STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 000	INITIAL COMMENTS On 11/09/2023, with information gathered through 11/22/2023, Surveyor conducted a standard licensure survey at Shay's Safe Haven. Nine deficiencies were identified. Census: 4	M 000		
M 284	88.05(3)(e)1 HEATING SYSTEM REQUIREMENTS The home shall have a heating system capable of maintaining a temperature of 74 degrees F. The temperature in habitable rooms shall not be permitted to fall below 70 degrees F. during periods of occupancy, except that the home may reduce temperatures during sleeping hours to 67 degrees F. Higher or lower temperatures, for certain residents, including but not limited to residents of advanced age and residents with physical disabilities, shall be provided to the extent possible when requested by a resident. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home's heating system was able to maintain a temperature of 74 degrees Fahrenheit (F). The temperature of the home was 68 degrees upon arrival. Findings include: On 11/09/2023, at approximately 10:30 AM, Surveyor arrived at the home and observed a	M 284		

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
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 284	Continued From page 1 sign hanging on the thermostat that read: "It is a requirement that the temperature remains at 68 Degrees. In the event that it is discovered to be Higher during your shift, an amount of $50.00 will be deducted from your paycheck." Surveyor also observed staff members walk in and out of the patio door which did not latch securely and continuously blew open, causing cooler air to blow through the home. On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated residents preferred the temperature to be cooler during sleeping hours. Administrator A stated s/he would ensure day shift temperatures were at 74 degrees F.	M 284		
M 310	88.05(3)(h)5 SPACE IN BEDROOMS A resident bedroom may accommodate no more than 2 persons. A resident bedroom shall have a floor area of at least 60 square feet per resident in shared bedrooms and 80 square feet in single occupancy rooms. For a person requiring a wheelchair, the bedroom space shall be 100 square feet for that resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 4 resident bedrooms had enough square footage (SF) for the non-ambulatory residents who resided in the room. Resident 1 and Resident 2, who both utilized	M 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 310	Continued From page 2	M 310		

wheelchairs, shared a bedroom with square footage of 184 SF. The space requirement for a resident using a wheelchair is 100 square feet of bedroom space per resident.

Findings include:

On 11/09/2023, at approximately 10:45 AM, Surveyor observed Resident 1's and Resident 2's bedroom. Resident 1 was sitting in his/her wheelchair and Resident 2 was in bed, with his/her wheelchair sitting at the foot of the bed. Surveyor observed the emergency exit diagram that detailed the room consisted of 184 SF.

On 11/20/2023, Surveyor reviewed the facility's department file. The facility was licensed on 06/29/2021, to serve up to 4 non-ambulatory residents. The floor plan on file, received on 06/07/2021, indicated Resident 1's and Resident 2's bedroom, identified as bedroom 1, contained 184 SF and would house 1 non-ambulatory resident and 1 ambulatory resident.

On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 was a short-term placement that became permanent. Administrator A stated that s/he was opening another facility and Resident 1 would transfer there.

On 11/22/2023, Surveyor reviewed Resident 1's record and determined that s/he had moved into the facility on 01/26/2023.

