Exhibit 4-1: **Effective** Documentation for Principle #4

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G145	483.14(g) Standard Coordination of patient services A written summary report for each patient is sent to the attending physician at least every 62 days. This standard is not met as evidenced by; Based on record review and staff interview, it was determined the home health agency failed to ensure a written summary report which included a compilation of pertinent factors of patient•s clinical progress had been sent to the physicians• office for 2 of 2 sampled patients (# 4, and 5) who required a 62 day summary. Findings include: 1. Patient #4 was admitted for home health services on XX/XX/XX. The plans of care for the certification periods XX/XX/XX to XX/XX/XX and XX/XX/XX to XX/XX/XX included goals which stated •Patient will experience stable cardiopulmonary status as evidenced by clear lung sounds, no chest pain, SaO2 (saturation of arterial blood) greater than or equal to 92%.• Summary reports addressing the patients progress or lack of progress were not available as part of the Patient•s clinical record. 2. Patient #5 was admitted for home health services on XX/XX/XX with the diagnosis of pressure ulcer and congestive heart failure. The plan of care for the certification period XX/XX/XX to XX/XX/XX included goals which stated •Patient will have pressure ulcer healed with no sign or symptoms in 10 weeks•. The summary report addressing the status of the patient•s wound was not available as part of the clinical record. Staff interview on XX/XX/XX confirmed the HHA had not sent written summary reports to the physicians, until after the surveyor inquiry when summary reports were then completed and faxed to the physician during the survey.

Correction Of Immediate Jeopardy During Survey

Exhibit 4-2 documents noncompliance with a participation requirement that resulted in a situation of immediate jeopardy. The HCFA-2567 includes the facility's actions to remove the immediate jeopardy while the survey team was on-site; however, as stated above, mere correction of the findings does not assure that necessary corrections, at the systems level, have taken place. Follow the directions for immediate jeopardy located in Appendix Q of the State Operations Manual.

Exhibit 4-2: **Effective** Documentation for Correction of IJ during Survey- Principle #4

TAG	SUMMARY STATEMENT OF DEFICIENCIES
F223 S/S= J	42 CFR 483.13(b) Requirement Abuse.. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The requirement is not met as evidenced by: Based on staff interviews and record review, the facility failed to prevent 1 of 21 sample residents (#5) from being assaulted by staff and failed to report the assault to the appropriate authorities in a timely manner and failed to take actions to prevent further such incidents to residents resulting in immediate jeopardy. Findings include: Interviews with 3 CNAs A, B, C, on duty on 7/10/XX, indicated that they observed a certified nursing assistant (CNA)(E-1) •throw• a resident (R#5) to the ground during a picnic at the facility on 5/26/XX. The CNA, who observed R#5 becoming agitated, went to the resident to bring him back into the facility. When the resident became •uncooperative and irritated• and refused to go into the building, the CNA gave the resident a •bear hug.• The resident fell to the ground at which time the CNA dragged the resident by the back of his shirt into the facility, a distance of approximately 30 - 40 feet. Nurses notes on 6/1/XX state that the resident had abrasions on the lower lumbar and upper left thoracic regions, but was not able to say how he got them. During an interview with the facility administrator on 7/11/XX, the administrator said, •I was not aware of the incident until 6/1/XX when a staff member asked for medication to put on {resident #5's} cuts. I notified the health department on 6/1/XX.• The administrator acknowledged he did not remove the CNA from providing resident care until questioned by the surveyor on 7/11/XX. The administrator was notified of the immediate jeopardy at 2:00 p.m. on 7/11/XX. At 3:00 p.m., the administrator notified the survey team that the involved CNA had been removed from duty and that the CNA would be fired.

Principle #5: Interpretive Guidelines

The deficiency citation demonstrates how the entity fails to comply with the regulatory requirements, not how it fails to comply with the guidelines for the interpretation of those requirements. Various appendices to the SOM contain •Interpretive Guidelines• or •Guidance to Surveyors•. These Guidelines were designed to assist surveyors to develop a better understanding of the requirements, to apply these requirements in a consistent manner across entities, and to suggest pathways for inquiry.

Although surveyors must use the information contained in Guidelines, they must be cautious in their use. Guidelines do not replace or supersede the law or regulation, and therefore, may not be used as the basis for a citation. However, they do contain authoritative interpretations and clarifications of statutory and regulatory requirements. Interpretive guidelines can include professionally recognized standards and assist surveyors in making determinations about an entity•s compliance with requirements. When an entity is found to violate a requirement because of its connection to a professionally recognized standard, the surveyor must indicate such on the HCFA 2567.

Surveyors should carefully consider how the practices of the entity relate to the illustrations within the Interpretive Guidelines, and then compare the entity•s practice to the specific language and requirement of the regulation before determining that a deficiency exists.

Exhibit 5-1: Interpretive Guidelines

REGULATION	GUIDANCE TO SURVEYORS
42 CFR 483.35 (h)(2) Sanitary Conditions. The facility must (2) store, prepare, distribute, and serve food under sanitary conditions; and	Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140 degrees Fahrenheit, and cold foods at or below 41 degrees Fahrenheit, etc... Referenced guidance 1999 FDA Food Code.

Exhibit 5-2 illustrates how material in Interpretive Guidelines can be used to support the citation. The critical factor is whether or not the evidence relates directly to the language and requirement within the regulation.

Exhibit 5-2: Effective Documentation for Principle #5

TAG	SUMMARY STATEMENT OF DEFICIENCIES
W214	42 CFR 483.440 (c) (3) (iii) The comprehensive functional assessment must identify the client•s specific developmental and behavioral management needs. This Standard is NOT MET as evidenced by: Based on observations, staff interview, and record review, the facility failed to include in the comprehensive functional assessment, the client•s cognitive ability for 2 of the 4 clients in the home (#2, #3). The findings include: Review of Client #3•s medical records, dated between XX/XX/XX and XX/XX/XX, revealed 11 evaluations conducted by the professional staff. None of the evaluations specified any deficits that may have contributed to his diagnosis or his reported developmental level of functioning. Observations on XX/XX/XX and XX/XX/XX confirmed that ....In an interview on XX/XX/XX, LPN1 said, •I am unclear about the client•s identified strengths.•

Principle #6: Citation of State or Local Code Violations

The entity's failure to comply with State or local laws or regulations is not documented in the HCFA-2567 except when the Federal regulation requires compliance with State or local laws. When the authority having jurisdiction for that State or local law has made a decision of noncompliance and has effectuated an adverse action which has been sustained through the hearing process (such as removal of the license to operate), the HCFA-2567 should note that the entity no longer has a license.

Federal certification requirements are uniform throughout the United States. However, States and localities may have additional requirements that the entity must meet in order to continue to operate within those jurisdictions. Some licensing requirements may be more stringent or prescriptive than Federal requirements. Licensure surveys are conducted to determine an entity's compliance with specific State or local laws and regulations. Entities that do not meet the State or local requirements for licensure may not be certified for participation in the Medicare/Medicaid programs.

In the event of a difference in the stringency of a Federal certification requirement and a corresponding State or local (e.g., licensing) requirement, the entity is to comply with the more stringent of the two. However, when enforcement of the more stringent requirement comes from an authority other than the Federal requirement, the evidence may be recorded on the HCFA-2567 only in the manner prescribed by HCFA.

