STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018562	A. BUILDING: _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST HAVEN	208 EAST HAVEN WATERTOWN, WI 53094

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N 000	Initial Comments On 11/12/2025, Surveyors conducted an abbreviated survey at East Haven. Three deficiencies were identified. Census: 6	N 000		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation, interview, and record review the provider did not ensure non-licensed caregivers who administered medications via enteral and nebulizer were delegated by a registered nurse. Two of 2 caregivers reviewed administered medications via enteral (gastrointestinal tube (G-tube)) and nebulizer to Resident 1 without RN delegation. Findings include: On 11/12/25, at 7:19am, Surveyor observed Lead Caregiver-B prepare morning medications for residents. Surveyor observed Lead Caregiver-B take out 2 cups for Resident 1's medication preparation. Two tablet medications with water to dissolve, were put into one of the cups and 30 cc	N 416		

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

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N 416	Continued From page 1	N 416		

of Max Tussin was put into the other cup. 670 cc of water was put into a cylinder. Surveyor then observed as Lead Caregiver-B repositioned Resident 1 and got the g-tube ready by attaching a syringe. A water flush was completed. Then the Max Tussin was administered, followed by another flush. Next, the dissolved medications were poured through the syringe into the g-tube, followed by the remaining water to flush. Surveyor asked if placement is checked before administering medications and was told the nurse told them not to. Resident 1 has never dislodged the g-tube or had a problem.

Surveyor observed as Lead Caregiver-B set up the nebulizer treatment and applied the face mask over Resident 1's nose and mouth. Resident 1 was in a seated position and the nebulizer was flowing as it should through the mask. Lead Caregiver-B stated he/she would come back in 10 minutes to remove the mask after the treatment and Resident 1 shook head in acknowledgement.

On 11/12/2025, Surveyor reviewed Resident 1's record. S/he was admitted 06/21/2021. Physician orders included scheduled cetirizine 10 MG 1 tablet every morning for allergies, phenobarbital 64.8 MG 2 tablets every morning for seizures, and mucus/chest liquid (Max Tussin Mucus and Chest) 200/10 ML 30 ML twice daily to be administered via G-tube, and ipratropium/albuterol solution 1 vial twice daily to be administered via nebulizer.

November 2025 Medication Administration Record (MAR):
Lead Caregiver B documented s/he administered Resident 1's cetirizine 10 MG, phenobarbital 64.8 MG, mucus/chest liquid (Max Tussin Mucus +

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Chest) 200/10 ML, and ipratropium/albuterol solution at 8:00 AM on 11/04/2025, 11/06/2025, 11/08/2025, 11/09/2025, and 11/12/2025.

Caregiver C documented s/he administered mucus/chest liquid (Max Tussin Mucus + Chest) 200/10 ML and ipratropium/albuterol solution on 11/01/2025, 11/04/2025, 11/05/2025, 11/06/2025, 11/07/2025, 11/10/2025, and 11/11/2025 at 8:00 PM.

On 11/12/2025, Surveyors reviewed Lead Caregiver B and Caregiver C's employee records.

Example 1- Lead Caregiver B
Lead Caregiver B was hired 04/01/2021. His/her record did not contain evidence that RN delegation was completed for medication administration via enteral or nebulizer.

Example 2 -Caregiver C
Caregiver C was hired 06/30/2025. His/her record did not contain evidence that RN delegation was completed for medication administration via enteral or nebulizer.

On 11/12/2025 at 9:12 AM, Surveyor interviewed Lead Caregiver B who stated s/he was not a licensed practical nurse or registered nurse. Lead Caregiver B stated s/he completed RN delegation over 20 years ago and only received general medication administration training since then.

On 11/12/2025 at approximately 9:20 AM, Surveyors interviewed Service Coordinator A who verified Lead Caregiver B's and Caregiver C's initials (documenting medication administration) on Resident 1's November 2025 MAR. Service Coordinator A stated if Lead Caregiver B was not delegated by their current RN (RN D), then

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N 416	Continued From page 3 Caregiver C was not either. On 11/12/2025 at 10:15 AM, Surveyors discussed concern of no RN delegation with Service Coordinator A and Lead Caregiver B. Service Coordinator A verbalized an understanding of RN delegation and stated s/he would request RN delegation be completed as soon as possible with all staff who administered medications.	N 416		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was clean and homelike. The shower was not clean and Resident 1's padded shower chair seat was cracked. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 6 residents within the client groups of alcohol/drug dependent, physically disabled, traumatic brain injury, developmentally disabled, and emotionally disturbed/mental illness. On 11/12/2025 at 10:03 AM while touring home with Service Coordinator A, Surveyors observed	N 481		

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N 481	Continued From page 4 in the "shower bathroom": -Resident 1's shower chair's padded seat cushion's surface was cracked in several places with foam exposed (Photo 4). -The walk-in shower floor was coated with various shades of brown substance (Photo 5). -The bottoms of the shower curtain and its liner were discolored the entire width and approximately 5" high from the bottom with varying shades of brown (Photo 6). -The hollow bathroom door had a square shaped hole, measuring approximately 2 ½" x 2 ½" with exposed wood splinters (Photo 7). On 11/12/2025 at 10:08 AM, Surveyor interviewed Lead Caregiver B who stated Resident 1's shower chair was replaced approximately 2 years ago. Lead Caregiver B stated the new shower chair broke shortly after received, they started using the current shower chair again then and have been trying to get a new shower chair for some time. Lead Caregiver B stated the shower floor was soiled "for a long time", was to be cleaned after every shower, and s/he tried to clean it multiple times. Lead Caregiver B stated Resident 1 backed into the door with his/her electric wheelchair causing the hole. On 11/12/2025 at 10:15 AM, Surveyor discussed environmental concerns with Service Coordinator A and Lead Caregiver B. Service Coordinator A stated s/he would notify maintenance about the door, and follow-up on the shower chair, shower floor and curtain/liner.	N 481		

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N 523	Continued From page 5	N 523		
N 523	83.47(2)(b) Exit diagram. Exit diagram. The disaster plan shall have an exit diagram that shall be posted on each floor of the CBRF used by residents in a conspicuous place where it can be seen by the residents. The diagram shall identify the exit routes from the floor, including internal horizontal exits under par. (f) when applicable, smoke compartments or a designated meeting place outside and away from the building when evacuation to the outside is the planned response to a fire alarm. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 3 of 3 posted exit diagrams identified exit routes or emergency exits on the diagrams. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 6 residents within the client groups of alcohol/drug dependent, physically disabled, traumatic brain injury, developmentally disabled, and emotionally disturbed/mental illness. On 11/12/2025 at approximately 10:00 AM while touring home with Service Coordinator A, Surveyor observed 3 of 3 exit diagrams (near the front door, side door and bathroom). None of the 3 diagrams identified the exit route or emergency exit doors (Photos 1, 2 and 3). On 11/12/2025 at 10:03 AM, Surveyor interviewed Lead Caregiver B who stated s/he drew composed the exit diagrams and forgot to include the routes and emergency exit doors.	N 523		

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N 523	Continued From page 6 On 11/12/2025 at 10:15 AM, Surveyor discussed concern with emergency exit diagrams with Service Coordinator A and Lead Caregiver B. Lead Caregiver B stated s/he would fix the diagrams right away.	N 523		