On 11/22/2023, Surveyor reviewed the Department facility file and determined that a temporary waiver had not been filed for two non-ambulatory residents to share a room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 310	Continued From page 3 smaller than 200 SF.	M 310		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 2 residents were evaluated, using the department's form, to determine s/he was able to evacuate the home without any help within 2 minutes. Resident 1 was assessed as a two-person assist and his/her fire safety evacuation plan documented him/her as a one-person assist. Findings include: On 11/09/2023, at approximately 11:30 AM, Surveyor observed two staff members assisting Resident 1 with personal cares. On 11/09/2023, Surveyor reviewed Resident 1's record. Resident 1 admitted to the home, 01/26/2023, with diagnosis including spastic quadriparesis.	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 344	Continued From page 4 Resident 1's individual service plan, dated 02/27/2023, documented: "Evacuation Capability in Emergency: Bed bound. Total assist in an emergency." "Physical Disabilities: Bed bound. Hoyer lift for transferring." Resident 1's "Care Card" documented: "Mobility/Transfers: 2 Staff" "Lift: Hoyer" Resident 1's "Resident Evacuation Assessment," dated 01/26/2023, documented: "Impaired Mobility: Needs Full Assistance - means the resident may require physical assistance from a staff member during most of the evacuation or the total time required for staff assistance and for the resident to evacuate the facility, is greater than the required evacuation time for the facility." "Need For Extra Staff: Needs Only One Staff - means there is no specific evidence that the resident needs help from two or more persons in a fire emergency." On 11/09/2023, Surveyor reviewed the provider's available 2023 fire drills which were dated 01/09/2023 and 02/08/2023. Resident 1 participated in the 02/08/2023 drill, which was conducted at 11:23 AM, by remaining in bed. On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would review Resident 1's evacuation assessment.	M 344		
M 386	88.06(2)(c) SERVICE AGREEMENT REQUIREMENTS	M 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 386	Continued From page 5 A service agreement shall specify all of the following: This Rule is not met as evidenced by: Based on record review and interview, the facility service agreement for 1 of 1 resident did not include the necessary elements required within the service agreement. Resident 1, who was his/her own person, did not sign the service agreement or the grievance procedure. The service agreement did not identify the monthly fee rates. Findings include: On 11/09/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/26/2023 and based on his/her "Resident Face Sheet," was his/her own person. Resident 1's "Resident Service Admission Agreement," dated 04/11/2023, did not contain a signature by Resident 1. The agreement documented: "The basic daily/monthly rate for services provided by [provider] is $ _____ per day/month $ _____. Residents or guardians will be notified in writing of changes or services." The receipt stating, "I have received and read the Resident Handbook provided to me by [provider], including information on the grievance procedure" was not signed by Resident 1.	M 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 386	Continued From page 6 Surveyor noted the provider's grievance procedure did not contain information on how to file a concern with the Department of Quality Assurance, Bureau of Assisted Living. On 11/09/2023, at approximately 11:30 AM, Surveyor asked Caregiver B if all resident documentation was in Resident 1's binder that had been provided to the Surveyor. Caregiver B stated, "As far as [s/he] knew." On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 is his/her own person and had difficulty signing his/her name. Administrator A stated a family member reviewed the document with Resident 1, but s/he did not have him/her sign the document. Surveyor reviewed Resident 1's record and did not find any documentation that outlined that Resident 1 had a resident representative.	M 386		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 4) Individual Service Plan (ISP) accurately identified current needs and abilities. Resident 4's ISP did not identify monitoring	M 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 410	Continued From page 7	M 410		

guidelines for his/her diagnosis of multiple sclerosis fatigue.

Findings include:

On 11/09/2023, Surveyor reviewed Resident 4's record.

Resident 4 moved into the home on 11/15/2021 with diagnosis including multiple sclerosis (MS).

Resident 4's October and November 2023 medication administration record (MAR) documented:
"Amphet/Dextr (Amphetamine and dextroamphetamine is a combination medicine) - Take ½ to 1 tablet by mouth twice daily as needed (PRN) for multiple sclerosis related fatigue."
Resident 4 was administered the medication on 10/17/2023 and 10/19/2023 at 9:00 AM. The MAR did not document if ½ a tablet or 1 tablet was administered. The MAR did not document why the medication was administered.

Resident 4's ISP, dated 12/15/2022, which contained no signatures from the resident and/or resident representative, the provider, or the placing agency, documented:
"Medications: Medications administered by CBRF (community-based residential facility) staff"
"Current Medications: Amphet/Dextr - MS fatigue"

Surveyor noted that Resident 4's ISP nor his/her MARs documented what the signs and symptoms were of MS fatigue and what guidelines needed to be met to determine medication dosage.

On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 410	Continued From page 8	M 410		

stated that Resident 4 was prescribed a PRN medication for MS fatigue, but his/her MARs and ISP did not identify the signs and symptoms to warrant the PRN administration and how much medication should be given. Administrator A stated s/he would review Resident 4's record.

