STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017522	A. BUILDING: _____ B. WING _____	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTLER HOUSE	12605 W COURTLAND AVE 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
N 000	Initial Comments On 07/19/2024, Surveyor conducted a standard survey and a complaint investigation. Four deficiencies were identified. One of the 4 deficiencies was a repeat violation. See Statement Of Deficiency (SOD) 0OH711, dated 02/24/2023 and SOD 0OH712, dated 07/13/2023. The complaint was substantiated. Census: 8	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the resident's right to receive medication in the dosage and at intervals as ordered by the prescriber. Due to no staff on duty from 6:05 PM on 05/12/2024 to 7:00 AM on 05/13/2024, 8 of 8 residents reviewed did not receive prescribed evening medications on 05/12/2024 PM. Findings include: The facility is licensed as a Class CNA	N 352		

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

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N 352	Continued From page 1 (nonambulatory) CBRF able to serve up to 8 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, physically disabled, terminally ill, advanced age, alcohol/drug dependent, correctional clients, traumatic brain injury and irreversible dementia/Alzheimer's. On 05/13/2024, the Department received a complaint regarding medications. On 07/19/2024 at 9:46 AM, Surveyor interviewed Administrator A who stated on 05/12/2024, Agency Caregiver B was scheduled to work 8:30 AM to 3:00 PM. Administrator A stated on 05/12/2024 at 12:48 PM, s/he contacted the agency requesting a PM caregiver for 05/12/2024 because the PM facility caregiver called in. Administrator A stated on 05/12/2024 at 2:20 PM, the agency contacted him/her stating Agency Caregiver B would stay until the agency found coverage for the PM shift. Administrator A stated s/he assumed Agency Caregiver B was staying for the entire PM shift as s/he had not heard further from the agency. Administrator A stated according to outside cameras, Agency Caregiver B left the facility on 05/12/2024 at 6:05 PM. Administrator A stated Caregiver C contacted him/her at 7:00 AM on 05/13/2024 AM shift and reported there was no staff at the facility. Administrator A stated after Agency Caregiver B left, there was no staff until 7:00 AM because the facility night shift caregiver was a no call/no show. Administrator A stated residents had not received their 8:00 PM medications on 05/12/2024. Administrator A stated the expectation was 24/7 staff coverage. On 07/19/2024 at 10:09 AM, Surveyor interviewed Resident 3 who stated on 05/12/2024	N 352		

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N 352	Continued From page 2	N 352		

there was no staff there and s/he did not receive his/her medications.

On 07/19/2024 at 10:12 AM, Surveyor interviewed Caregiver C who stated when s/he arrived for his/her AM shift on 05/13/2024 there was no staff at the facility. Caregiver C stated s/he immediately checked on all the residents, and they were fine and s/he notified Administrator A.

On 07/22/2024 7:10 PM, Surveyor received Medication Administration Records (MAR), on 07/19/2024 10:34 AM, received resident face sheets, on 07/21/2024 at 7:35 PM and 07/22/2024 at 9:46 AM received resident individual service plans (ISP) from Administrator A via email.

On 07/23/2024, Surveyor reviewed the resident records.

Example 1- Resident 1
Resident 1 was admitted 08/05/2022. Diagnoses included: unspecified dementia and hallucinations.

Scheduled physician ordered medications included: Serevent Discus 50mcg Aer inhale 1 puff into the lungs twice a day for asthma (start date:09/07/2023); risperidone 0.5 MG 1 tablet twice daily for hallucinations and anxiety/depression (start date 08/11/2023); gabapentin 600 MG 1 tablet 3 times daily for nerve pain (start date: 01/30/2024); famotidine 20 MG 1 tablet twice daily for GERD (start date: 08/11/2023); Desitin 13% Cream apply to rash area after cleansing and pat dry 2-3 times daily until healed (start date: 08/06/2022); and Pulmicort Flexhaler IN 90 MCG inhale 2 puffs into

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N 352	Continued From page 3 the lungs twice daily for chronic obstructive pulmonary disease (start date 01/16/2024). May 2024 MAR: No documentation of administration of 05/12/2024 8:00 PM Serevent Discus, risperidone, gabapentin, Gamotidine, Pulmicort Flexhaler, or application of Desitin cream. ISP dated 09/10/2023: In the area of Medication Management: " ...Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]." Example 2- Resident 2 Resident 2 was admitted 10/28/2021. Diagnoses included traumatic brain injury. Scheduled physician ordered medications included: atorvastatin 40 MG 1 tablet at bedtime for hyperlipidemia (start date: 03/10/2024); Eliquis 5 MG 1 tablet twice daily for pulmonary embolism/atrial fibrillation (start date: 11/28/2023); melatonin 3 MG 2 tablet at bedtime for insomnia (start date: 11/27/2023); Nyamyc 100MU/GM powder apply topically to affected area of lower abdomen twice daily (start date: 05/14/2024) and trazadone 100 MG 1 tablet at bedtime (start date: 03/12/24). May 2024 MAR: No documentation of administration of 05/12/2024 8:00 PM Atorvastatin, Eliquis, melatonin, Nyamyc powder, or trazadone.	N 352		