Failure of the entity to meet State or local requirements is recorded on the HCFA-2567 at a Federal data tag for one of two reasons:

1) the language of the Federal regulation explicitly requires compliance with State or local laws and codes. Deficiency citations made under these requirements should include a reference to the particular State or local code with which the entity is noncompliant. This insures that there is legal authority to describe any conditions or practices described as deficient. Surveyors always should review their findings relative to the specific Federal requirement to determine if and when an entity's failure to achieve compliance with a licensure requirement is sufficient evidence to cite noncompliance with a Federal certification requirement.

Exhibit 6-1 is consistent with Principle #6. The entity's practice of using LPNs to conduct the health status review was deficient specifically relative to the requirement; or

Exhibit 6-1: **Effective** Documentation for Principle #6

TAG	SUMMARY STATEMENT OF DEFICIENCIES
W345	42 CFR 483460(d) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section. This STANDARD was NOT MET as evidenced by: Based on record review, the facility for the period between 7/1/xx and 9/30/XX, utilized Licensed Practical Nurses (LPNs) to review the health status of residents for 4 of 10 sampled records (2, 6, 12, 19) . Section 76543 of the Code of Professional Health Practices (State Requirement) requires that this function be performed only by Registered Nurse (RNs).

2) the authority having jurisdiction has made a determination of noncompliance with State or local law, has taken and sustained an adverse action (See Exhibit 6-2.).

An adverse action is any procedure taken by a State Agency that goes beyond the approval of a plan of correction, such as, fines, ban on admissions, loss of license, etc. The authority having jurisdiction is the person or persons who have the authority to make a final determination of noncompliance and are responsible for signing the correspondence notifying the facility of the adverse action. A final determination means the determination has not been appealed or is no longer being appealed by the entity.

Exhibit 6-2: **Effective** Documentation for Principle #6

TAG	SUMMARY STATEMENT OF DEFICIENCIES
F492	42CFR483.75(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This requirement is NOT MET as evidenced by: Based on evidence in the attached notice of determination of non-compliance, the entity did not meet (state or local) Law # XXX. An adverse action was taken against the entity by (the authority having jurisdiction.) See attached.

Principle #7: Cross-References

The cross-referencing of requirements is an acceptable form of documentation on the HCFA-2567 only when it is applicable and provides additional strength to the linked citations. Descriptive evidence (facts and findings) from one citation may be linked into the evidence for a citation at another requirement. The evidence being linked into that requirement must support the determination of non-compliance with that requirement. Each citation must contain all components described in this document independent of the additional information being linked into that citation. Cross-referencing is most effective when the linked citations have a direct cause and effect relationship to the deficient practices described in both citations. In all instances, each citation must contain sufficient evidence to demonstrate noncompliance for the referenced regulation. Additional guidance for cross-referencing for COP level citations is provided in POD #8.

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G170	42 CFR 484.30 Skilled Nursing Services The HHA furnishes skilled nursing services in accordance with the plan of care. This requirement is NOT MET as evidenced by: Staff interview and review of seven clinical records requiring RN skilled services revealed that the RN did not comprehensively assess the patients or furnish the frequency of visits required by the Plan of Care for 4 of the 7 patients (H3 H5, H6, H7). See G174 for additional information regarding patients H3, H5, and H7. 1.Review of H3's clinical record indicated physician orders for twice daily RN visits from 10/01 to 10/08/XX to administer IV antibiotics, assess the stats of and perform a dressing change to the Stage 3 ulcer of the left heel. The aide sheet for 10/04 reflected that the aide had changed the heel dressing that AM. The record shows two LPN visits and an evening dressing change by the LPN on 10/04 but does not contain information of an RN visit, assessment or dressing change on 10/04/XX. Interview at 10:30 A.M. on 11/10/XX with supervising nurse confirmed that on 10/04/XX an aide had performed the AM dressing change on H3's Stage 3 pressure ulcer of the heel. The supervising nurse reported that although the RN was ill and had not made the planned AM or PM visits that day, the agency•s LPN had performed the visits and supervised the aide. 2. Review of H5's clinical record indicated that the Plan of Care for H5 required RN visits from 4 to 5 times the week of 10/07/XX and 3 times a week for 3 weeks beginning 10/4/XX to assess the patient•s response to changes in the medication to control her angina and blood pressure. The RN visited only 3 times (10/07, 10/08 and 10/10) during the week of 10/07 and limited her assessment to checking breath sounds and blood pressure. The RN did not evaluate for signs and symptoms or complications of either hypo or hypertension or for compliance with dietary restrictions or known side effects which accompany the use of calcium channel blockers. 3. Review of H6's clinical record indicated the RN did not visit H6 twice daily as required by the Plan of Care to monitor the institution of sliding scale insulin for the newly diagnosed brittle diabetic. The Plan of Care required twice daily visits from -- to --. The actual visit frequency was --.

G170	42 CFR 484.30 (Cont.) 4. Review of H7's clinical record indicated the RN did not assess, record, and report to the physician the change in the status of the suture line of the hip wound on 10/21/XX. The Plan of Care required RN visits 5 times a week for 1 week then 3-5 times a week for 2 weeks or until the wound healed to change the dressing and assess the character of the post operative wound. The therapist's progress notes from the therapy visit on 10/21 at 10 A.M. (3 hours prior to the RN visit) reflect that the patient complained to the therapist of burning and dampness at the suture line.

Principle #8: COP Deficiencies

The evidence for the citation of noncompliance with a Condition Of Participation explains how the extent or severity of deficient practices justifies a conclusion of noncompliance at the COP level. The COP citation includes a statement(s) of deficient entity practice(s) and findings to support the determination of non-compliance with a condition level requirement. The findings may be incorporated either by cross references to those requirements which must be corrected to find the COP in compliance or by narrative description of the individual findings. The COP citation includes ONLY those requirements that must be corrected to achieve compliance with the COP.

The determination that an entity is not in compliance with an applicable COP is one of the most serious decisions the RO or SA can make. The decision as to whether there is compliance with a particular COP depends upon the manner and degree to which the entity satisfies the various requirements and standards within each COP. If a COP is determined to be deficient, the HCFA-2567 should identify the specific practices that must be corrected before the entity can be found to be in compliance. If these practices refer to requirements specified at Standards or other subsidiary requirements, the deficient practices and individual findings would be cited at the relevant requirements. The findings under these subsidiary requirements may be referenced under the COP citation.

For certain provider and supplier types, a COP may stand alone at a single survey data tag without accompanying standards or other requirements. The text of the particular COP may have multiple components. Based on the evaluation of the evidence, an entity can be cited at a COP level even if it violates only one component of multi-component regulations.

For example, in the Ambulatory Surgery Center program, 42 CFR 416.43 Condition for Coverage - Evaluation of Quality, (tag Q 9) has multiple requirements: (1) conduct an ongoing, comprehensive self-assessment of the quality of care provided; (2) include active participation of the medical staff; (3) include review of the medical necessity of the procedures performed and appropriateness of care; (4) use the findings, when appropriate, in the revision of the center policies and (5) use the findings, when appropriate, in the consideration of clinical privileges.

There may be entity practices relevant to standards that are deficient, yet not essential for a determination of compliance with the COP. Most likely it is because the nature of these practices, individually or collectively, does not justify a conclusion of noncompliance and warrant an adverse action. Such requirements are not referenced at the COP citation. They are included at the appropriate tag number and corresponding CFR reference in the HCFA-2567.