"Fatigue and lassitude. People with MS can experience fatigue that is unrelated to having MS. ... Several different kinds of fatigue occur in people with MS. For example, people who have bladder dysfunction (producing night-time awakenings) or nocturnal muscle spasms, may be sleep deprived and experience fatigue as a result. People who are depressed may also have fatigue. Anyone who needs to expend considerable effort just to accomplish daily tasks (e.g., dressing, brushing teeth, bathing, preparing meals) may also experience additional fatigue as a result. In addition to these sources of fatigue, there is another kind of fatigue - referred to as "lassitude" - that is unique to people with MS. Lassitude or "MS fatigue" is different from other types of fatigue in that it: Generally occurs on a daily basis; May occur early in the morning, even after a restful night's sleep; Tends to worsen as the day progresses
Tends to be aggravated by heat and humidity; Comes on easily and suddenly; Is generally more severe than normal fatigue; Is more likely to interfere with daily responsibilities. MS-related fatigue does not appear to be directly correlated with either depression or the degree of physical impairment." (Source: National Multiple Sclerosis Society website, Fatigue and lassitude, 2023, https://www.nationalmssociety.org/Symptoms-Diagnosis/MS-Symptoms/Fatigue, (retrieval date - 11/22/2023).)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 424	Continued From page 9	M 424		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 resident's (Resident 1, Resident 2, Resident 3, Resident 4) Individual Service Plans (ISP) were reviewed at least once every six months by the licensee, the resident and/or resident's guardian, or the placing agency. Findings include: On 11/09/2023, Surveyor reviewed Resident 1, Resident 2's and Resident 3's record. Resident 1 moved into the home on 01/26/2023. Resident 1's record contained an ISP, dated	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 424	Continued From page 10	M 424		

02/27/2023, which contained no signatures from the resident and/or resident representative, the provider, or the placing agency.
Resident 1's ISP was due to be reviewed in 08/2023.
Resident 1's record contained a managed care organization Care Plan dated 07/29/2022 to 01/31/2023.

Resident 2 moved into the home on 01/21/2022.
Resident 2's record contained an ISP dated "upon admission," which contained no signatures from the resident and/or resident representative, the provider, or the placing agency.
Resident 2's ISP was due to be reviewed in 07/2022, 01/2023 and 07/2023.

Resident 3 moved into the home on 11/15/2021.
Resident 3s record contained an ISP, dated 11/15/2021, which contained no signatures from the resident and/or resident representative, the provider, or the placing agency.
Resident 3's ISP was due to be reviewed in 05/2022, 11/2022, 05/2023 and 11/2023.

Resident 4 moved into the home on 11/15/2021.
Resident 4's record contained an ISP, dated 12/15/2022, which contained no signatures from the resident and/or resident representative, the provider, or the placing agency.
Resident 4's ISP was due to be reviewed in 06/2023.
Resident 4's record contained a managed care organization Care Plan dated 05/01/2022 to 10/31/2022.

On 11/09/2023, at approximately 11:30 AM, Surveyor asked Caregiver B if the ISPs located in the resident binders that had been provided to the Surveyor were the ISPs that caregivers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 424	Continued From page 11 referenced. Caregiver B stated, "As far as [s/he] knew, the documentation was the most current." On 11/20/2023 at 1:07 PM, Surveyor emailed Administrator A verifying that the ISPs that were provided to the Surveyor on 11/09/2023, during the onsite survey, were the most current ISPs. On11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated all resident ISPs would be reviewed and signatures would be obtained.	M 424		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor 2 of 2 residents (Resident 1, Resident 4) health by referring them to a health care provider when experiencing a change of condition. Resident 1 experienced constipation for 4 days prior to a PRN (as needed) medication was administered and his/her catheter was plugged for 3 days prior to seeking emergency treatment. Resident 4 experienced constipation for 7 days with no documented treatments or communication with his/hr health care provider. Findings include:	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 448	Continued From page 12	M 448		

On 11/09/2023, Surveyor reviewed Resident 1's and Resident 4's record.

Example 1: Resident 1

Resident 1 moved into the facility, 01/26/2023, with diagnoses including spastic quadriparesis (cerebral palsy), neurogenic bladder (urinary condition), and ileus (gastrointestinal disorder).

Resident 1's "Resident Risk Declaration" documented:
"This resident has been assessed to be at risk for the following: constipation. The following precautions will be taken. See Attached Protocols."
Surveyor did not observe any attached protocols for constipation.

Resident 1's "Bowel Movement Record" did not document any bowel movements (BM) from 11/02/2023 at 11:00 AM until 11/07/2023 at 7:00 AM.