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N 352	Continued From page 4 ISP dated 11/01/2023: In the area of Medication Management: " ...Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]." Example 3-Resident 3 Resident 3 was admitted 04/07/2023. Diagnoses included: diffuse traumatic brain injury. Scheduled physician ordered medications included: baclofen 10 MG 1 tablet at bedtime (start date: 08/17/2023); buspirone 15 MG 1 tablet twice daily for anxiety (start date: 08/17/2023); divalproex 250 MG 1 tablet 3 times daily for psychosis (start date: 05/03/2023); tamsulosin 0.4 MG 1 capsule after supper for BPH (start date: 08/17/2023); halobetasol 0.05% cream apply topically to the affected area twice daily for dermatitis (start date: 08/18/2023); Aspercreme 4% lido cream apply to affected knee four times daily (start date: 08/18/2023); and ketoconazole 2% cream apply topically to affected area twice daily (start date: 08/14/2023). May 2024 MAR: No documentation of administration of 05/12/2024 8:00 PM baclofen, buspirone, divalproex, tamsulosin, or application of halobetasol cream, Aspercreme, or ketoconazole cream. ISP dated 09/21/2023: In the area of Medication Management: " ...Resident is unable to safely manage his/her own medications. Staff administer all medications	N 352		

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N 352	Continued From page 5	N 352		

prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]."

Example 4- Resident 4
Resident 4 was admitted 04/07/2023. Diagnoses included mild cognitive impairment of uncertain or unknown etiology; and cognitive, social, or emotional deficit following cerebral infarction. Scheduled physician ordered medications included mirtazapine 7.5 MG 1 tablet at bedtime (start date: 08/08/2023).

May 2024 MAR:
No documentation of administration of 05/12/2024 8:00 PM mirtazapine.

ISP dated 04/01/2024:
In the area or Medication Management: "
...Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]."

Example 5- Resident 5
Resident 5 was admitted 05/23/2022. Diagnoses included unspecified intracranial injury.

Scheduled physician ordered medications included: clonazepam 1 MG 1 tablet at bedtime (start date: 03/05/2024); fluticasone 50 MCG Spray 1 spray in each nostril daily (01/25/2024); bepotastine 1.5% instill 1 drop in both eyes twice daily (start date: 01/25/2024); and Restasis 0.05% EMU instill 1 drop in both eyes twice daily

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N 352	Continued From page 6 (01/25/2024). May 2024 MAR: No documentation of administration of 05/12/2024 8:00 PM clonazepam, fluticasone, bepotastine drops or Restasis drops. ISP dated 05/04/2024: In the area of Medication Management- " ...Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]." Example 6- Resident 6 Resident 6 was admitted 04/26/2023. Diagnoses included: major depressive disorder, recurrent, unspecified; developmental disorder of scholastic skills, unspecified; and epilepsy. Scheduled physician ordered medications included: acetaminophen 500 MG 1 tablet 3 times daily (start date: 11/28/2023); benztropine 0.5 MG 1 tablet twice daily for dementia (start date: 06/13/2023); Comperm LFD (compression bandage) on every morning and off every night at bedtime (start date: 04/25/2023); divalproex 500 MG ER 2 tablets at bedtime for seizures (start date: 02/01/2024); donepezil 10 MG 1 tablet at bedtime for dementia (start date: 06/12/2023); risperidone 1 MG 1 ½ tablets (1.5 MG) twice daily for mood disorder (start date: 01/08/2024); tamsulosin 0.4 MG 1 capsule at bedtime (start date: 12/11/2023); and Systane Ultra Solution 1 drop in affected eye(s) twice daily for dry eyes (start date: 02/26/2024).	N 352		

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N 352	Continued From page 7 May 2024 MAR: No documentation of administration of 05/12/2024 8:00 PM acetaminophen, benztropine, divalproex, donepezil, risperidone, tamsulosin, and Systane Ultra Solution drops or application Comperm LFD (compression bandage). ISP dated 04/01/2024: In the area of Medication Management: " ...Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]." Example 7- Resident 7 Resident 7 was admitted 03/25/2024. Diagnoses included Asperger's syndrome. Scheduled physician ordered medications included buspirone15 MG 1 tablet twice daily (start date: 06/12/2024). May 2024 MAR: No documentation of administration of 05/12/2024 8:00 PM buspirone. ISP dated 04/01/2024: In the area of Medication Management- " ... Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]."	N 352		