Exhibit 8-1: **Effective** Documentation for Principle #8

TAG	SUMMARY STATEMENT OF DEFICIENCIES
Q003	416.41 Condition Governing Body and Management The ambulatory surgical center must have a governing body, that assumes full responsibility for determining, implementing and monitoring policies governing the centers total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the center must assure that these services are provided in a safe and effective manner. This Condition is not met as evidenced by; Based on staff interview and review of administrative records, policies and procedures, and infection control and quality assurance documentation, it was determined that the ambulatory surgery center's governing body failed to assume full responsibility for determining, implementing and monitoring policies governing the center's total operation. The governing body failed to ensure that practitioners had been appointed to the medical staff and had been granted privileges to practice at the ASC (refer to Q19, Q20, Q21, and Q22), failed to ensure that a comprehensive quality assurance program was in place (refer to Q9); failed to ensure that an effective infection control program had been established (refer to Q14). The cumulative effect of these systemic problems resulted in the surgery center's inability to ensure the provision of quality health care in a safe environment.

CONCLUSION:

All requirements are binding. The structures, processes and outcomes required by the regulations are necessary for the entity to provide quality care, prevent negative outcomes, and facilitate positive outcomes. Failure of the entity to provide any of the required services or to meet required conditions constitutes evidence of noncompliance regardless of the presence of outcomes. The purpose of these Principles of Documentation is to provide structure and consistency to the construction of a citation.

Correctly documenting the Statement of Deficiencies (HCFA-2567) is the key to the success of the survey and certification process. Effective documentation of the survey signals the provision or denial of financial participation in the Medicare/Medicaid program, as well as the provision of or lack of quality care in health care settings.

Keep in mind that one of the roles of the surveyor is to ensure that quality health care is provided by those entities participating in the Medicare/Medicaid program. It is the surveyor's knowledge of the regulations and how to interpret and apply these regulations in a consistent manner during the survey that will produce a clear description of the entity's deficient practice. When the deficient practices are resolved by the entity, quality of care and quality of life can be a reality in health care settings.

COMPONENTS TO BE DOCUMENTED IN A DEFICIENCY CITATION

DOES THE CITATION INCLUDE.....	YES	NO	N/A
Data Tag			
In CFR/LSC/CLIA order			
CFR/LSC/CLIA Reference			
CFR/LSC/CLIA Requirement			
Statement that requirement is "Not Met"			

Evidence: Each Statement of deficient practice with corresponding findings (repeat each practice)	Yes (Y)	No (N)	N/A	NOTES
Statement of deficient practice:				
extent of deficient practice				
identifiers (confidential)				
description of violation of regulation				
source of evidence				
State/Local code reference, if applicable				
Findings/Facts:				
who				
what				
when				
where				
how				
outcome				
observations: date, time, location				
interviews: date, time, identifier				
record/document reviews: date(s), record type				
sequential organization of facts				
Is the Deficiency Citation.....	**YES**	**NO**	**N/A**	
Applicable to requirement cited?				
Written in plain language?				
Free of extraneous remarks and advice?				

Appendix B
Enforcement Report

Assisted Living Facility Citations

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Helen House II	12/27/02	83.21(4)(p)	Resident #1 was exhibiting increased confusion, hallucinations, and symptoms of urinary tract infection from 6/14 - 6/23/02 without appropriate intervention or medical treatment (with the exception of prn anti-anxiety medication that was described as ineffective and may have contributed to subsequent falls.) The resident fell on 6/26/02, sustaining a bruise on her hip and upper thigh. She complained of right hip and knee pain for several hours. No medical treatment was sought. On 6/27/02, the resident was found on the floor by her bed at 5:45 a.m. Emergency treatment was not obtained until 6:41 a.m., during which time the resident remained on the floor. The resident sustained a hip fracture that was attributed to the fall that occurred the night before.	$550 ($50/day for 6/18, 6/22, and 6/23/02 and $400 6/26/02)	Event ID: IMC211
Bangor					
La Crosse					
Western					
Sapphire Villa	12/27/02	83.14(1)(d)	Fire Safety, First Aid & Choking. Two staff not trained.	$100	Event ID: HMKS11
Neenah		83.14(4)	Approved Training Two staff did not receive approved training.	$100	
Winnebago		83.33(2)(a)	The facility did not provide adequate supervision for a vulnerable resident with a pattern of attempting to leave the building. On 10/3/02, the resident wandered from the building to a four-lane highway and fell in gravel on the side of the road. A passing motorist picked her up. The facility was unaware the resident was missing until the resident's family called 30 minutes later. The resident sustained face injuries and required stitches to her forehead. Her family removed her from the facility the same day.	$500 (10/3/02)	
Northeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Tender Elder Care I Ashland Ashland Northern	12/27/02	83.07(10)(a)1	Plans of Correction The facility received a statement of deficiencies for 27 violations on 9/20/02 and was granted an extension for the submission of plans of correction through October 2002. Despite frequent phone calls from BQA requesting plans of correction into November 2002, the facility has not submitted plans. Order: Pursuant to chpt. 50.03(5g)(b)6, the facility is ordered to comply with requirements specified in 50.03(5g)(b)4 and 83.07(10)(a)1 and shall submit plans of correction within ten days.	$470 ($10/day from 11/1/02 - 12/17/02 = 47 days) Order (see note)	
East View Terrace Milwaukee Milwaukee Southeastern	12/26/02	83.21(4)(p)	A resident was admitted without pressure sores and developed a pressure sore on 6/6/02. Treatment did not occur until 6/11/02 when duoderm was applied without a physician's order. Documentation on 6/12/02 indicates the pressure ulcer was worsening and new sores were forming. The resident's ISP id not address the resident's risk for developing pressure sores. Order: Pursuant to ch. 50.03(5g)(b)6, the licensee shall ensure facility staff receive training from a qualified health care professional within thirty days on how to provide appropriate treatment to prevent pressure sores and how to treat skin breakdown, including assessment, development of a treatment plan, implementation of the plan and monitoring.	$300	Event ID: IFMX12