Resident 1's "Residential Daily Progress Report" documented:
"11/01/2023 5:00 AM to 1:00 PM - ... catheter is not working. [S/he's] waiting to hear from [his/her] doctor."
"11/01/2023 1:00 PM to 9:00 PM - ... catheter is not working ..."
"11/02/2023 1:00 PM to 9:00 PM - ... catheter is not working ..."
"11/03/2023 9:16 AM - ... catheter is clogged ..."
"11/03/2023 - ... around 3 [Resident 1] was then ready to go to the hospital due to [his/her] catheter so we called the ambulance ..."
"11/06/2023 - ... took a depository at [his/her] request and drank MiraLAX."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 448	Continued From page 13	M 448		

Resident 1's "Individual Service Plan (ISP)," dated 02/27/2023, documented:
"Controls own medication"
"Current Medications (for constipation): polyethylene glycol, simethicone, docusate sodium, bisacodyl."
"Toileting: supra pubic cath (catheter) Total Assist BM"

Example 2: Resident 4

Resident 4 moved into the facility, 11/15/2021, with diagnoses including multiple sclerosis.

Resident 4's "Bowel Movement Record" did not document any bowel movements (BM) from 11/02/2023 at 10:30 AM until 11/09/2023 (day of survey).

Resident 4's October and November 2023 medication administration record did not list a PRN constipation medication.

Resident 4's ISP, dated 12/15/2022, documented:
"Medication administered by CBRF (community-based residential facility) staff"
"Toileting: supra pubic catheter. Total w/BM"

On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Surveyor stated that Resident 1's and Resident 4's ISP did not outline constipation/catheter guidelines for caregivers. Administrator A stated every resident binder had additional documentation, not included in the ISP, for protocol regarding constipation and catheter care. Administrator A stated Resident 1 self-administered his/her medications and makes his/her own medical decisions. Surveyor explained that the provider is responsible for all resident health monitoring. Surveyor noted there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 448	Continued From page 14	M 448		

was no documented communication regarding how Resident 1 was informed that s/he should administer a PRN medication when s/he had experienced constipation and if follow up occurred with Resident 1's doctor regarding his/her catheter. Resident 1 went approximately 3 days with a clogged catheter. Surveyor stated Resident 4 does not have a PRN medication for constipation and his/her progress notes did not document any guidance on how his/her constipation was being addressed. Resident 4 had been documented as constipated for 7 days. Administrator A stated s/he would review the monitoring documentation that staff utilize and determine if each resident had a specific physician order.

"There is urine leaking around the catheter. This is called bypassing and happens when the urine cannot drain down the catheter. This will cause it to leak around the outside of the catheter. ... This could also indicate your catheter is blocked (see above). Go to your local emergency department immediately as the catheter may need to be changed. ... Avoid constipation." (Source: Department of Health - Western Australia, Troubleshooting for your catheter, 2017-2023, https://www.healthywa.wa.gov.au (retrieval date - November 21, 2023).)

Surveyor noted that Resident 1 had been experiencing constipation while his/her catheter was clogged.

"The normal length of time between bowel movements varies widely from person to person. Some people have them three times a day. Others have them just a few times a week. Going longer than 3 or more days without one, though, is usually too long. After 3 days, your

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 448	Continued From page 15 stool gets harder and more difficult to pass. What are the Symptoms? Few bowel movements: Trouble having a bowel movement (straining to go); Hard or small stools; A sense that everything didn't come out; Belly bloating. You also may feel like you need help to empty your bowels, such as pressing on your belly or using a finger to remove stool from your bottom." (Source: WebMD, What is Constipation, November 15, 2021, https://www.webmd.com/digestive-disorders/digestive-diseases-constipation (retrieval date - November 21, 2023).) "Constipation is a condition in which a person has uncomfortable or infrequent bowel movements. Generally, a person is considered to be constipated when bowel movements result in passage of small amounts of hard, dry stool, usually fewer than three times a week. ... The following are the most common symptoms of constipation ... Difficult and painful bowel movements, bowel movements fewer than three times a week, feeling bloated or uncomfortable, feeling sluggish, abdominal pain." (Source: Hopkins Medicine website, Constipation, 2022, https://www.hopkinsmedicine.org/health/conditions-and-diseases/constipation, (retrieval date - November 21, 2023).)	M 448		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner.	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 474	Continued From page 16 This Rule is not met as evidenced by: Based on observation and interview, the provider did not store food under sanitary conditions. Surveyor found food items in the refrigerator that were not properly sealed to avoid contamination. Surveyor found food packages stored in the dry food area that were exposed to toxic chemicals. Surveyor found food items that had expired. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses. Findings include: The licensee is able to serve up to 4 residents within the client groups of Emotionally Disturbed/Mental Illness, Developmentally Disabled, Physically Disabled, Alcohol/Drug Dependent, Terminally Ill, Advanced Aged, Irreversible Dementia/Alzheimer's and Traumatic Brain Injury. On 11/09/2023, at approximately 10:30 AM, Surveyor toured the home and observed the following: Refrigerator: -An opened package of what appeared to be hotdogs that was not dated. -A white plastic grocery bag wrapped around a food item that was not labeled or dated. -A clear plastic Ziploc baggy that had an item wrapped in what appeared to be paper toweling that was not labeled or dated. -A white paper bowel that was semi-covered in what appeared to be aluminum foil that was not labeled or dated. -A gray bowl that contained what appeared to be breakfast cereal with milk that was not securely sealed or dated.	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 474	Continued From page 17	M 474		

