STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010990	A. BUILDING: _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANG HOME	1234 NEWPORT DR OCONOMOWOC, WI 53066

(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 08/08/2023, with information obtained through 08/16/2023, Surveyor conducted a standard licensing survey at Lang Home, a community-based residential facility (CBRF) located in Oconomowoc, WI. As a result of the survey, 6 deficiencies were identified. Census: 7	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an incident involving Resident 1 which resulted in emergency room treatment and hospital admission was reported to the Department within 3 working days. The provider did not report to the Department when Resident 1 received 5 staples in his/her head and was hospitalized due a subarachnoid hemorrhage, small left subdural hematoma, and traumatic brain injury status post fall. Findings include: On 08/11/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider	N 165		

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

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N 165	Continued From page 1 on 06/23/2021. Surveyor reviewed a hospital discharge summary, dated 04/03/2023, and observed the following: - "Brief hospital course: Came with traumatic brain injury and had subdural hemorrhage/hematoma." - "[History of present illness (HPI)] from [history and physical exam (H&P)]: [Resident 1]...presents with a chief complaint of a fall...The patient was carrying a laundry basket down the stairs this morning when [s/he] had a witnessed seizure and fell down approximately 3 stairs. [S/he] hit the back of [his/her] head on a stair. Patient currently reports headache..." The report noted that Resident 1 "had 2 staples placed in [emergency department (ED)] and 3 more by general surgery..." and that Resident 1 was admitted to the hospital from 03/26/2023 until discharge on 04/03/2023. While hospitalized Resident 1 was evaluated by neurosurgery and had head imaging completed. On 08/11/2023, Surveyor reviewed the Department facility file and did not find evidence of a report submitted regarding the above incident. On 08/16/2023, at approximately 10:30 a.m., Surveyor interviewed Director C and asked if there was a self-report submitted for the above incident. Director C reported s/he was unable to find any and that s/he wasn't sure if someone else from the company submitted one. Director C acknowledged Surveyor's observation that there was no evidence in the Department records that a self-report for the above incident was ever received.	N 165		

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N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that 5 of 7 residents were provided the least restrictive conditions necessary to achieve the purposes of their admission. Five of seven residents (Residents 1 - 5) were regularly monitored by staff via motion detectors that chimed at a volume audible throughout the house upon detecting motion near their bedrooms. Staff reported the detectors were utilized for general resident supervision. Findings include: According to Wis. Admin. Code § DHS 83.01(2), "The chapter is intended to ensure all CBRFs provide a living environment for residents that is as homelike as possible and is the least restrictive of each resident's freedom; and that care and services a resident needs are provided in a manner that protects the rights and dignity of the resident and that encourages the resident to move toward functional independence in daily living or to maintain independent functioning to	N 356		

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the highest possible extent."

On 08/09/2023, from 7:30 a.m. until approximately 7:50 a.m., Surveyor toured the home. Upon walking down the hallway opposite the dining area, Surveyor heard a chime that sounded throughout the area. Surveyor observed what appeared to be a sensor affixed to the wall at the end of the hallway, which was in view of an additional hallway and a staff office room. Surveyor continued walking down the hallway where it made a 90° turn and continued towards 4 resident bedrooms. Upon walking down that hallway towards the front 4 bedrooms, Surveyor heard a chime that sounded throughout the area. Surveyor observed what appeared to be an additional sensor affixed to the wall at the end of the hallway, which was in monitoring view of the 4 bedrooms. There were no other rooms down that hallway. Surveyor walked in and out of both hallways twice, and a chime sounded each time that Surveyor turned into either of the hallways.

Surveyor then walked downstairs to observe the home's lower level, where 2 bedrooms were located. Upon walking into the lower level's back bathroom (from the hallway), Surveyor heard a chime that sounded throughout the lower level. Surveyor observed what appeared to be a sensor affixed to the hallway wall across the bathroom. The sensor appeared to be facing towards the 2 bedrooms. There were no other rooms located in that hallway. Upon leaving the bathroom and walking towards the bedrooms, the chime sounded again. Surveyor walked in and out of the bathroom and around the 2 lower level bathrooms twice, and each time a chime sounded.