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Glen Supportive Living	12/26/02	83.19(1)(d)	Facility did not provide notice to a resident's physician and did not seek medical treatment when the resident experienced nausea, emesis, and weakness from 1/15/02 through 1/24/02 [with the exception of obtaining an order for anti-nausea medication on 1/22/02]. On 1/23/02, the resident was falling backwards as if "collapsing" and the MD was not contacted. On 1/24/02, the resident fell and hit her head (early morning shift). The MD was not contacted. Later that day, the resident's daughter requested the facility call 911 and the resident was hospitalized. The resident died on 1/30/02.	$1,000	Event ID: IPMF11
Whitewater		83.21(4)(p)	A resident was readmitted on 6/14/02 showing signs of increased weakness and not eating. No assessment was completed. Records describe the resident as confused, lethargic, poor appetite. The resident fell on 6/19, 6/20, and 6/21/02. On 6/21/02, the resident did not eat or drink all day. On 6/22/02, documentation indicated the resident "won't eat or move voluntarily." The resident was not assessed by a nurse and was not seen by a physician from 6/14/02 - 6/23/02. The resident was hospitalized on 6/23/02 when found unresponsive with a blood glucose of 37. She was admitted with dehydration, sepsis, and electrolyte imbalance and a pulse of 38. The resident died on 6/24/02. A second resident with a history of falls, including falls with injury, did not receive prompt or adequate treatment to prevent falls. The record did not contain an assessment of falls and no contact was made with the resident's physician regarding an increase in falls. The resident required assistance to the bathroom and requested assistance on 1/22/02. Staff interviews confirmed that assistance was not provided. The resident fell on 1/22/02 and sustained a laceration to her forehead. She was sent to the emergency room and did not return to the facility.	$2,800 (Example 1 $1,000. Example 2 $800).	
Walworth					
Southeastern					
Our House	12/26/02	83.14(1)(a)	Client specific training not provided.	$100	
Reedsburg		83.14(2)	Dietary training not provided.	$100	
Sauk					
Southern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Rose Acres 1	12/26/02	83.13(7)(b)	8 of 8 employee files did not include complete criminal record checks. Order: Comply with requirements specified in 83.13(7) and maintain personnel records, including criminal background information, at the facility, available for review by the department.	Order (see note)	
New London		83.14(1)(d)	2nd cite. 2 staff had not received training in fire safety, first aid, and procedures to alleviate choking.	$150	
Outagamie		83.21(4)(p)	A resident with a history of urinary tract infections complained of pain with urination on 6/5/02. Notes on 6/8/02 indicate the resident's urine has a strong odor and that a nurse should be notified. No such notification occurred. The physician was not contacted until 7/9/02, more than a month following the initial complaint of painful urination. Treatment was delayed for 33 days.	$660 ($20/day for 33 days)	
Northeastern		83.33(2)(a)	Supervision. A confused resident with a history of wandering attempts was transferred to the facility on 8/17/02 and exited the building unnoticed on 8/18/02 and 8/19/02. On 8/19/02, the resident was found .3 miles from the facility on a country road.	$200 (assessed on the 8/19/02 incident)	
Rose Acres 2	12/26/02	83.15(1)(a)	Staffing patterns. Staffing in the facility was not sufficient to address the needs of a resident with dementia and a history of elopement. The resident exited the building on multiple occasions (wandering on a country road and in a wooded area) when staff were providing assistance to other residents. The ombudsman observed that residents were left unattended when staff left the building to retrieve the wandering resident. A review of time cards revealed the facility scheduled one caregiver per building for 235 hours from 6/27/02 through 8/13/02. Based on the needs of the residents, one caregiver per building was not sufficient.	$2,350 (235 hours at $10/hr.)	
New London		83.20(2)(b)1	The facility relocated five residents from one building to another without notifying family members in advance.	$200	
Outagamie		83.21(4)(p)	The facility did not provide prompt and adequate treatment appropriate to the needs of resident #6. The physician was not contacted when the resident fell and sustained injuries. The facility did not provide services at a level and frequency necessary to monitor and assist the resident with ambulation and fall prevention. The resident experienced falls with injury on 1/1/02, 3/9/02, 3/17/02, and 6/22/02. The fall on 6/22 resulted in a head laceration that required staples to close.	$1,500 (1/1/02 = 250, 3/9/02 = 250, 3/17/02 = 250, 6/22/02 = 750)	
Northeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Loving Care Villa	12/23/02	83.15(1)(a)	Staffing Patterns Following brain surgery, resident #1 required 2 staff to transfer. Two staff were available only during shift changes. Resident #1 had a pressure sore on his coccyx and was observed for extended periods of time without repositioning and without changing for incontinence. The resident was left in bed and "begged to get up." Staff confirmed that the resident's incontinence pad was saturated when changes did occur and that the resident's buttocks were red and inflamed. On 10/9/02, resident #1 remained in a geri-chair without repositioning or changing from 10:15 a.m. until 7:08 p.m. because only one caregiver was available. On 10/10/02, the resident was not washed and did not have his incontinence pad changed for more than 8 hours. On 10/15/02, was not repositioned or changed from 8:30 a.m. to 2:00 p.m.	$1,200 (10/9/02-10/13/02 5 days/120 hours @$10/hr)	Event ID: COH211
Wisconsin Rapids		83.15(1)(b)	Facility did not have a qualified staff person in charge of the facility on a daily basis to ensure safe and adequate care and services for 27 days from 3/11/02-10/13/02. Residents' needs were not met. For example, on 7/2/02, resident #5 had elevated blood sugar. A supervisor could not be reached. The caregiver, unsure how to respond, gave insulin to the resident in the absence of a current physician's order from a syringe that had been drawn on 10/1/01.]	$270 ($10/day for 27 days)	
Wood		83.18(1)(d)1	Identification and Admission Data The facility program statement did not include provisions for respite care. The facility inappropriately admitted a resident for respite care on 10/4/02 without obtaining sufficient information to care for the resident. The resident became ill on 10/5/02 and staff called 911. There was no information to provide emergency medical technicians about the resident's medications or medical history.	$200	
Northern		83.18(3)	Records The licensee falsified records, including "blacking out" entries in resident records and documenting fire drills that had not been conducted.	$100	
		83.19(1)(d)	Resident #1's physician was not contacted when the resident was injured and/or experienced a change of condition. The resident was not treated for a urinary tract infection until symptoms had been present for 16 days. Falls with injury occurred on 7/20 and 7/22/02 and the physician was not contacted.	$300	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Loving Care Villa (cont.)	12/23/02	83.21(4)(p)	Resident #1 did not receive prompt and adequate treatment for incontinence, weakness, pressure sores.	$1,200 (Dates of violation: 10/9/02 - $500, 10/10/02 - $200, 10/15/02 - $500.)	
		83.33(2)(c)	Activity programming was not provided for 5 of 5 residents.	$200	
		83.33(2)(G)(3)	Residents #1 and #2 did not receive medical interventions in a timely manner. From 6/9/02 to 6/28/02, resident #2 was treated with Immodium for diarrhea when, in fact, the resident had an impaction and chronic constipation and could only pass liquid stool. Medical care was not obtained until the resident was hospitalized on 6/28/02. Symptoms of a urinary tract infection were present on 5/28/02 with no follow-up by the facility until 6/10/02. Medical treatment was not sought on 7/20/02 or 7/22/02 when resident #1 sustained injuries from falls. The physician was not notified when resident #1 experienced weakness and required additional staff assistance with transfers from 8/20/02 - 10/1/02. The physician was not contacted when indicated to address a developing pressure sore from 10/7/02 - 10/16/02.	$1,020 (7/20/02 $100; 7/22/02 $100; $10/day for 82 days)	
		83.33(3)(A)1	Resident #5 was given an injection of insulin on 7/2/02 from a syringe that had been filled on 10/1/01. The physician's order for insulin was discontinued on 4/22/02.	$100	
		83.35(1)(a)	Resident #7 required a special diet (rich in protein) due to being on dialysis. The facility did not have sufficient food to meet the nutritional needs of residents. Staff stated residents received only toast and coffee for breakfast. Due to insufficient meat, hamburgers were cut in half in order to serve all residents during a meal.	$500	
Hearthside	12/19/02	83.14(1)(c)	Universal Precautions (3 of 5 staff not trained)	$100	
Janesville		83.14(1)(d)	Fire Safety, First Aid & Choking (2 of 5 staff not trained)	$100	
Rock		83.32(2)(a)	Two residents with complex medical and mental health needs did not have Individual Service Plans that fully addressed their needs or included goals and services to promote their well-being. Resident #8 has diagnoses of Depression, CVA, and History of Korsakoff's Syndrome. The ISP does not address personal care, behavior patterns, physical health, or measures to address psychosocial, emotional needs. Resident #2 is diabetic with circulatory problems including a "black toe" and requires accu-checks. In addition, the resident has periods of depression and isolates self. The ISP did not address the medical or psychosocial needs of resident #2. Staff C was unaware of how to treat the resident's foot condition.	$250	
Southern			Forfeiture:		

