STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018908	A. BUILDING: _____ B. WING _____	C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHAS II CBRF	**404 W WATER ST PRINCETON, WI 54968**

(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 06/04/2025, with information gathered through 06/11/2025, Surveyor conducted a standard survey and 1 complaint investigation at Marthas II in Princeton. One (1) of 1 complaint was unsubstantiated. As a result of the survey, 4 deficiencies were identified. Census: 14	N 000		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees (Caregiver B) received at least 15 hours of continuing education per calendar year which included standard precautions, resident rights, and preventing and reporting of abuse, neglect and misappropriation.	N 277		

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

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N 277	Continued From page 1 Caregiver B was hired on 09/09/2022. Caregiver B's employee record did not contain 15 hours of continuing education in 2023 and 2024 including education in standard precautions, resident rights, and preventing and reporting of abuse, neglect and misappropriation. Findings Include: On 06/04/2025, Surveyor conducted an employee record review as part of the standard survey process. A sample of employees was selected, including the employee record of Caregiver B. Caregiver B was hired on 09/09/2022. Surveyor noted Caregiver B's employee file did not include any continuing education in 2023 and 2024. On 06/04/2025 at approximately 11:30 AM, Surveyor interviewed Administrator A regarding continuing education training for Caregiver B. Administrator A stated, "I do not know where the rest of them [continuing education training] are." Administrator A had indicated Caregiver B did receive some continuing education already in 2025, but acknowledged there was no record of Caregiver B receiving any training in 2023 and 2024.	N 277		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals	N 381		

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N 381	Continued From page 2 receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not assess each resident's needs, abilities and physical and mental condition when there was a change in condition for 1 of 1 (Resident 1) residents reviewed. Resident 1 was observed to have quarter bilateral siderails on his/her bed. Resident 1's record did not contain an assessment for the use of the quarter bilateral siderails to determine if the siderails were a repositioning tool or a physical restraint. Findings Include: On 06/04/2025, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1. Resident 1 was admitted to the facility on 05/10/2024 with diagnoses to include multiple sclerosis (MS). Resident 1's Individualized Service Plan (ISP) dated 04/03/2025 indicated Resident 1 is aphasic, needs staff assistance to stand and transfer, "does not leave bed... [Resident 1] is full assist." The ISP did not indicate usage of quarter bilateral siderails. On 06/04/2025, at approximately 1:30 PM, Surveyor and Administrator A observed Resident	N 381		

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N 381	Continued From page 3 1 laying in bed in his/her room. Surveyor observed quarter bilateral siderails on the bed. While Surveyor spoke with Resident 1, Resident 1 had sporadic involuntary arm and leg movements, at one point causing the blanket that was covering Resident 1 to fall off. Surveyor did observe Resident 1 grab the right siderail to roll him/herself to the side. On 06/04/2025, at approximately 2:00 PM, Surveyor interviewed Administrator A regarding an assessment for the use of the quarter bilateral siderails. Administrator A verified Resident 1's did not contain an assessment for the use of the siderails to determine if they were a repositioning tool or a restraint.	N 381		
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 interview, the provider did not implement and follow the ISP (individualized service plan) for 1 of 1 (Resident 1) residents reviewed. Resident 1 was observed lying in bed with an ecigarette and storing additional smoking materials in a bed pocket attached to siderail, both were contrary to Resident 1's ISP. Findings Include: On 06/04/2025, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1.	N 388		

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N 388	Continued From page 4 Resident 1 was admitted to the facility on 05/10/2024 with a diagnoses of Multiple Scerlosis (MS). Resident 1's most recent ISP dated 04/03/2025 indicated Resident 1 "does not leave bed" and is a "full assist" with ambulation/mobility. The ISP indicated Resident 1 does smoke and agrees with smoking policy. Additionally, the ISP stated "due to [him/her] not being able to go outside, resident vapes in bedroom with window open." The ISP continued to state, Resident 1 has a history of smoking indoors and staff are to document and report if smoking indoors. Lastly, the ISP indicated staff are to store the smoking materials when not in use. The section titled, "Demonstrates safe use of cigarettes and no indication of burns on skin or clothing, unsafe disposal, smoking indoors, etc" was left blank. A facility policy titled, "SMOKING POLICY" with no date states, "NO Smoking within the facility Smoking is permitted in the following designated areas only Front Porch Area Back Patio Area No smoking between the hours of 10pm-6am Cigarettes must be put out completely in one of the fire safe containers on either porch Please pick up your empty packs and dispose of them properly" The policy does not address ecigarettes and the use of them within the facility. On 06/04/2025, at approximately 1:20 PM, Surveyor and Administrator A interviewed Resident 1. Resident 1 was laying in bed in room. Surveyor observed Resident 1 holding an ecigarette. Surveyor asked Resident 1 if s/he smokes in room. Resident 1 acknowledged s/he did by nodding head up and down. Surveyor asked Resident 1 if s/he keeps smoking materials in room. Resident 1 acknowledged s/he did by nodding head up and down and then indicating	N 388		

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N 388	Continued From page 5 s/he kept them in a bed pocket located attached to the left siderail on the bed. Surveyor observed at least 3 more ecigarettes in the bed pocket. On 06/04/2025, at approximately 1:45 PM, Surveyor interviewed Administrator A. Administrator A acknowledged Resident 1 smoke in his/her room. Surveyor reviewed facility Smoking Policy with Administrator A. Administrator A acknowledged the smoking policy did not allow for smoking in the building and did not address the use of ecigarettes. Administrator A stated they will review the smoking policy and make corrections. Administrator A and Surveyor discussed Resident 1's ISP. Administrator A acknowledged the ISP did not indicate whether Resident 1 was safe or unsafe using ecigarettes in his/her room, staff did not ensure safe storage of smoking materials, and the ISP did not reflect an accurate facility smoking policy.	N 388		
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 did not ensure cleaning compounds and toxic substances were labeled and stored in a secure area. The facility is licensed as a Class CNA (non-ambulatory) CBRF to provide services for up to 15 residents who may be advanced aged, physically disabled, terminally ill, emotionally	N 499		

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N 499	Continued From page 6 disturbed/mental illness and/or have irreversible dementia and/or Alzheimer's. Findings include: On 06/04/2025 at approximately 9:45 AM, Surveyor conducted a tour of the facility. Surveyor observed a laundry room located in the hallway of resident rooms located to the left of the common space and main entrance. The laundry room door was unlocked and wide open. On the shelf to the left of the doorway, Surveyor observed 7 bottles of Purell/Germ X hand sanitizer, approximately 10 bottles of Pledge furniture polish, 1 container of Clorox disinfecting wipes, 4 cans of Microban sanitizing spray, 2 bottles of clorox toilet bowl cleaner, 1 can of Lysol disinfecting spray and 15 spray bottles of cleaning solutions. On 06/04/2025 at approximately 1:30 PM, Surveyor and Administrator A observed the laundry room unlocked and the door wide open. Surveyor interviewed Administrator A if the door should be open. Administrator A stated, "No, it should be closed all the time." Administrator A noted there was a resident who was found in the laundry room awhile back and should not have been in there. Administrator A stated that is why the door should also be closed and locked.	N 499		