STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018293	A. BUILDING: _____ B. WING _____	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD I	584 EDGEWOOD DRIVE BURLINGTON, WI 53105

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M 000	INITIAL COMMENTS On 09/05/2023, Surveyor completed a standard licensing survey and two complaint investigations at Edgewood I. Three deficiencies were identified. Two complaints were substantiated. Census: 3	M 000		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not obtain documentation that 1 of 3 staff reviewed had been screened for TB, within 90 days before the start of providing service. Caregiver F was screened for other illnesses detrimental to residents and had first TB test injection on 01/11/2023; however, Caregiver F did not come back to have the TB test read to complete the test. Findings include:	M 232		

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

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M 232	Continued From page 1 On 09/01/2023 at 8:00 a.m., Surveyor reviewed Caregiver F's employee record. Caregiver F was hired on 01/13/2023. Caregiver F's file contained a communicable disease screen, dated 01/11/2023. Caregiver F's record did not contain a complete TB skin test. Caregiver F received first TB test injection on 01/11/2023. For the interpretation or read date, the box contained a handwritten note indicating, "no show.' Caregiver F's record did not contain TB screening test results 90 days before the start of providing service. On 09/05/2023 at 11:00 a.m., Surveyor interviewed Licensed Practice Nurse (LPN) B, who stated s/he oversaw caregivers completing the TB and communicable disease screening. LPN B explained when caregivers were hired, they would go to a clinic to get their first TB injection and get screened for TB. LPN B told Surveyor s/he did not notice Caregiver F did not have the TB injection read.	M 232		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it.	M 556		

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M 556	Continued From page 2	M 556		

This Rule is not met as evidenced by:
Based on record review and interview the provider restricted 1 of 1 resident (Resident 1) freedom of choice. Resident 1 was not given a choice to go to another Adult Family Home (AFH) during the day.

Findings include:

On 08/25/2023, Surveyor conducted a complaint investigation and standard survey at Edgewood I.

On 08/29/2023, Surveyor reviewed Resident 1's record and the following was identified:

Resident 1 was admitted to the facility on 07/08/2021 with diagnoses that included anemia, alcohol use, unspecified with alcohol-induced persisting dementia, major depressive disorder, recurrent, agoraphobia with panic disorder and nicotine dependence. Resident 1 had legal co-guardians.

Surveyor reviewed Resident 1's individualized service plan (ISP), updated 06/26/2023. Under social participation, community contacts, stated, "Olive Branch is working to create more involvement among residents, and [Resident 1] will be included in activities at other houses during the week. Licensee A discussed this with Guardian C on 06/26/2023 and s/he agreed that this would be good for [Resident 1]."

Resident 1's ISP, updated 06/26/2023, did not exhibit a statement of agreement with the plan to go to other facilities during the day. It was not dated and signed by all persons involved in the development of the plan.

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M 556	Continued From page 3	M 556		

Interviews:

On 08/25/2023 at 10:04 a.m., Surveyor interviewed Resident 1, who stated s/he felt forced to go to another facility location, an adult family home (AFH). There were mornings s/he wanted to just stay home, but the staff rushed him/her out the door between 8:00 a.m. and 9:00 a.m. Resident 1 stated s/he had to take his/her morning medication as s/he was rushing out the door. S/He felt it was very early to be making him/her leave to go to another house. When s/he would get to the other house, s/he would just sit on the couch all day. There was nothing really happening there. The staff at the other house did not have his/her as needed (PRN) anxiety medication. If s/he needed or wanted it, s/he would have to wait until s/he got back to Edgewood I.

On 08/25/2023 at 10:10 a.m., Surveyor interviewed Guardian C, who stated s/he did not approve of the facility taking Resident 1 to another home during the day.

On 08/25/2023 at 10:40 a.m., Surveyor interviewed Licensed Practical Nurse (LPN) B, who explained in the mornings, all the residents who did not go to day programs, went to one of the provider's other adult family homes for activities. Resident 1 was agreeable in the beginning. If something small upset him/her, s/he would complain to Guardian C. LPN B explained Resident 1's PRN medication was available to him/her if s/he needed it. LPN B stated staff would have to come back to Edgewood to get it.

On 08/25/2023 at 2:04 p.m., Surveyor interviewed Caregiver D who explained Resident 1 was

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M 556	Continued From page 4	M 556		

usually up by 5:15 a.m. When the other residents got picked up in the morning, s/he would go in the van with them and get dropped off at the other AFH, usually around 8:15 a.m. S/He had been going to the other AFH during first shift.

On 08/25/2023 at 2:30 p.m., Surveyor interviewed LPN B, who explained Resident 1 was supposed to move. The provider had been adjusting the staff schedule. Resident 1 ended up going to the other AFH 4-5 times. "We thought s/he was okay with it."