-(2) clear Ziploc baggy that had what appeared to be an onion that was not dated.
-A 2 pound container of vanilla yogurt that had a "Best By" date of 08/19/2023.

Pantry:
-An opened 24-ounce bottle of honey with a "Best By" date of 03/25/2023
-An opened container of seasoning that was not properly sealed.

Surveyor noted that when s/he walked into the pantry, a strong ammonia-like scent was detected. Surveyor observed the mop bucket that contained water and the mop sitting in the mop bucket. Surveyor noted there was a bag of hotdog buns, hamburger buns and loaves of bread sitting in the pantry that could absorb the ammonia scent into the food item.

"Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24-hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration (FDA) Food Code, 2022, Section 3-501.17)

"Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 474	Continued From page 18 for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3) On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated staff knew that the mop and mop bucket were to be stored in the hallway closet. Administrator A stated s/he would discuss with staff the importance of dating food items and verifying "best by" dates.	M 474		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by:	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 570	Continued From page 19	M 570		

Based on observation, record review, and interview, the provider did not safeguard residents from environmental hazards.
The provider's water temperature exceeded 115° Fahrenheit (F) at resident bathroom sink faucet.
The provider's cleaning compounds and toxic substances were not securely stored.
The provider did not ensure when resident is a point-of-rescue (POR) their bedrooms contained fire rated doors.

Findings include:

The licensee can provide cares for up to 4 residents in the client groups: traumatic brain injury, advanced aged, irreversible dementia/Alzheimer's, physically disabled, correctional clients, and developmentally disabled.

Example 1: Water Temperature

On 11/09/2023, at approximately 11:30 AM, Surveyor toured the environment. Surveyor tested the hot water temperatures at the residents' bathroom sink faucet which tempted at 132.1 °F.

Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA publication P-01942, Hot Water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 570	Continued From page 20 Temperatures in Adult Family Homes, 08/2017). On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would adjust the hot water heater. Example 2: Toxic Chemicals On 11/09/2023, at approximately 11:30 AM, Surveyor toured the environment. Surveyor observed the following cleaning compounds in the unsecured kitchen sink cabinet: - 32 fluid ounce bottle of glass cleaner - 3-quart bottle of multi-surface cleaner - pine scent - 21-ounce bottle of powder cleanser with bleach - 38-ounce jug of dishwashing liquid - 13-ounce spray can of oven cleaner - 19-ounce spray can of disinfectant spray - 30-ounce spray bottle of bathroom disinfecting cleaner On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated there is a lock on the cabinet and staff know they should utilize it. Example 3: Fire Doors On 11/09/2023, Surveyor reviewed the provider 2023 fire drills which documented: "01/09/2023 2:00 PM - [Resident 3] in bedroom door closed" "02/08/2023 11:23 AM - [Resident 1] in bed, room door closed. [Resident 3] in recliner, will notify EMT (emergency medical technician)." On 11/09/2023, at approximately 11:30 AM, Surveyor toured the home and noted that the	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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
M 570	Continued From page 21 resident bedrooms did not contain 20-minute fire-rated doors. On 11/09/2023, at approximately 11:30 AM, Surveyor interviewed Caregiver B. Caregiver B explained that if the residents were up in their wheelchairs, they would exit through a designated fire exit door. If the residents were in bed, the residents would remain in bed, their bedroom door would be closed, and the fire department would be notified due to all residents required a Hoyer lift. On 11/22/2023, at approximately 1:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he had been trained that bedbound residents could be left in their room if the bedroom door was closed and the fire department was notified. Administrator A stated s/he did not realize the bedroom doors needed to be a fire-rated door.	M 570		