At approximately 7:50 a.m., Surveyor toured the home with Assistant Program Manager D. Upon

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walking in the main level hallway towards the office and towards the front 4 bedrooms (past the first sensor-appearing object), a chime sounded. Upon turning into the hallway where the 4 bedrooms were located, another chime sounded. Surveyor asked Assistant Program Manager D what the chiming was and if it was related to the objects on the wall that appeared to be sensors/detectors. Assistant Program Manager D confirmed that what was observed by Surveyor were 2 motion detectors and that they audibly chimed when they detected motion. Surveyor asked how many motion detectors were throughout the home. Assistant Program Manager D replied that there were 3 total - 2 on the main level and 1 on the lower level. Upon observing the 4 bedrooms in range of one of the motion detectors with Assistant Program Manager D, Surveyor observed each of the 4 bedrooms, which were occupied and belonged to Resident 1, Resident 2, Resident 3, and Resident 4. Upon entering and leaving each of the 4 bedrooms, Surveyor heard chiming consistent with the motion detector catching Surveyor's movement from the bedrooms in and out of the hallway. Surveyor asked Assistant Program Manager D how long the motion detectors had been in place. Assistant Program Manager D replied that all 3 detectors have "been there since I started in September." Surveyor asked why the motion detectors were being utilized. Assistant Program Manager D replied that they were "for tracking residents' movements." Surveyor observed 2 additional bedrooms on the main level located past the bathroom. Assistant Program Manager D reported that these were the bedrooms occupied by Resident 6 and Resident 7. Surveyor did not observe any sensor/detector on the hallway walls near these bedrooms and did not hear any chiming when Surveyor walked

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in and out of the bedrooms. Assistant Program Manager D confirmed there was no motion detector near these 2 bedrooms but reported s/he wasn't sure why.

Surveyor then toured the lower level with Assistant Program Manager D and observed both the lower level bedrooms - only one of which was occupied and belonged to Resident 5. From walking back and forth between Resident 5's bedroom and the lower level back bathroom, Surveyor heard chiming consistent with the motion detector catching Surveyor's movement. Assistant Program Manager D confirmed that the sensor-appearing object on the wall observed earlier by Surveyor, which pointed to the lower level 2 bedrooms, was the lower level motion detector.

On 08/10/2023, Surveyor reviewed the records for Resident 1, Resident 3, and Resident 5. All 3 residents' rooms were located in areas monitored by the motion detectors observed on 08/09/2023 by Surveyor.

Resident 1 was admitted to the provider on 06/23/2021 with diagnoses including Prader-Willi syndrome (PWS), moderate intellectual disability, and intermittent explosive disorder. Resident 1's current individual service plan (ISP), dated 06/22/2023, did not indicate any need for or use of motion detection monitoring.

Resident 3 was admitted to the provider on 06/26/2017 with diagnoses including PWS and generalized anxiety disorder. Resident 3's current ISP, dated 02/08/2023, did not indicate any need for or use of motion detection monitoring.

Resident 5 was admitted to the provider on

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06/28/2005 with diagnoses including PWS, mild intellectual developmental disorder, and other specified bipolar and related disorder. Resident 5's current ISP, dated 06/27/2023, did not indicate any need for or use of motion detection monitoring.

On 08/16/2023, at approximately 10:30 a.m., Surveyor interviewed Program Coordinator A and Director C. Surveyor asked about the purpose of motion detection monitoring. Director C reported that the motion detectors were used to tell if residents were outside of their rooms. Director C acknowledged Surveyor's observation that the motion detection monitoring was not addressed in the ISPs of Residents 1, 3, and 5. Surveyor discussed the concern that it wasn't clear why 5 of the 7 residents were under motion detection monitoring and why the motion detectors were monitoring the movements in/out of their bedrooms as well as the lower level bathroom. Director C reported that the provider's clinical team would maybe have information about the motion detection monitoring in the residents' behavior plans.

On 08/16/2023, Surveyor reviewed the current behavior plans for Residents 1, 3, and 5, provided by Director C. There was no information in any of the plans about the need for or use of motion detection monitoring.

On 08/16/2023, from approximately 12:35 p.m. - 4:00 p.m., Surveyor interviewed Director C via e-mail. Surveyor reported that s/he was not able to find information about the bedroom motion detection monitoring in the behavior plans for Residents 1, 3, and 5. Surveyor asked who decided to place the motion detectors, when they were placed, and why they were used to monitor

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N 356	Continued From page 7 the bedroom-area movements of Residents 1-5 but not Residents 6-7. Director C replied that the "detectors are in place to support general 24 hour active supervision provided by [the provider], and are not specific to residents. The sensors in the back hallway and downstairs hallway were added in those specific place[sic] due to the barriers in providing visual support to those areas. The areas where there are not motion detectors are in the general line of site of the common areas, so audio support is not needed in order to provide standard supervision." Surveyor replied concern of resident privacy and the apparent use of the detectors as a substitute for staff supervision. Director C did not reply.	N 356		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need	N 404		