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N 352	Continued From page 8 Example 8- Resident 8 Resident 8 was admitted 10/26/2021. Diagnoses included residual schizophrenia. Scheduled physician ordered medications included: melatonin 5 MG 1 tablet at bedtime (start date: 03/28/2024) and trazadone 100 MG 1 tablet at bedtime (start date: 06/02/2024). May 2024 MAR: May 2024 MAR: No documentation of administration of 05/12/2024 8:00 PM trazadone and melatonin. ISP dated 01/01/2023: In the area of Medication Management- " ... Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]." General facility note dated 05/13/2024 at 7:45 AM by Caregiver C- "Observation for Butler House: Upon my arrival, I noticed staff there were no staff in the home. I walked around and to ensure all residents were in their rooms and accounted for. I contacted administration to notify [him/her] of this. I noticed that 8pm [sic] medications were not passed out from yesterday. I asked residents if they were okay and how their night went. They told me that staff left yesterday night at around 7pm [sic] and didnt [sic] get their medications. They all said they went to bed around 7pm [sic] and woke up when I came in to check on them." On 07/24/2024 at 12:25 PM, Surveyor discussed concern of residents not receiving PM medications on 05/12/2024 with Administrator A.	N 352		

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N 352	Continued From page 9 Administrator A stated all 8 residents were at the facility during the PM shift on 05/12/2024. Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow Individual Service Plan N0397 DHS 83.36(1)(b) Qualified Staff On Duty and Awake	N 352		
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 record review and interview, the provider did not ensure the individual service plans were followed as written for 8 of 8 residents reviewed. Supervision and cares identified on the individual service plans (ISP) were not provided when staff were not present at the facility from 6:05 PM on 05/12/2024 to 7:00 AM on 05/13/2024 including: supervision and wellness checks; medication administration; cues/assistance with dressing, toothbrushing and toileting; incontinence care; fall prevention; and monitoring for potential seizures, behaviors, and leaving the home unattended. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 8 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, physically disabled, terminally ill, advanced age, alcohol/drug	N 388		

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dependent, correctional clients, traumatic brain injury and irreversible dementia/Alzheimer's.
On 05/13/2024, the Department received a complaint regarding staffing.

On 07/19/2024 at 9:46 AM, Surveyor interviewed Administrator A who stated on 05/12/2024, Agency Caregiver B was scheduled to work 8:30 AM to 3:00 PM. Administrator A stated on 05/12/2024 at 12:48 PM, s/he contacted the staffing agency requesting a PM caregiver for 05/12/2024 due to PM facility caregiver calling in. Administrator A stated on 05/12/2024 at 2:20 PM, the agency informed him/her that Agency Caregiver B would stay until they secured coverage for the PM shift. Administrator A stated s/he assumed Agency Caregiver B was staying for the entire PM shift as s/he had not heard further from the agency. Administrator A stated according to outside cameras, Agency Caregiver B left the facility on 05/12/2024 at 6:05 PM. Administrator A stated Caregiver C notified him/her at 7:00 AM on 05/13/2024 of no night shift staff at the facility. Administrator A stated the facility night shift caregiver did not show up for the 05/12/2024 night shift. Administrator A stated residents did not receive their 8:00 PM medications on 05/12/2024. Administrator A stated the expectation and goal is 24/7 staff coverage.
On 07/19/2024 at 10:09 AM, Surveyor interviewed Resident 3 who stated on 05/12/2024 there was no staff there and s/he did not receive his/her medications.

On 07/19/2024 at 10:12 AM, Surveyor interviewed Caregiver C who stated when s/he arrived for his/her AM shift on 05/13/2024 there was no staff at the facility. Caregiver C stated s/he immediately checked on all the residents,

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and they were fine and s/he notified Administrator A.

On 07/22/2024 7:10 PM, Surveyor received Medication Administration Records (MAR), on 07/19/2024 10:34 AM, received resident face sheets, on 07/21/2024 at 7:35 PM and 07/22/2024 at 9:46 AM received resident individual service plans (ISP) from Administrator A via email.

On 07/23/2024, Surveyor reviewed records of Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8.

Example 1- Resident 1
Resident 1 was admitted 08/05/2022. Diagnoses included: unspecified dementia and hallucinations. Resident remained his/her own health care decision maker and was a FULL CODE (full code includes CPR and everything possible to save a person's life if the person is not breathing and has no heartbeat).

ISP dated 09/01/2023:
" ...SUPERVISION WHILE IN THE HOME ...is unable to be in the home without proper supervision. AHC provides 24 hour awake staff to ensure that resident is never in the home unsupervised ...DRESSING - Assist Resident with choosing proper attire and with assist with dressing/undressing. Schedule: Daily@ 8:00 AM, Bed Time [sic], As Needed ...Resident needs assistance with getting dressed and undressed each morning and night and as needed ensuring resident is clean and presentable during the day and in comfortable attire at bedtime ...ORAL CARE ...needs some verbal cues to brush teeth properly ...Daily@ 8:00 AM, 8:00 PM Current

