/he said you cannot watch all the residents and properly take care of them. On 06/15/2022 at approximately 8:45 a.m., Surveyor interviewed RCC3 G on the phone. Surveyor inquired if there was enough staff to properly supervise the residents. RCC3 G told Surveyor there was not enough staff to prevent falls and elopements. S/he said, "Many times I had to pick people up (off the floor) by myself." RCC3 G said s/he worked alone on 3rd shift and knew of other staff members who had worked alone on 3rd shift.	N 396		

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N 396	Continued From page 8 On 06/15/2022 at 11:00 AM, Surveyor interviewed Administrator A. Administrator A discussed the facility's large amount of incident reports in the previous 6 months. Administrator A stated the reason for many of the medication errors was that staff were in a hurry. Surveyor asked if it was typical to have roughly 60 falls and 9 elopements in 2 months. Administrator A stated the volume of incidents ebbed and flowed from month to month; some months there were none, some months there were a lot. Surveyor asked if management had discussions when there was an increase in incidents to determine possible causes and solutions. Administrator A stated the resident health coordinators discussed individual incidents and resident behavior changes amongst themselves, but there was no system to analyze the system as a whole. Surveyor asked if Administrator A thought 2 or 3 staff could meet the needs of the residents and provide adequate supervision. Administrator A stated other departments (dietary and life enrichment) were willing to assist when needed, so s/he believed the current staffing pattern was meeting resident needs. Administrator A stated there were 5 residents that required assistance of 2 staff for transfers. Surveyor asked if s/he was aware of any time when there were less than 2 staff at the facility. Administrator A stated, "There might have been a couple times." Surveyor reviewed the June 2022 schedule provided on 06/08/2022. The schedule indicated staff were provided in the following patterns for dates 06/01/2022 through 06/08/2022: 1	N 396		

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N 396	Continued From page 9 medication passer and 2 caregivers on 1st and 2nd shifts (6:00 AM to 10:30 PM); 1 caregiver and 1 medication passer on 3rd shift (10:00 PM to 6:30 PM). The provider's census was 48. Cross references: N0432 DHS 83.38(1)(h) Medication Administration	N 396		
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 interview, the provider did not ensure all medications were locked with a key available only to personnel that were identified by the provider. Findings include: On 06/08/2022 at approximately 8:40 p.m., Surveyor observed a cardboard box with multiple medication cards in it. The medication cards did contain medications. Customer Service Representative (CSR) J was in the conference room at the time. Surveyor asked CSR J why the medications were in the cardboard box and CSR J said s/he was not sure. Surveyor inquired who had access to the conference room. Staff said all the managers have keys to access the conference room. CSR J confirmed that would include dietary managers and maintenance. Surveyor explained all medications needed to be kept secure. CSR J said s/he would get the medications locked up and s/he removed the box.	N 419		

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N 432	Continued From page 10	N 432		
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. 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: 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, record review and interview, the provider did not provide medication administration appropriate to meet the residents' needs. Findings include: On 03/07/2022, the Department received a complaint with allegations that staff were not accurately administering medications. the complaint alleged staff were not checking the medication administration record (MAR) with the medication label, resulting in multiple medication errors. The provider is licensed to care for 77 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's disease. On 06/08/2022, the census was 48. The provider's Medication Observation and Competency evaluation form, indicated the following skills, in part, for staff to complete when	N 432		

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passing medications:
"Washes hands 20 seconds or utilizes hand sanitizer. Med Passer is in possession of medication keys at all times. Retrieves one Resident medication at a time within physician orders/timeline.
Verifying MAR drug instructions with medication package label...
Place the drug(s) directly in med cup upon Resident agreement to take medication.
Double check the 6 R's on MAR and medication package 3 times prior to administration:
Right drug
Right Resident
Right dosage
Right route
Right time/frequency
Right documentation
Wait for Resident to swallow medication(s).
Return to Medication Area, perform self-check of the 6 R's, then initials med pass completion on MAR..."

On 06/08/2022, from approximately 5:45 p.m. until 7:00 p.m., Surveyor observed Resident Care Coordinator 3 (RCC3) E administer medications. At 6:23 p.m., RCC3 E took Resident 9's medication cards out of the medication cart. RCC3 E went through each card and signed the medication on the MAR as given. RCC3 E said s/he administered the medications to Resident 9 earlier in the evening but did not sign them out as another resident was having behaviors. Surveyor inquired what time RCC3 E had given Resident 9 his/her medications. RCC3 E said s/he administered Resident 9's medications around 4:30 p.m.

On 06/08/2022 at approximately 6:55 p.m., Surveyor interviewed RCC3 E. RCC3 E told

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N 432	Continued From page 12 Surveyor s/he was the only medication passer for second shift that day. S/he explained the evening medication pass started at 3:00 p.m. and went until 6:59 p.m. S/he said the bedtime medication pass started at 7:00 p.m. and went until 10:59 p.m. Surveyor inquired how often it happens that s/he passes medications and signs them off the MAR as given later. RCC3 E said it "does not happen often." S/he explained another resident attempted to elope 3 times and it was a busy day. On 06/08/2022, Surveyor reviewed the provider's medication error reports from 01/01/2022 -03/31/2022. There were 16 individual medication error reports that indicated the following: 8 reports - staff were not taking the time to read the MAR when administering medications. 3 reports - staff signed the medication as given, but the medication was later found in the top drawer of the medication cart. 1 report - staff did not stay with the resident until they swallowed their medications, as the medications were found under the dining room table. 2 reports - staff did not administer a pain ointment and documented the ointment was not in the medication cart. The report indicated there was a new tube of ointment in the cart. 1 report - staff administered a medication that was on hold. Another medication error report indicated on 02/10/2022, 14 residents did not receive their evening medications from RCC3 G. RCC3 G documented the following on the discipline form: "I'll do someone else's job when someone helps with mine." On 06/15/2022 at approximately 8:40 a.m., Surveyor interviewed RCC3 G on the phone.	N 432		