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Family House 6 Milwaukee Milwaukee Southeastern	12/16/02	83.14(1)(d)	2 of 3 staff did not receive training in fire safety, first aid, and procedures to alleviate choking.	$100	
Marquette House South Milwaukee Milwaukee Southeastern	12/16/02	83.32(2)(d)	Facility did not respond with appropriate, timely interventions to address a resident's repeated falls. The resident experienced falls resulting in injury, including an internal injury with abdominal pain, a head contusion, and bruises. (After the facility developed a plan to address the resident's risk of falling on the outside steps, the van driver (non-facility staff) failed to follow the plan and the resident fell, sustaining injuries that led to death.)	$1,500 (3/13/01 $500, 4/16/01 $250, 5/18/02 $250, 10/13/01 $500)	Paid
Northfield Center	12/16/02	83.14(7)(b)	Five of five staff had not received 12 hours of annual continuing education as required.	$100	SOD #10006264 Event ID: HH6L11
Hixton		83.32(2)(a)5	Resident #12's service plan did not address the resident's self-injury behaviors. In the past, the resident had injured self, resulting in an ankle fracture. Per review of the resident's record on 10/21/02, the resident sustained a second broken ankle that staff attributed to self-injury.	$100	
Jackson Western		83.33(2)(a)	Due to insufficient supervision, resident #12 engaged in unsafe behaviors, including theft, drinking, and breaking into a cabin to spend the night. On 4/5/02, the resident left the facility and was not found until the next morning. The outdoor temperature ranged from 18 to 31 degrees. The resident was taken to the hospital, treated, and released.	$1,000 (three incidents: 3/12/02 $250, 3/15/02 $250, 4/5/02 $500.)	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Century Ridge 2	12/13/02	83.13(4)(a)	Communicable Disease Control Five employees had not been screened for TB, including staff hired between 1999 to present.	$100	Event ID: AWIJ12
Green Bay		83.14(1)(c)	Universal Precautions Training Two staff had not received training.	$100	
Brown		83.32(2)(a)	Individual Service Plan (second citation) A resident's wandering behaviors and interventions were not adequately addressed on ISP and resident wandered from the building at high risk for injury on several occasions.	$100	
Northeastern		83.33(3)(A)(2)	Review of Medication (second citation) Facility did not convey pharmacist's recommendations to physician and did not follow plan of correction for previous violation. Resident #9 receives three medications for sleep. The pharmacist expressed concern about multiple sleep medications and resident's weakness in the morning. The recommendation was made in August of 2000, August of 2001, and on 8/30/02 without follow-through by the facility.	$300	
		83.33(3)(F)2	Reassessed Quarterly for Medication (second citation) Two residents receiving psychotropic medications did not have quarterly assessments.	$100	
	12/13/02	83.33(3)(J)1	Destruction of Medications (second citation)	$50	
		83.33(2)(a)	Resident with dementia exited the building on multiple occasions and was returned to the building by non-staff citizens or law enforcement. Forfeitures are assessed for the following incidents: 6/15/02 ($250) 6/28/02 ($500) Resident was missing from 4:20 to 8:00. Dogs, helicopter, fire department, and volunteers searched for resident. Hospital staff discovered broken glass in the resident's bra. 6/30/02 ($250) 7/5/02 ($250) 10/27/02 ($250) Order: Facility shall provide sufficient staff to monitor the whereabouts of resident #1 at all times and shall detail in the plan of correction sufficient measures to ensure the safety of the resident 24 hours per day.	$1750 (see note) Order: provide adequate supervision to ensure safety of res. #1.	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Family House 2 Milwaukee Milwaukee Southeastern	12/13/02	83.05(2)(a)	Class A Ambulatory License. Facility admitted a resident on 8/15/02 who relies on a wheelchair for mobility. The resident has had a leg amputation and has a prosthesis that he does not wear. He is unable to ambulate independently to exit the building. The facility did not complete an evacuation assessment or an ISP. This is the third violation of this code. Facility persists in admitting residents for whom safety is compromised. Order: Discharge resident #4 or comply with an appropriate class of licensure within 45 days. Pending discharge, the facility shall immediately complete an evacuation assessment and develop a plan to ensure the evacuation needs of resident #4 can be accomplished safely in the event of an emergency.	$500 Order to discharge or comply with appropriate licensure.	SOD #10006036 Event ID: VB0911
Encore Sr. Villa Janesville Rock Southern	12/10/02	50.065(2)(bm)	Facility did not complete an out of state background check for 1 of 2 staff who reported they had resided out of state within the last three years.	$100	Event ID: 3SZN13 Paid
Belwood VIII Martin Milwaukee Milwaukee Southeastern	12/9/02	83.43(4)(b)1.d 83.14(3) 83.14(1)(c)	The facility had not installed smoke detectors in common areas as required. The dining room on the first floor and the "Blood Work Room" on the second floor did not contain smoke detectors. Four of 8 staff responsible for medication administration had not received training in medication management. Two of 8 staff had not received training in universal precautions.	Order to install. $100 $100	Event ID: 831M11

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Bromeisl Group Home Chippewa Falls Chippewa Western	12/9/02	83.43(4)(b)3	Facility had not installed an interconnected smoke detection system by January 1, 2002. Note: January 1, 2002 to January 22, 2002 (plans submitted) = $220 ($10/day for 22 days.) Plans were approved on April 9, 2002. April 10, 2002 to April 29, 2002 (installation) = $200 ($10/day for 20 days)	$420 (see note)	Event ID: 2NVM11 SOD #10006265
Just Like Home Twin Lakes Kenosha Southeastern	12/6/02	83.14(1)(c) 83.14(3)(b)	2 of 5 staff had not completed training in universal precautions. Two staff responsible for assisting residents with medications did not receive training in medication management and administration.	$100 $100	Event ID: 28RM11 Paid Paid