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N 388	Continued From page 12 Status:...needs some verbal assistance with brushing [his/her] teeth ...Still needs verbal cues to brush [his/her] teeth ...BOWEL MOVEMENT MONITORING ...Monitor and document their bowel movement ...Daily@...10:30 PM, As Needed ...If Resident does not have a bowel movement in 3 days, staff will notify administration ...2 HOUR TOILET CHECK ...Follow Resident toileting schedule and assist in toileting every 2 hours and as needed ...Daily@ 12:30 AM, 2:30 AM, 4:30 AM, 6:30 AM ...6:30 PM, 8:30 PM, 10:30 PM ...[Resident 1] does have incontinence of BM and urine at times. Staff should check [him/her] every two hours to see if [s/he] is soiled or needs to use the bathroom ...TOILETING ...is incontinent at times and needs some assistance with cleaning up after having incontinence ...[S/He] does use the bathroom a majority of the time independently ...MEDICATION MANAGEMENT ...is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident ...WELLNESS CHECK/ROUNDS Staff are to check on resident to ensure wellness and safety as well as their whereabouts. Ask the resident how they are doing, ask if they need anything etc ...Daily @ 12:30 AM, 2:30 AM, 4:30 AM, 6:30 AM ...6:30 PM, 8:30 PM, 10:30 PM ...FALL RISK ...has a history of falls. Resident needs to be monitored and assisted to ensure falls do not occur ..." Example 2- Resident 2 Resident 2 was admitted 10/28/2021. Diagnoses included traumatic brain injury. Resident 2 had an activated Power of Attorney for Health Care document and was a FULL CODE.	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017522	A. BUILDING: _____ B. WING _____	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTLER HOUSE	12605 W COURTLAND AVE BUTLER, WI 53007

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N 388	Continued From page 13 ISP dated 11/01/2023: " ...General Questions ...Staff to administer medications ...SUPERVISION WHILE IN THE HOME ...is unable to be left in the home at anytime [sic] unsupervised ...Due to [his/her] cognitive delay, [s/he] is unable to make appropriate decisions should [s/he] be left in the home without supervision ...DRESSING - PARTIAL ASSISTANCE ...tends to wear the same clothes day in and day out. [S/He] needs to be reminded to change into clean clothes ...Daily@ 8:00 AM, Bed Time [sic] ...[S/He] needs verbal cues and sometimes partial assistance to remove dirty clothes and put clean clothes on ...ORAL CARE ...needs verbal cues to brush [his/her] teeth twice per day. At times, staff may need to set up this task for him ...Daily@ 8:00 AM, Bed Time [sic] ...WELLNESS CHECK/ROUNDS ...Staff are to check on resident to ensure wellness and safety as well as their whereabouts ...Daily@ 1:00 AM, 3:00 AM, 5:00 AM, 7:00 AM ...7:00 PM, 9:00 PM, 11:00 PM ..." Example 3- Resident 3 Resident 3 was admitted 09/01/2021. Diagnoses included: diffuse traumatic brain injury. Resident 3 was under guardianship and was a FULL CODE. ISP dated 9/21/2023: " ...SUPERVISION WHILE IN THE HOME ...Current Status: is unable to be left in the home without staff supervision for [his/her] health and safety ...Unable to leave the home unsupervised ...At times [s/he] will ask if [s/he] and another resident can go to the gas station. [S/He] should be gently reminded that [s/he] is unable to be out in the community without supervision ...DRESSING ...Daily@ 8:00 AM, Bed Time[sic], ,	N 388		

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N 388	Continued From page 14 As Needed ...will ask for assistance due to being sore or tired ...needs prompts to change into pajamas ...Due to [his/her] unsteady gait, staff need to ensure that [s/he] putting [his/her] clothes on properly without falling ...ORAL CARE ...needs verbal prompts to brush [his/her] teeth twice daily ...needs staff assistance to brush thoroughly ...Schedule: Daily@ 8:00 AM, Bed Time[sic], As Needed...BOWEL MOVEMENT MONITORING ...Monitor and document their bowel movement. Schedule: Daily@...10:30 PM, As Needed ...TOILETING ...is only incontinent during sleep hours. Staff toilet check [Resident 3] every 2 hours during sleep hours asking [him/her] if [s/he] needs to use the bathroom, and to check and see if [s/he] is incontinent ...Daily@ 8:00 PM, 10:00 PM, 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM ...MEDICATION MANAGEMENT ... is unable to manage [his/her] own medication. All medications are locked in the medication cart and administered by staff at scheduled medication pass and PRN. ...WELLNESS CHECK/ROUNDS ...check on resident to ensure wellness and safety as well as their whereabouts ...Daily@ 1:00 AM, 3:00 AM, 5:00 AM, 7:00 AM, ...7:00 PM, 9:00 PM, 11:00 PM ...FALL RISK ... due to [his/her] unsteady gait ...[S/He] needs to be reminded that [s/he] should walk slow with [his/her] walker and ensure [s/he] is paying attention to things around [him/her]. At times [s/he] may lose [his/her] balance and fall. [S/He] should be wearing proper foot wear [sic] while walking. [S/He] should always have at least stand by assistance when transferring ...SEIZURE ACTIVITY ...Resident has a seizure disorder or has a history of seizures. Document seizures in a seizure report and call Administration immediately. Should a seizure last longer than 2 minutes and/or member hits head or is injured during a seizure, Ambulance must be contacted ...	N 388		