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AMERY MEMORY CARE	215 BIRCH STREET WEST AMERY, WI 54001

(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 13 Surveyor inquired if s/he remembered what happened the night of 02/10/2022, when 14 residents did not receive their evening medications. RCC3 G explained that his/her shift started at 6:00 p.m., relieving RCC3 F. S/he explained that it was expected that RCC3 F would have had all the evening medication pass completed and s/he would administer the bedtime medication pass. RCC3 G said RCC3 F had to leave prior to completing the narcotic counts with RCC3 G. RCC3 G said it took him/her an hour to do all the narcotic counts. It was 7:00 p.m., which was too late for the evening medication pass and time to start the bedtime medication pass. RCC3 G said s/he did not finish administering the evening medication pass that RCC3 F did not finish, as it was no longer within the correct time to administer the medications. RCC3 G said s/he did not want to give a resident a "double dose" of a medication by administering the evening and bedtime medications at the same time. On 06/15/2022 at approximately 12:30 p.m., Surveyor interviewed Administrator A on the phone. Surveyor inquired how s/he was addressing the large volume of medication errors. Administrator A said staff had been receiving one on one re-education from the registered nurse. S/he said, "A lot of it is, they are in a hurry. We told them they need to slow down." The provider did not provide medication administration appropriate to meet residents' needs.	N 432		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and	N 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 441	Continued From page 14 prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident Care Coordinator 3 (RCC3) E followed hand hygiene procedures according to the Centers for Disease Control and Prevention (CDC). This is a repeat deficiency. See Statement of Deficiency (SOD) BGEG12, dated 8/24/18. Findings include: According to the CDC, hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e., alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis. Gloves are not a substitute for hand hygiene. The clinical indications for hand hygiene include: - Immediately before touching a patient - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids or contaminated surfaces - Immediately after glove removal The provider is licensed to care for 77 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's disease. On 06/08/2022, the census was 48. On 06/08/2022 at approximately 5:45 p.m., Surveyor observed RCC3 E conduct part of the evening medication administration pass.	N 441		

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N 441	Continued From page 15 At approximately 6:00 p.m., RCC3 E prepared Resident 4's medications. RCC3 E told Surveyor that Resident 4 had his/her medications crushed and mixed with applesauce. RCC3 E said s/he was all out of applesauce on this side of the building. RCC3 E then went outside, through the courtyard, to the other side of the building to retrieve more applesauce. When RCC3 E returned with the applesauce, s/he did not perform hand hygiene and continued to prepare Resident 4's medications. RCC3 E opened Resident 4's cranberry capsule with his/her bare hands and emptied the contents of the capsule into the applesauce. RCC3 E administered Resident 4 his/her medications. RCC3 E then donned gloves, without any hand hygiene, and administered eye drops to Resident 4. RCC3 E removed gloves and did not perform hand hygiene. At approximately 6:15 p.m., Surveyor observed RCC3 E administer Resident 5 his/her eye drops. RCC3 E did not perform hand hygiene and donned gloves. S/he administered the eye drops to Resident 5 and removed his/her gloves. S/he did not perform hand hygiene and proceeded to chart the medication pass. RCC3 E then prepared Resident 6's medication. This was a small ½ tablet. The ½ tablet stuck to the medication card and RCC3 E used his/her bare hands to grab the ½ tablet and place it into the medication cup. RCC3 E did not perform hand hygiene prior to or after touching the medication with his/her bare hands. At approximately 6:30 p.m., Surveyor observed RCC3 E administer Resident 7 his/her medications in Resident 7's room. RCC3 E had Resident 7's skin repair cream to apply to Resident 7's peri area. Resident 7 went into the	N 441		

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N 441	Continued From page 16	N 441		

bathroom and sat down to use the toilet. Resident 7 told RCC3 E that s/he had diarrhea earlier and had an accident in his/her underwear. RCC3 E donned gloves without hand hygiene prior. When Resident 7 was finished, Resident 7 stood up and RCC3 E assisted Resident 7 with cleaning his/her peri area. RCC3 E then applied the skin repair cream to Resident 7's peri area with the same dirty gloves. RCC3 E removed his/her gloves and did not perform hand hygiene. RCC3 E returned to the medication cart and began charting the medication pass. RCC3 E then began preparing Resident 8's medications. RCC3 E prepared a fiber powder mixed with water. RCC3 E removed the paper covering from a straw, held the straw in his/her bare hands and assisted Resident 8 with his/her medications by placing the straw to Resident 8's mouth. RCC3 E then donned gloves, without hand hygiene, and administered eye drops to Resident 8. RCC3 E removed his/her gloves and did not perform hand hygiene.

Surveyor observed RCC3 E administer medications to 11 residents from approximately 5:45 p.m. - 6:57 p.m. Surveyor observed RCC3 E perform hand hygiene once during this time and that was after s/he had assisted a resident with his/her shoes.

At approximately 6:57 p.m., Surveyor interviewed RCC3 E. Surveyor explained concerns that RCC3 E did not perform hand hygiene between residents and with glove changes. RCC3 E said s/he would pay closer attention to that. Surveyor inquired if RCC3 E had performed any hand hygiene after assisting Resident 7 with the bathroom. RCC3 E told Surveyor, s/he just removed his/her gloves.

RCC3 E did not follow hand hygiene procedures

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N 441	Continued From page 17 in accordance with the CDC.	N 441		