On 08/31/2023 at 8:10 a.m., Surveyor interviewed Registered Nurse Care Manager (RN CM) H, who recalled the provider "simply didn't have the staff." When Surveyor requested clarification, CM RN H explained provider was having difficulty finding staff who could be with Resident 1 and transport him/her around to his/her activities.

On 08/31/2023 at 8:10 a.m., Surveyor interviewed Care Manager (CM) G. Surveyor requested information on facility staffing during day shift for Resident 1. Care Manager G stated the provider had Resident 1 go to another AFH if they did not have enough staff. The provider discussed doing this with Guardian C present at the August 2023 care planning meeting. At the meeting, Resident 1 stated s/he felt s/he did not have a choice to go or not.

On 08/31/2023 at 8:26 a.m., RN CM H confirmed Resident 1 requested his/her PRN anxiety medication while at other home and the staff did not have it.

On 09/05/2023 at 11:14 p.m., during the exit conference, Licensee A confirmed Resident 1 went to other homes for activities. Licensee A

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M 556	Continued From page 5 explained s/he believed Resident 1 was willing to go to the other homes.	M 556		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on records review and interviews, the provider did not ensure 1 of 1 resident received all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive the prescribed Clonazepam between 03/02/2022 and 03/22/2022. Findings include: On 08/15/2023, the Department received a complaint alleging the provider did not provide Resident 1 all his/her prescribed medications. On 08/29/2023, Surveyor reviewed Resident 1's record and the following was identified: Resident 1 was admitted to the facility on 07/08/2021 with diagnoses that included anemia, alcohol use, unspecified with alcohol-induced persisting dementia, major depressive disorder, recurrent, agoraphobia with panic disorder and	M 582		

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M 582	Continued From page 6	M 582		

nicotine dependence. Resident 1 had legal co-guardians.

Resident 1's March 2022 medication administration record (MAR) indicated Resident 1 was prescribed Clonazepam, 1 milligram (mg), take 1 tablet by mouth three times a day (at 8:00 a.m., 2:00 p.m., and 8:00 p.m.). The start date read 02/04/2022 and the end date was 03/23/2022. Resident 1's March 2022 MAR contained an "OTH" in the box where staff documented where the 2:00 pm medication was administered. Based on the March 2022 MAR charting code, "OTH" indicated "other-enter specific reason in notes." Between 03/02/2022 and 03/22/2022, Resident 1 did not receive her/his 2:00 p.m. prescribed Clonazepam.

Resident 1's MAR notation dated 03/02/2022 read, 'nurses order'. Resident 1's MAR notation dated 03/03/2022 and 03/04/2022 read, 'per nurse'.

On 08/30/2023 at 2:30 p.m., Surveyor conducted an interview with Pharmacy Technician M on to confirm physician's orders:

-Clonazepam, 1 mg tablet, by mouth, three times a day. Take one tablet at 8:00 a.m., 2:00 p.m., and 8:00 p.m. The start date read 02/04/2022 and the end date was 03/23/2022.

Pharmacy Technician M confirmed Resident 1 had a physician order prescribing clonazepam which remained in effect until dose was decreased in June 2022.

On 08/31/2023 at 8:10 a.m., Surveyor interviewed Registered Nurse Care Manager (RN CM) H, who stated they did not have any documentation on

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M 582	Continued From page 7 Resident 1 not receiving his/her 2:00 p.m. clonazepam. On 09/01/2023, [Physician's Office] letter issued by Physicians Assistant (PA) I prescribed "Clonazepam, 1 milligram tablet, by mouth, three times a day starting 01/20/2022. Take one tablet at 8:00 a.m., 2:00 p.m., and 8:00 p.m." On 09/01/2023, at 10:00 a.m., Surveyor interviewed Clinical Director J who confirmed Resident 1 was prescribed scheduled clonazepam, 1 mg tablet, by mouth, three times a day starting 01/20/2022, with instructions to take one tablet at 8:00 a.m., 2:00 p.m., and 8:00 p.m. Clinical Director J reviewed Resident 1's record and confirmed that there had been no change to Resident 1's clonazepam prescription from 01/20/2022 to 06/9/2022. On 09/05/2023 at 11:14 p.m., during the exit conference, Licensed Practical Nurse (LPN) B and Licensee A confirmed they monitored all prescribed medications to ensure residents received all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Licensee A explained Resident 1 was more lethargic at the end of February 2022 and Guardian C requested medication be held. Licensee A explained they tried to get a hold of Resident 1's physician, but the physician never returned the telephone calls. Licensee A stated they received verbal updates, but they did not have a physician's order to not administer Resident 1's 2:00 p.m. medication.	M 582		