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N 388	Continued From page 15 AGGRESSIVE/COMBATIVE ...has a history of being physically and mentally abusive to others ...such as insulting others by calling them names, swearing at them, shouting racial slurs etc ...is easy to re-direct depending on approach of staff and others ..." Example 4- Resident 4 Resident 4 was admitted 04/07/2023. Diagnoses included anxiety disorder, unspecified; mild cognitive impairment of uncertain or unknown etiology; and cognitive social or emotional deficit following cerebral infarction. Resident 4 had an activated Power of Attorney for Health Care and was a FULL CODE. ISP dated 04/01/2024: " ...SUPERVISION WHILE IN THE HOME ...is unable to be in the home without proper supervision. AHC [Absolute Home Care LLC] provides 24 hour awake staff to ensure that resident is never in the home unsupervised ...DRESSING - ASSISTANCE ...Assist Resident [sic] with choosing proper attire and with assist with dressing/undressing ...Daily@ 8:00 AM, Bed Time [sic], As Needed Current Status: Resident needs assistance with getting dressed and undressed each morning and night and as needed ensuring resident is clean and presentable during the day and in comfortable attire at bedtime ...MEDICATION MANAGEMENT- ...Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic] ...WANDERING/ELOPEMENT - SUPERVISION ...Provide supervision and redirection to avoid	N 388		

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and prevent wandering episodes ... Daily@ As Needed ...[S/He] typically wants to go out into the community to go to the gas station, however, does not elope. [S/He] is not competent enough to understand where to come back to should [s/he] get lost ...WELLNESS CHECK/ROUNDS ...Staff are to check on resident to ensure wellness and safety as well as their whereabouts ...Daily@ 12:30 AM, 2:30 AM, 4:30 AM, 6:30 AM ...6:30 PM, 8:30 PM, 10:30 PM Current Status: Staff do rounds at least every 2 hours to ensure wellness and safety as well as his/her whereabouts ..."

Example 5-Resident 5
Resident 5 was admitted 05/23/2022. Diagnoses included unspecified intracranial injury. S/he remained his/her own health care decision maker and was a FULL CODE.

ISP dated 05/04/2024: " ...SUPERVISION WHILE IN THE HOME ...is unable to be in the home without proper supervision. AHC provides 24 hour awake staff to ensure that resident is never in the home unsupervised ...MEDICATION MANAGEMENT - ... Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]. ...WELLNESS CHECK/ROUNDS ...Staff are to check on resident to ensure wellness and safety as well as their whereabouts ...Daily@ 12:30 AM, 2:30 AM, 4:30 AM, 6:30 AM ...6:30 PM, 8:30 PM, 10:30 PM ...
Current Status: Staff do rounds at least every 2 hours to ensure wellness and safety as well as his/her whereabouts ..."

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N 388	Continued From page 17 Example 6- Resident 6 Resident 6 was admitted 04/26/2023. Diagnoses included: major depressive disorder, recurrent, unspecified; developmental disorder of scholastic skills, unspecified; and epilepsy. Resident 6 was under guardianship and was a FULL CODE. ISP dated 04/01/2024: " ...SUPERVISION WHILE IN THE HOME ...is unable to be in the home without proper supervision. AHC provides 24 hour awake staff to ensure that resident is never in the home unsupervised ...ORAL CARE - ...sometimes [s/he] needs verbal cues to start this task ...Daily@ 8:00 AM, 8:00 PM ...2 HOUR TOILET CHECK ...Follow Resident's [sic] toileting schedule and assist in toileting every 2 hours and as needed. Change [his/her] brief as needed ...Daily@ 12:30 AM, 2:30 AM, 4:30 AM, 6:30 AM ...6:30 PM, 8:30 PM, 10:30 PM ...BOWEL MOVEMENT MONITORING ...Monitor and document their bowel movement. Schedule: Daily@ 6:30 AM ...10:30 PM, As Needed ...MEDICATION MANAGEMENT ... Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic] ...WELLNESS CHECK/ROUNDS ...Staff are to check on resident to ensure wellness and safety as well as their whereabouts ...Daily @ 12:30 AM, 2:30 AM, 4:30 AM, 6:30 AM ...6:30 PM, 8:30 PM, 10:30 PM ..." Example 7- Resident 7 Resident 7 was admitted 03/25/2024. Diagnoses included Asperger's syndrome. Resident was his/her own health care decision maker and was	N 388		

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N 388	Continued From page 18 a FULL CODE. ISP dated 04/01/2024: " ...SUPERVISION WHILE IN THE HOME ...is unable to be in the home without proper supervision. AHC provides 24 hour awake staff to ensure that resident is never in the home unsupervised ...MEDICATION MANAGEMENT - ... Resident is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications without staff administering them to Resident [sic]. WELLNESS CHECK/ROUNDS ...Staff are to check on resident to ensure wellness and safety as well as their whereabouts ...Daily@ 12:30 AM, 2:30 AM, 4:30 AM, 6:30 AM ...6:30 PM, 8:30 PM, 10:30 PM ..." Example 8- Resident 8 Resident 8 was admitted 10/26/2021. Diagnoses included residual schizophrenia. S/he remained his/her own health care decision maker and was a FULL CODE. ISP dated 10/01/2023: " ...SUPERVISION WHILE IN THE HOME ...is unable to be in the home without proper supervision. AHC provides 24 hour awake staff to ensure that resident is never in the home unsupervised. DRESSING - Assist Resident [sic] with choosing proper attire and with assist with dressing/undressing ...Daily@ 8:00 AM, Bed Time [sic], As Needed ...MEDICATION MANAGEMENT ...is unable to safely manage his/her own medications. Staff administer all medications prescribed to him/her as scheduled and PRN. Medications are locked up in the medication cart and resident is unable to access the medications	N 388		