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Maple Road Group Home	12/6/02	83.21(4)(m)	Abuse. There were several witnessed incidents in the facility when caregiver "B" implemented "timeouts" that were abusive to residents including: - pulling a wheelchair-bound resident's arms behind his back and pushing up on the arms until the resident's head was in his lap -grabbing a resident's arm and yelling -throwing a resident to the ground to "tussle with him until both arms were behind his back" - sitting on residents while residents were laying on the ground with their hands behind their backs.	Forfeiture: $1000 Orders for training and supervision (see notes).	Event ID#P1RV13
Menomonee Falls			Notes: Order: All caregivers, house manager, and residential manager shall receive training, from a qualified human service professional, on appropriate, therapeutic behavior management for all client groups served, including residents with developmental disabilities or mental illnesses. All caregivers, house managers, and residential manager shall receive training in recognizing abuse and in requirements for reporting, preventing, and investigating abuse. Order: The facility shall develop and maintain a monitoring procedure to ensure residents are protected from abuse. Staff A will not work in the facility, unsupervised or in a supervisory capacity, until completing the training ordered by the department and until the department determines the facility has achieved substantial compliance with HFS Chapter 83.		
Waukesha					
Southeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Catlett Country Home Janesville Rock Southern	12/5/02	88.10(3)(A)	Fair Treatment. Licensee became angry with resident #1, yelled at the resident and grabbed his clothing and "hauled" him in the house. Order: Pursuant to 88.03(6)(g)2.g. the licensee must receive formal training, by a qualified human service professional, in the following areas: (1) client-specific training [client group: mental illness], including content regarding therapeutic interventions to manage behavioral symptoms, (2) resident rights, and (3) conflict resolution. The licensee's training plan must be approved by the Bureau of Quality Assurance (BQA) prior to the licensee's participation. The licensee is ordered to submit a written training plan that includes the above topics to the BQA, Southern Regional Office, within 30 days of receipt of this notice. The written plan shall include the titles of the proposed training courses, an outline of course content, the name(s) and qualifications of the instructor(s), and the address and telephone number of the organization or individual providing the training. The completion of training shall occur within 120 days following approval of the training program.	Order. (see note)	7FJV12
Guiding Hand Marshfield Wood Northern	12/5/02	50.65(2)(b)	Facility had not obtained the Integrated Background Information System (IBIS) report for 1 of 5 staff.	$100	Event ID #MNF611
Heavenly Care Group Home Milwaukee Milwaukee Southeastern	11/27/02	83.43(5)(a)	Facility did not have smoke detectors that were interconnected with the remainder of the smoke detection system in three areas of the facility (two areas of the basement and in the kitchen).	$300 forfeiture	Event ID: KY2P11

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*	
HIL - Sandstone House	11/27/02	83.14(1)(a)	2 of 8 staff did not receive client-related training within six months of hire. Both staff received the training in June 2002, eight months after they were hired.	$50 forfeiture	Paid	Event ID: CL9C11
Fort Atkinson		83.14(1)(d)	2 of 8 staff did not complete training in fire safety and first aid within the first 90 days of hire. Staff A (hired 1/18/01) completed fire safety on 8/7/01 and first aid and choking on 6/21/01. Staff B (hired 10/17/00) completed fire safety training and first aid training 5 months after being hired.	$50 forfeiture	Paid	
Jefferson		83.21(4)(p)	Resident completed physical therapy in January 2002 with instructions to continue PT exercises. Resident was not assisted with this and began losing range of motion, prompting a second round of physical therapy. Resident also lost 25 lbs. in three months in early 2002 and this weight loss was not assessed, evaluated, or reported to the physician.	$400 forfeiture	Paid	
Southeastern						
Iris Manor	11/27/02	83.14(1)(d)	3rd cite. 1 of 2 staff hired since the survey had not been trained in fire safety.	$300 forfeiture	Appeal rec'd 12/13/02	
Wauwatosa		83.14(2)	3rd cite. 1 of 2 staff hired since the survey had not received dietary training.	$300 forfeiture	Appeal rec'd 12/13/02	
Milwaukee		83.14(3)	2nd cite. 1 of 2 staff hired since the survey had not been trained in medication administration.	$150 forfeiture	Appeal rec'd 12/13/02	
Southeastern		83.33(3)(e)5	3rd cite. 32 medications had not been charted as given or refused during November 2002.	$640 forfeiture ($20/medication)	Appeal rec'd 12/13/02	
Pennsylvania House	11/27/02	83.33(2)(a)	The facility did not appropriately supervise one resident who had a history of eating foreign objects such as coffee grounds, tea, spices, coins, and garbage. The facility did not have an ISP that addressed this behavior with approaches to deal with it. On 2/25/02, the resident died from complications of having eaten foreign materials, including a chicken bone that perforated the sigmoid colon.	$1000 forfeiture	Appeal rec'd 12/13/02	Event ID: FJQ411
Milwaukee						
Milwaukee						
Southeastern						
Grace Edgewood	11/22/02	83.14(1)(d)	Several employees had not completed training in Fire Safety, First Aid, and Procedures to Alleviate Choking.	$100	Event ID: 72EP11	
Altoona						
Eau Claire						
Western						

