STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND PLACE	444 MERTON HARTLAND, WI 53029

(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 09/21/2023, Surveyor conducted a verification visit at Hartland Place. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See statement of deficiency (SOD) #QPFI12, dated 12/01/2022. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 31	{N 000}		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes,	N 243		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND PLACE	444 MERTON HARTLAND, WI 53029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 243	Continued From page 1	N 243		

communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment.
Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.
Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 2 of 2 employees reviewed completed training in all employee training. Caregiver Z and Caregiver AA did not have documentation for completion of training in client groups or challenging behaviors.

This is a repeat violation. See statement of deficiency (SOD) QPFI12, dated 12/01/2022.

Findings include:

On 09/18/2023, Surveyor conducted a review of 2 employees to verify compliance with all employee training requirements. Surveyor requested training records from Administrator A.

Client Group:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND PLACE	444 MERTON HARTLAND, WI 53029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 243	Continued From page 2 The record for Caregiver Z, hired 04/27/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver AA, hired 05/08/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors: The record for Caregiver Z, hired 04/27/2023 did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. The record for Caregiver AA, hired 05/08/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 09/21/2023 at 12:17 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A stated s/he does all employee training annually in November. Administrator A noted s/he just recently found out that all employee training had to be completed within 90 days of hire. Administrator A stated it was his/her fault that Caregiver Z and Caregiver AA did not complete all employee training within 90 days. Administrator A stated s/he would be signing up all staff who needed all employee training as soon possible.	N 243		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND PLACE	444 MERTON HARTLAND, WI 53029

(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 3	N 432		

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 record review and interview, the provider did not ensure 2 of 2 residents reviewed (Resident 1 and Resident 10) received medication administration appropriate to his/her needs.

Findings include:

On 09/21/2023, Surveyor reviewed Resident 1's and Resident 10's record. The following was found:

Example 1-Resident 1

Resident 1 was admitted 07/15/20216 with diagnoses including mononeuropathy, polyneuropathy, low back pain, and weakness. Resident 1 is their own legal decision maker. Resident 1's individual service plan (ISP) dated 08/24/2023 indicated the provider administered and ordered Resident 1's medications.

Resident 1's physician orders included:
"Oxycodone 5 mg, take 1 tablet every 4 hours as needed, with a start date of 06/09/2023.
Oxycodone-Acetaminophen 5-325 mg, take ½ tablet by mouth 3 times a day, with a start date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND PLACE	444 MERTON HARTLAND, WI 53029

(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 4 07/07/2023." Resident 1's July 2023 medication administration record (MAR) documented: Oxycodone: 07/01/2023: 8am-"2", 4pm-"OTH", 8pm-"n/a" 07/02/2023: 8am-"OTH", 4pm-"OTH", 8pm-"OTH" 07/03/2023: 8am-"OTH", 4pm-"3", 8pm-"OTH" 07/04/2023: 8am-"2", 4pm-"4", 8pm-"4" 07/05/2023: 8am-"OTH", 4pm-"5", 8pm-"5" The charting codes documented: OTH=Other Problems-Must Call RD on Call, 2=Hold, 3=unknown, 4=discontinued, 5=unknown. 07/01/2023 notations included "needs refill" 07/02/2023 notations included "reorder" and "not available" 07/03/2023 notations included "not on med cart" and "not available" 07/05/2023 notations included "not on med cart" and "old order" Resident 1's August 2023 MAR documented: Oxycodone-Acetaminophen: 08/02/2023: 8am-"1", 4pm-"OTH", 8pm-"2" 08/03/2023: 8am-"1", 4pm-"2", 8pm-"OTH" 08/04/2023: 8am-"OTH", 4pm-"OTH", 8pm-"2" 08/02/2023 notations included "not available" 08/03/2023 notations included "needs refill" and "med not available" 08/04/2023 notations included "needs refill" and "med not here" Example 2-Resident 10 Resident 10 admitted 07/26/2023. Resident 10 is their own legal decision maker.	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND PLACE	444 MERTON HARTLAND, WI 53029

(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 5 Resident 10's physician orders included: "Lansoprazole 30 mg, take 1 capsule 1x/daily, with a start date of 07/31/2023. Lutein-Zeaxanthin-Bilberry 20-1-2.2 mg, take 1 capsule 1x/daily, with a start date 07/31/2023. Sotalol 120 mg, take ½ tablet by mouth 2x/daily, with a start date of 07/31/2023. Vitamin D3 1000 unit, take 1 tablet 1x/daily, with a start date of 07/31/2023. Diclofenac Sodium 1%, apply 4 times per day to affected area, with a start date of 09/07/2023. Eliquis 2.5 mg, take 1 tablet 2x/daily, with a start date of 09/11/2023." Resident 10's August 2023 MAR documented: 08/15/2023-"OTH" for the following medications: Lansoprazole 30 mg Lutein-Zeaxanthin-Bilberry 20-1-2.2 mg Sotalol 120 mg Vitamin D3 1000 unit 08/15/2023 notations included "not in strip." Resident 10's September 2023 MAR documented: Diclofenac Sodium 1%: 09/15/2023-"2", 09/19/2023-"1" Eliquis 2.5 mg: 09/17/2023-"OTH" notations included "not in the cart", 09/18/2023-"2" notations included "not on cart" Lutein-Zeaxanthin-Bilberry 20-1-2.2 mg: 09/12/2023-"OTH" notations included "not in strips", 09/17/2023-"OTH" notations included "not in the cart", 09/18/2023-"OTH" notations included "not on cart" Vitamin D3 1000 unit: 09/03/2023-"OTH" On 09/21/2023 at 12:17 PM, Surveyor conducted an exit conference and shared findings with	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND PLACE	444 MERTON HARTLAND, WI 53029

(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 6 Administrator A. Administrator A stated the provider administers and orders Resident 1's and Resident 10's medications. Administrator A stated if the pharmacy does not have the script or right authorization, they will not send the medication right away. Administrator A noted the pharmacy will follow up with the residents physician and the provider will send a series of faxes to get the medication ordered. Surveyor asked Administrator A if s/he could provide evidence the provider communicated with Resident 1's and Resident 10's physician regarding the above medications not being available. Administrator A stated s/he would need additional time to look for documentation. On 09/22/2023 at 9:58 AM, Administrator A sent the Surveyor an email stating the provider was still going through paperwork to find supporting documents for the medications that were not on the cart.	N 432		