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N 388	Continued From page 19 without staff administering them to Resident [sic] ...WELLNESS CHECK/ROUNDS ...Staff are to check on resident to ensure wellness and safety as well as their whereabouts ...Daily@ 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM, 5:00 AM, 6:00 AM ...6:00 PM, 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM, 11:00 PM ..." General facility note dated 05/13/2024 at 7:45 AM by Caregiver C- "Observation for Butler House: Upon my arrival, I noticed staff there were no staff in the home. I walked around and to ensure all residents were in their rooms and accounted for. I contacted administration to notify [him/her] of this. I noticed that 8pm [sic] medications were not passed out from yesterday. I asked residents if they were okay and how their night went. They told me that staff left yesterday night at around 7pm [sic] and didnt [sic] get their medications. They all said they went to bed around 7pm [sic] and woke up when I came in to check on them." On 07/24/2024 at 12 12:26 PM, Surveyor discussed concern of ISPs not followed as written with Administrator A. Administrator A stated staff were to provide 2-hour checks on each resident. Administrator A stated all 8 residents were at the facility during the PM and Night shifts on 05/12/2024. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0397 DHS 83.36(1)(b) Qualified Staff On Duty and Awake	N 388		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake.	N 397		

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N 397	Continued From page 20 The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure at least 1 qualified resident care staff was present in the facility when 1 or more residents were in need of 24-hour supervision, had intermittent physical condition that may become critical at any time or intermittent agitated episodes, were at risk for leaving facility unattended, or who had a diagnosis of dementia. On 05/12/2024, residents were left alone at the facility from 6:05 PM on 05/12/2024 to 7:00 AM on 05/13/2024. Findings include:	N 397		

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N 397	Continued From page 21 The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 8 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, physically disabled, terminally ill, advanced age, alcohol/drug dependent, correctional clients, traumatic brain injury and irreversible dementia/Alzheimer's. On 05/13/2024, the Department received a complaint regarding medications. On 07/19/2024 at 9:46 AM, Surveyor interviewed Administrator A who stated on 05/12/2024, Agency Caregiver B was scheduled to work 8:30 AM to 3:00 PM. Administrator A stated on 05/12/2024 at 12:48 PM, s/he contacted the agency requesting a PM caregiver for 05/12/2024 because the PM facility caregiver called in. Administrator A stated on 05/12/2024 at 2:20 PM, the agency contacted him/her stating Agency Caregiver B would stay until the agency found coverage for the PM shift. Administrator A stated s/he assumed Agency Caregiver B was staying for the entire PM shift as s/he had not heard further from the agency. Administrator A stated according to outside cameras, Agency Caregiver B left the facility on 05/12/2024 at 6:05 PM. Administrator A stated Caregiver C contacted him/her at 7:00 AM on 05/13/2024 AM shift and reported there was no staff at the facility. Administrator A stated after Agency Caregiver B left, there was no staff until 7:00 AM because the facility night shift caregiver was a no call/no show. Administrator A stated residents had not received their 8:00 PM medications on 05/12/2024. Administrator A stated the expectation was 24/7 staff coverage. On 07/19/2024 at 10:09 AM, Surveyor	N 397		

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interviewed Resident 3 who stated on 05/12/2024 there was no staff there and s/he did not receive his/her medications.

On 07/19/2024 at 10:12 AM, Surveyor interviewed Caregiver C who stated when s/he arrived for his/her AM shift on 05/13/2024 there was no staff at the facility. Caregiver C stated s/he immediately checked on all the residents, and they were fine and s/he notified Administrator A.

On 07/22/2024 7:10 PM, Surveyor received Medication Administration Records (MAR), on 07/19/2024 10:34 AM, received resident face sheets, on 07/21/2024 at 7:35 PM and 07/22/2024 at 9:46 AM received resident individual service plans (ISP) from Administrator A via email.

On 07/23/2024, Surveyor reviewed the resident records.

On 07/23/2024, Surveyor reviewed records of Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8.

Example 1- Resident 1
Resident 1 was admitted 08/05/2022. Diagnoses included: unspecified dementia and hallucinations. Resident remained his/her own health care decision maker and was a FULL CODE (full code includes CPR and everything possible to save a person's life if the person is not breathing and has no heartbeat).