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
OakWood House West	11/22/02	88.05(2)(A)	Resident #1 ambulates with difficulty and is unable to easily negotiate stairs. The resident's bedroom is on the second floor (there are no first floor bedrooms) and exits from the AFH require the resident to descend stairs.	Order: Discharge resident to appropriate setting.	Event ID: YP3L12
Waukesha		88.05(2)(D)	Above.	Continue order issued on 1/28/02 for no new admissions until compliance is achieved.	Order lifted on 12/19/02 per PB; corrected.
Waukesha					
Southeastern					
Haack's Tendercare	11/19/02	83.32(2)(a)	Three residents did not have ISPs that addressed complex needs and services. Third citation.	$300	Event ID: X07U14
Madison		83.32(2)(d)	A resident with pancreatic cancer began receiving hospice services on 10/14/02. The ISP indicated the resident's health was "fair" and did not address the cancer or services for terminal care. Second citation.	$100	
Dane		83.33(3)(E)5	Medications were administered on 13 occasions without proper documentation. Second citation.	$130 ($10 per incident)	
Southern		83.42(3)(f)	The facility had not conducted a simulated night-time fire drill. The licenser had concerns with residents' capabilities for evacuating during an emergency and initiated a fire drill during survey.	$100	
Martha's, Inc.	11/19/02	83.43(4)(b)3	Facility does not have an interconnected smoke detection system. As of 9/20/02, plans had not been submitted.	$2,630 ($10/day from Jan. 1 through 9/20/02 and $10/day until plans are submitted and $10/day from date of approval to installation.)	Event ID: ONJY12
Princeton		see note	83.14(1)(a), 2 of 4 staff did not have client-specific training. 83.14(c), 6 of 7 staff did not have training in universal precautions. 83.14(1)(d), 6 of 8 staff did not have training in fire safety, first aid. 83.14(2), 2 of 3 staff did not have dietary training. 83.14(3)(b) 5 of 7 staff did not have training in medication management prior to assisting residents with medications.	$500 ($100 per training violation)	
Green Lake		50.065(2)(b)	Facility had not completed background checks for 8 staff.	Order: Complete caregiver background requirements for all staff within 14 days.	
Northeastern		83.32(2)(c)1	Repeat violation. Facility did not provide residents with an opportunity to complete a satisfaction evaluation within 30 days prior to the annual evaluation of resident needs. Files for sample residents did not contain satisfaction surveys, including a resident admitted in 1991 and a resident admitted	$50	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Mertin's Home Care	11/19/02	50.065(4m)(c)	Had not conducted background checks for one caregiver.	$100	Event ID: 6XQ812
Watertown		83.33(3)(E)2.A.	Facility did not have written physician orders for medications for two residents and did not record medications as given on Oct. 28, 29, 30, 31 and Nov. 3, 4, 5, 6.	$180 ($10/day for days meds were not recorded and $100 for failure to have written MD order.)	
Dodge		83.33(3)(E)5	See above.		
Southern					
Casa Clare I	11/18/02	83.14(1)	Two of seven staff did not receive required initial training within 6 months after starting employment.	$100	
Appleton		83.14(1)(c)	Two of seven staff did not receive universal precations training prior to providing direct care to residents.	$100	
Outagamie		83.14(1)(d)	Three of seven staff did not receive required training in fire safety, first aid, and procedures to alleviate choking.	$100	
Northeastern					
Our House Memory Care	11/18/02	83.21(4)(p)	Resident #1 was observed (by facility staff) with multiple bruises between 9/1/02 and 9/14/02. Large, dark-colored bruises were observed on her arms, back, breasts, and groin area. The resident experienced a swollen ankle and a fall. The facility did not investigate the source of the bruises and did not contact the physician or resident's spouse until the day of discharge, 9/15/02.	$1,750 ($350/day for each day bruises/injury were noted - 9/1, 9/8, 9/10, 9/13, 9/14.)	Event ID: QTBF11. SOD #10006011
Whitewater			Above. Order: Training for all staff by a qualified professional on proper procedures and regulations (including chpts. 13 and 83) regarding preventing, investigating, and reporting abuse and injuries of unknown source.	order: see note	
Walworth					
Southeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Brotoloc Harbour Village East	11/11/02	83.19(1)(d)	Resident fell in bathroom on 4/13/02 and complained of pain. The physician was not contacted. On 4/15/02, the resident was taken to the emergency room. X-rays revealed multiple left rib fractures.	$250	Event ID#L10211
Kenosha		83.21(4)(p)	Staff did not use a gait belt when transferring resident #1on 4/13/02. Resident was holding the towel bar. Staff pulled a towel from under the resident's hand and the resident fell on the toilet, hitting her ribs. The resident complained of pain and was sent to the emergency room on 4/15/02 with fractured ribs.	$500	
Kenosha					
Southeastern					
Homestead of Elkhorn	11/11/02	83.14(1)(d)	2nd cite. Staff training not provided.	$150	Event ID: 041913 SOD# 10005938
Elkhorn		83.15(1)(c)1	Facility did not ensure staff were on duty when residents where in the building.	$500	
Walworth		83.21(4)(r)	Resident #4 did not receive Glucosan twice daily as ordered.	$75 ($25 per day - 6/24/02, 6/26/02, 6/28/02)	
Southeastern					
State Street Care Home	11/11/02	83.05(2)(a)	Facility is licensed for Class A Ambulatory and has two semi-ambulatory residents.	Order: Discharge res #1 or upgrade license. Complete evac assess for res. #2. Submit to RO for review.	Event ID# Z7U311
Adams		83.11(3)(a)	Licensee was not providing adequate oversight to facility and 24 citations were issued.	Order: No new admissions until violations are substantially corrected.	
Adams		83.13(3)	Employee C did not complete several areas of required training.	$100	
Southern					
		83.35(8)(b)	Bathroom carpeting was urine saturated with strong odor. Manager indicated carpet is "impossible to keep clean."	Order: Replace carpet in bathroom used by residents with washable-surface flooring within 30 days.	
	11/11/02	83.41(1)(a)2	Bedroom doors contain wood slab-type doors, suspended from tracks with nails protruding from wall as door stop. Doors do not have handles.	Order: Install rigid, swing-type doors within 30 days.	
		83.42(3)(f)	Facility did not perform night-time simulated fire drill in past year.	$100	
		83.43(3)(a)	Facility did not test and document smoke detection system as required.	Order: Test system within 3 days and maintain a written record.	
		83.43(3)(b)1	and 83.43(3)(b)2. Smoke detection system was not cleaned and inspected by a service company in the past year.	Order: Obtain test/inspection within ten days.	
		83.43(4)(b)2.c.	Basement smoke detector was not installed.	Order: Install basement smoke detector within ten days.	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Aurora Baldwin	11/8/02	83.32(2)(a)1	Resident had a history of pressure sores, 7/01. Facility did not develop service plan to address prevention of pressure sores. New sore developed 8/02. Service plan did not address nursing interventions for the treatment of new pressure sore. Ulcer worsened and resident was hospitalized and admitted to a nursing home.	$300	Appealed
Baldwin					
St. Croix					
Western					
Kare Center	11/8/02	83.21(4)(o)	Facility did not ensure that two residents received medications as ordered by the physician. In addition to an order to ensure that residents receive all medications as ordered, the RO will instruct the facility to contact the physician and legal represenatives regarding the need for funding for medications for two identified residents.	Order: Ensure that all residents receive medications as ordered by physician.	
Kenosha					
Kenosha					
Southeastern					
Care Partners IV	11/6/02	83.33(2)(G)3	Facility did not monitor the health status of resident #1 resulting in hospitalization for fecal impaction. Resident did not have a bowel movement 4/4 through 4/1/02 with no intervention by facility. Following hospitalization for impaction, facility did not adequately monitor resident for bowel	$400	Event ID: BOHU11 - SOD #10003808
Plover		83.33(4)(H)	The facility did not provide structured activities for 9 residents with dementia.	$200	
Portage					
Northern					
Weber Haus	11/6/02	50.065(2)(b)	The facility did not request or maintain criminal background information on 2 of 5 staff.	$100	Event ID: R65L12
Wonewoc		83.14(1)(a)	Client Related Training. Two staff had not received training. Second citation.	$150	
Juneau		83.14(1)(d)	Two staff had not received training for fire safety, first aid & choking.	$100	
Southern		83.14(2) & (3)	Two staff had not received training in dietary services and menu planning. One staff member responsible for administering medications had not received training	$200 ($100 for Dietary, $100 for Medication)	
		83.14(6)(a)1	Second citation. Facility did not ensure the local fire dept performed an annual fire inspection.	$100	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Living Hope	11/5/02	83.14(1)(a)(3)	Facility did not provide client-specific training for 3 staff. Resident #1 had a history of mental illness and self-injurious behavior and displayed suicidal symptoms.	$100	Event ID H43011. SOD #10005997
Twin Lakes		83.19(3)(c)	During hospitalization, resident #1 reported an incident of inappropriate sexual contact by two other residents that allegedly occurred at the facility. The hospital reported the allegation to the facility. No investigation was conducted and no report was filed with the Department.	Order to investigate allegation and submit report to RO within five days. Order to train staff in reqs. to prevent, investigate, and report abuse.	
Kenosha		83.21(4)(p)	Resident #1 drank toilet bowl cleaner on 6/3/02. Facility did not document interventions or monitoring. Medical treatment was not sought. Physician was not contacted.	$300	
Southeastern		83.21(4)(w)	Cleaning chemicals were not kept in secure area and resident #1 ingested cleaner on 6/3/02. Resident has a history of mental illness and self-injury (including cutting self). Razor blades were not kept in a secure area and resident #1cut wrists	$600 ($200 for first incident and $400 for second incident.)	
Bayshore Pines	11/4/02	83.33(2)(a)	Resident, with a history of attempting to leave the facility over the preceding 2-3 months, wandered out of the facility on 6/27/02 and was found 1-2 blocks from the facility, near the hospital. A "stranger" returned the resident to the facility. Resident had become more persistent in attempts to leave and more difficult to redirect. Facility informed family that personal alarms would be installed on exit doors.	$200	Appealed. Event ID 2YTP12. SOD #10006158
Marinette		83.14(1)(c)	Universal Precautions Training - 2 of 8 staff had not received training.	$100	Appealed.
Marinette					
Northeastern					
Hil Pewaukee House	11/4/02	83.56(2)	Plan Review. Facility installed an interconnected smoke detection system without submitting plans for dept. review and approval.	$100. Order to submit plans and fee.	SOD #10005996
Pewaukee					
Waukesha					
Southeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
SH Friedenheim SC 1	11/4/02	83.11(3)(h)	Permitting conditions of risk. Facility did not pay utility bills. No washer/dryer for five days. Gas (hot water) was off. No telephone 7/14-7/15/02. Insufficient supplies to meet resident needs for incontinence care. Six residents affected. Mortgage had not been paid for over one year. Payroll was not met and four staff members quit. (Assessed: $50/day x 14 days, including 8 days for no supplies, one day for no gas/hot water, $200 additional for no telephone for emergencies.)	License revocation. No new admissions. $900	Appealed. Event ID GFR015 - SOD #10005994
Slinger		83.20(2)(b)1	Five residents were relocated to sister facility due to staff shortage on 10/19/02. As of 10/21/02, no family members/legal reps had been notified.	$200	Appealed..
Washington					
Southeastern					
SH Friedenheim SC 2	11/4/02	83.11(3)(h)	Permitting conditions of risk. Facility did not pay utility bills. No washer/dryer for five days. Gas (hot water) was off. No telephone 7/14-7/15/02. Insufficient supplies to meet resident needs for incontinence care. Fourteen residents affected. Mortgage had not been paid for over one year. (Assessed: $75/day x 14 days, including 8 days for no supplies, one day for no gas/hot water, $200 additional for no telephone for emergencies.)	$1250. No new admissions. Produce evidence of financial stability within 10 days.	Event ID#U2Z114 - SOD #10005995
Slinger		83.21(2)(p)	Prompt and adequate treatment. Resident frequently did not receive assistance to the toilet despite asking for help. Due to lack of assistance, resident was incontinent and stated she felt ashamed, upset.	$250	
Washington		83.41(4)(a)	Heating. Facility did not turn heat on until 10/13/02. Residents complained of cold. On 10/14/02, resident room was 61 degrees. From 9/13/02-10/13/02, low temperatures ranged from 33 degrees to 49 degrees.	$775 ($25/day for 31 days)	
Southeastern					
Homestead of Elkhorn	11/2/02	83.15(1)(a)	SOD #10005939 - Survey 7/22/02 Did not provide staff to meet resident needs.	$1,680 ($240/day for six days)	
Elkhorn		83.33(2)(c)	Facility did not provide activities.	$600 ($300/day for two days)	
Walworth					
Southeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Abbey Manor	11/1/02	88.10(3)(P)	Resident #1 did not receive services to prevent pressures sores or to treat pressure sores that had developed. Order: Facility staff to receive training from a qualified health care professional within thirty days on how to provide appropriate treatment to prevent skin breakdown and how to treat skin breakdown, including assessment, development of a treatment plan, implementation of the plan and monitoring.	Order issued for staff training.	
Greenfield					
Milwaukee					
Southeastern					
Harmony Home	11/1/02	83.33(2)(a)	Facility did not supervise resident #1 who left the facility on 5/22/02 and on 9/20/02. The resident attempted to stop traffic and stepped into the path of moving vehicles to obtain a ride. The police and a local store clerk intervened. Police received no answer when calling the facility on 5/22/02 and received no answer when knocking on the door.	$650 ($250 for 5/22/02 incident and $400 for 9/20/02 - second, repeat incident)	SOD #10005384 Appealed
Cameron					
Barron					
Western					
Stone Crest Residence	10/31/02	83.14(1)(c)	3 of 4 staff had not completed training in universal precautions.	$100 forfeiture	
Wausau		83.14(1)(d)	3 of 4 staff had not completed training in first aid and choking and 2 of these 3 had not completed training in fire safety.	$100 forfeiture	
Marathon		83.33(4)	Resident was to be transferred with a gait belt, as identified in her ISP. On 8/4/01, two weeks after admission for respite care, a staff person attempted to transfer the resident without a gait belt. The resident fell and sustained a fractured shoulder. Subsequently, she required the assist of two and a mechanical lift for transfers.	$500 forfeiture	Appealed
Northern		83.15(1)(a)	Facility did not have 2 staff available to assist 1 resident who wanders w/risk of elopement; 5 residents who wander; 1 resident who is combative to staff; and 2 residents who need 2-person transfers.	$500 forfeiture	Appealed
		83.19(3)(f)	Caregiver did not use gait belt to transfer resident as ordered; resident sustained fractured shoulder and became a 2-person transfer; and facility did not report incident of hospitalization.	$500 forfeiture	Appealed