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N 404	Continued From page 8 physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was obtained for findings of an annual medication storage system review completed by a physician, pharmacist, or registered nurse in 2022. Findings include: On 08/09/2023, Surveyor conducted an on-site standard licensing survey. Surveyor requested results from the medication storage system review for either 2023 or 2022 from Program Coordinator A. Nothing further was received. On 08/10/2023, at approximately 10:37 a.m., Surveyor requested the medication storage system review record for 2022 via e-mail from Director C. Director C replied to Surveyor at 1:41 p.m. and reported that staff were having difficulty locating the record. On 08/16/2023, at approximately 10:30 a.m., Surveyor interviewed Director C and Program Coordinator A. Director C confirmed staff were unable to locate a record of the review and that there was an internal miscommunication regarding who was responsible for maintaining record of the review. Program Coordinator A reported s/he thought the medication storage system review would have been conducted at the same time the medication regimen for residents was reviewed by the provider's pharmacy in September of 2022, but confirmed s/he did not have a record of that.	N 404		

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N 408	Continued From page 9	N 408		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's individual service plan (ISP) included a rationale for use and a detailed description of the behaviors indicating the need for his/her as-needed (PRN) psychotropic medication. Findings include: On 08/16/2023, Surveyor reviewed Resident 1's medication administration record (MAR) from 07/01/2023 - 08/16/2023 and observed that on 08/01/2023, at 10:49 a.m., Resident 1 received a	N 408		

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N 408	Continued From page 10 PRN diphenhydramine 25 mg capsule. The reason listed was "having anxiety." Surveyor reviewed Resident 1's prescriptions, which included diphenhydramine 25 mg capsules, prescribed on 04/26/2023, with the following instructions: "Take one capsule by mouth every four hours as needed for anxiety or itching." On 08/16/2023, Surveyor reviewed Resident 1's current ISP, which was last reviewed on 06/22/2023. The "Medication Administration" section had a box for staff to indicate Resident 1's PRN psychotropic medication use, along with spots for the medication name and reason for use, however, these entries were blank and the box was unchecked. There was no other information in Resident 1's ISP about the rationale for use and detailed description of behaviors indicating the need for his/her PRN diphenhydramine related to his/her anxiety. On 08/16/2023, at approximately 10:30 a.m., Surveyor interviewed Director C. Director C acknowledged Surveyor's observation that there wasn't evidence in Resident 1's ISP of diphenhydramine use for an anxiety intervention and said s/he would look into it further.	N 408		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any 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.	N 488		

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N 488	Continued From page 11 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the dryer vent tubing was of a rigid material. Findings include: On 08/09/2023, at approximately 8:30 a.m., Surveyor observed the laundry area with Program Coordinator A. Surveyor observed that the dryer vent tubing appeared to be of flexible material. Program Coordinator A reported that the dryer was fairly new. At approximately 11:00 a.m., Surveyor interviewed Program Coordinator A and Case Coordinator B. Both acknowledged Surveyor's concern that the dryer vent tubing did not appear to be of rigid material and reported they would discuss this with their maintenance staff to change out.	N 488		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 617		

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did not ensure that the temperature of 2 of 4 bathroom sinks utilized by residents did not exceed 115° Fahrenheit (F).

Findings include:

The provider is licensed to serve up to 8 residents within the client groups of developmentally disabled. According to the provider's program statement, reviewed by Surveyor in the Department file and dated 01/01/2022, the provider "primarily serves individuals with a diagnosis of Prader-Willi Syndrome (PWS)."

According to the Prader-Willi Syndrome Association, people with PWS can commonly have a high pain threshold as impacted by "lack of typical pain signals." This "may mask the presence of infection or injury" due to having decreased pain sensation (Source: Prader-Willi Syndrome Association, Prader-Willi Syndrome Medical Alerts by Medical Specialists in Prader-Willi Syndrome, 2015, https://www.pwsausa.org/wp-content/uploads/2015/11/newMAbookfinal.pdf (retrieval date - August 10, 2023).).

On 08/09/2023, at approximately 8:54 a.m., Surveyor tested the water temperature in the sink located in the main level bathroom, which was utilized by residents. The temperature reached 137.5°F.

At approximately 8:57 a.m., Surveyor tested the water temperature in the sink located in the downstairs bathroom (next to the med room), which was utilized by residents. The temperature reached 137.8°F.

At approximately 11:00 a.m., Surveyor discussed

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N 617	Continued From page 13 the water temperature concerns with Program Coordinator A and Case Coordinator B. both agreed with Surveyor that the high water temperatures were a concern and reported that they would discuss this further with maintenance. At approximately 4:10 p.m., Surveyor received an e-mail from Director C. Director C reported that maintenance staff would address the water temperatures the next day.	N 617		