Individual Service Plan (ISP) dated 09/01/2023 (summarized):
Resident 1's ISP identified that s/he required

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N 397	Continued From page 23 24-hour supervision, wellness checks every 2 hours, assistance with medication administration, dressing, oral care and toileting every 2 hours. Example 2- Resident 2 Resident 2 was admitted 10/28/2021. Diagnoses included traumatic brain injury. Resident 2 had an activated Power of Attorney for Health Care document and was a FULL CODE. ISP dated 11/01/2023 (summarized): Resident 2's ISP identified that s/he required 24-hour supervision due to inability to make appropriate decisions independently related to cognitive delay, wellness checks every 2 hours, medication administration, and reminders for dressing and brushing teeth. Example 3- Resident 3 Resident 3 was admitted 09/01/2021. Diagnoses included: diffuse traumatic brain injury. Resident 3 was under guardianship and was a FULL CODE. ISP dated 9/21/2023 (summarized): Resident 3's ISP identified that s/he required: 24-hour supervision; monitoring for seizures, verbal/physical behaviors toward other residents, going into the community unsupervised, and incontinence; verbal prompts to change into pajamas; verbal prompts and staff assistance to brush teeth; monitoring for physical and verbal aggression toward other residents, and monitoring for seizures and emergency response for seizure lasting greater than 2 minutes. Example 4- Resident 4 Resident 4 was admitted 04/07/2023. Diagnoses included mild cognitive impairment of uncertain or unknown etiology; and cognitive social or	N 397		

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emotional deficit following cerebral infarction. Resident 4 had an activated Power of Attorney for Health Care and was a FULL CODE.

ISP dated 04/01/2024 (summarized): Resident 4 required 24-hour supervision, assistance with medication administration and dressing/undressing, monitoring and redirection to prevent any wandering episodes out into the community, and wellness checks every 2 hours.

Example 5-Resident 5
Resident 5 was admitted 05/23/2022. Diagnoses included unspecified intracranial injury. S/he remained his/her own health care decision maker and was a FULL CODE.

ISP dated 05/04/2024 (summarized): Resident 5 required 24-hour supervision, assistance with medication administration, and wellness checks every 2 hours.

Example 6- Resident 6

Resident 6 was admitted 04/26/2023. Diagnoses included: major depressive disorder, recurrent, unspecified; developmental disorder of scholastic skills, unspecified; and epilepsy. Resident 6 was under guardianship and was a FULL CODE.

ISP dated 04/01/2024 (summarized): Resident 6 required 24-hour supervision, assistance medication administration, toileting/changing his/her brief as needed every 2 hours, and wellness checks every 2 hours.

Example 7- Resident 7
Resident 7 was admitted 03/25/2024. Diagnoses included Asperger's syndrome. Resident was his/her own health care decision maker and was

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	0017522	A. BUILDING: _____ B. WING _____	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTLER HOUSE	12605 W COURTLAND AVE BUTLER, WI 53007

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N 397	Continued From page 25 a FULL CODE. ISP dated 04/01/2024 (summarized): Resident 7 required 24-hour supervision, assistance with medication administration, and wellness checks every 2 hours. Example 8- Resident 8 Resident 8 was admitted 10/26/2021. Diagnoses included residual schizophrenia. S/he remained his/her own health care decision maker and was a FULL CODE. ISP dated 10/01/2023 (summarized): Resident 8 required 24-hour supervision, assistance medication administration and dressing/undressing, and wellness checks every 2 hours. General facility note dated 05/13/2024 at 7:45 AM by Caregiver C- "Observation for Butler House: Upon my arrival, I noticed staff there were no staff in the home. I walked around and to ensure all residents were in their rooms and accounted for. I contacted administration to notify [him/her] of this. I noticed that 8pm [sic] medications were not passed out from yesterday. I asked residents if they were okay and how their night went. They told me that staff left yesterday night at around 7pm [sic] and didnt [sic] get their medications. They all said they went to bed around 7pm [sic] and woke up when I came in to check on them." On 07/24/2024 at 12 12:26 PM, Surveyor discussed concern of no at facility with Administrator A. Administrator A stated all 8 residents were at the facility during the PM and Night shifts on 05/12/2024. Cross Reference:	N 397		

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N 397	Continued From page 26 N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0388 DHS 83.35(3)(c) Implement, Follow Individual Service Plan	N 397		
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 environment was clean and homelike. This is repeat deficiency. See Statement Of Deficiency (SOD) 0OH711, dated 02/24/2023 and SOD 0OH712, dated 07/13/2023. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 8 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, physically disabled, terminally ill, advanced age, alcohol/drug dependent, correctional clients, traumatic brain injury and irreversible dementia/Alzheimer's. On 07/19/2024 Surveyor arrived 8:29 AM. Caregiver C stated it would take Administrator A approximately an hour to arrive. When asked,	N 481		

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N 481	Continued From page 27 Caregiver C stated it was fine for Surveyor to start touring the home and interviewing residents. On 07/19/2024 at 8:30 AM, Surveyor observed the following: Example 1-Front Lawn: Grass grown up and litter on the front lawn (Photos 1 and 2). Example 2-Living Room: Front entrance door heavily soiled above doorknob and a pillowcase covering the door's window (Photo 2). Carpet soiled in front of love seat and a stationary chair (Photos 3 and 4). Living room chair seat cushion soiled (Photo 5). Windows soiled. Example 3-Dining Room: Only folding chairs used at both tables (Photos 6 and 8). Carpet soiled with dark areas and an orange substance on the carpet next to a table leg (Photo 7, 8 and 9). Pedestal table legs of 1 table soiled (Photo 10). Dead bugs on windowsills (Photos 11, 12, and 13). Pieces of tape on exterior door window. Door transition from dining room to hallway soiled with black substance (Photo 15) Windows soiled. Example 4- Kitchen: Low cupboards soiled with food drips (Photos 16 and 17). Upper cupboards soiled with grease and food splatters (Photos 18 and 19). Backsplash behind stove soiled with yellow substance (Photo 20).	N 481		

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N 481	Continued From page 28 Range hood vent heavily soiled with grease (Photo 20). Surface of range hood was yellow and greasy (Photo 21). Exterior top of oven door was heavily soiled with black substance and greasy (Photo 22). Interior of oven door and oven was heavily soiled (Photo 23). Stove's drawer heavily soiled and contained food debris including multiple burnt French fries (Photo 24). Interior of microwave heavily soiled with black and yellow substances (Photo 25). Garbage can, wall, floor and vent behind garbage can were soiled with food splatters and dirt (Photo 26). Example 5- Hallway: Black marks on wall between bathroom and kitchen (Photo 27). Black marks on wall between Resident 4's and Resident 5's bedrooms (Photo 28). Example 6- Resident's main bathroom Sink faucet heavily soiled with white substance and faucet mildly loose (Photo 29). Wall between back of toilet and door soiled (Photo 30). Bottom of interior side of bathroom door significantly scuffed (Photo 31). Example 6- Resident 4's room- Multiple small splatters of brown substance on wall above heat vent and accumulation of dust on heat vent and cold air return vent (Photos 32 and 33). Window blinds heavily covered with dust. Windows soiled. Example 7- 2nd living room: Windows soiled. On 07/19/2024 at 8:46 AM, Surveyor interviewed	N 481		

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N 481	Continued From page 29 Caregiver C who stated staff cleaned the kitchen after every meal and vacuumed often. Caregiver C stated someone was at the home the week prior and measured the carpet for replacement. Caregiver C stated staff were "supposed to wash off the windowsills and stuff." On 07/19/2024 at 8:53 AM, Surveyor interviewed Resident 4 who stated staff assisted with laundry and housekeeping. On 07/19/2024, Administrator arrived at 9:00 AM. On 07/19/2024 at approximately 10:30 AM, Surveyor discussed concerns of environment with Administrator A and verbalized most examples of Surveyors observations which Administrator A noted. Surveyor offered to show Administrator A what Surveyor had observed throughout the home but Administrator A stated s/he needed to leave shortly for a meeting. Administrator A stated they were in process of replacing carpet with flooring. Mon 07/22/2024 10:33 AM, Surveyor received an email from Administrator A stating (summarized): Pictures were attached to the email identifying corrections and Administrator A listed the following corrections completed since 07/19/2024 including: stove and hood replaced 07/21/2024; microwave cleaned while Surveyor was onsite 07/19/2024; windowsills cleaned; attempted but unable to clean chair cushion so ordering washable seat cushions 07/22/2024; tape removed from dining room exterior door; splash board behind stove cleaned; dining room table legs cleaned; garbage can and area around it cleaned; kitchen cabinets cleaned; Resident 4's room cleaned; Maintenance D] put panel on bathroom door and wall between Resident 4 and	N 481		

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N 481	Continued From page 30 5's rooms to ensure protection; all windows and windowsills cleaned; and yard mowing and weed removal are done bi-weekly and completed afternoon of 07/19/2024. Administrator A also stated, "I HOPE that with the immediate corrections, this could help with you writing the Survey Results." On 07/19/2024, Surveyor reviewed the Admission Agreement on file with the Department: " ...Services Covered in the Agreed Upon Rate of this Agreement ...b. Laundry/ Housekeeping services and supplies ..." On 07/24/2024 at 12:25 PM, Surveyor conducted an exit conference with Administrator A via phone. Per Administrator A's request, Surveyor described each concern depicted in photos taken by Surveyor on 07/19/2024. Administrator A stated Caregiver C was also a manager and both s/he and Caregiver C monitored cleaning of the home. Administrator A stated within 12 hours of Surveyor's interview on 07/19/2024 at approximately 10:30 AM, environment issues were corrected and s/he sent pictures to Surveyor. Administrator A stated the managed care organization allowed the folding chairs in the dining room and BAL corrected previous citation regarding dining room chairs after the folding chairs were obtained. On 07/24/2024, Surveyor reviewed SOD 0OH711, dated 02/24/2023 and SOD 0OH712, dated 07/13/2023. The facility was cited for stains on oak wood chairs and per DQA procedure there was no documentation specifying how the facility corrected the concern.	N 481		