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Charlton House	10/30/02	83.05(2)(a)	Two residents do not meet the requirements for Class AA (the residents are unable to respond to a fire alarm without verbal or physical assistance from staff.)	Order requiring discharge or upgrade license.	SOD #10006529 Appealed
Beaver Dam		83.14(1)(d)	Fire Safety, First Aid & Choking. 2 of 5 staff not trained.	$100	Appealed
Dodge		83.14(2)	Dietary. 2 of 5 staff not trained.	$100	Appealed
Southern		83.15(1)(c)1	Facility had an out-dated waiver (1987) allowing one resident home alone for 3 hours per day. Facility had not reassessed as directed. Resident is treated for seizures and requires food preparation and monitoring during meals due to choking risk, but had been left alone at lunch time. Resident was told to self-administer noon medication.	$300 and order to have staff present whenever residents are in the facility.	Appealed
		83.41(4)(b)2	Facility did not ensure that gas furnace had been inspected at least once in the past three years.	Order to have gas furnace serviced within 7 days.	Appealed
Charlton House (cont.)	10/30/02	83.41(10)(a)	Building not maintained in good condition.	Submit plan of correction and order to repair exterior stair railing that is used for emergency evacuation (w/in 3 days).	Appealed
Beaver Dam		83.43(3)(a)	Facility did not maintain a written record of tests of smoke detection system.	$50 (2nd citation) and an order to test system and maintain a written record w/in 3 days and comply with HFS 83 for subsequent tests.	Appealed
Dodge		83.43(4)(b)2.b	Facility did not have smoke detectors installed in the first floor staff office or the third floor staff bedroom.	$200	Appealed
Southern					
Loving Care Villa	10/30/02	83.21(4)(p)	Prompt and adequate treatment to resident who needed frequent medical treatment.	Order to not admit new residents	Appealed.
Wisconsin Rapids		83.11(1)	Facility has not produced sufficient information of financial stability to permit operation of facility for at least 60 days.	Order to not admit new residents	Appealed.
Wood					
Northern					
Wells Nature View VI (II)	10/30/02	83.15(1)(a)	Facility did not provide adequate staff to safely evacuate 15 of 19 residents. Evacuation drill exceeded 7 minutes and all residents had not evacuated when the drill was terminated. Facility staffed only one caregiver at night from 6/12/02-8/22/02 and one caregiver from 3:00-3:30 p.m. daily. Several residents were identified with physical and/or cognitive limitations including resident #1 who recently required a 2-person transfer.	$860 ($360 assessed @ 10/hr for 72 days for having only one caregiver from 3:00-3:30 p.m. $500 for failing to have an emergency plan w/adeq staff.)	SOD#10003797 Appealed
Marshfield			Above	Order: Develop emerg plan within 10 days	Appealed
Wood					
Northern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Comforts of Home	10/28/02	83.11(1)(a)	Facility had not been paying staff, grocery or utility bills.	Order to provide proof of financial stability.	SOD #10006260 Appealed
Black River Falls		83.06(1)(a)3	Facility admitted and retained a resident with aggressive behaviors. The resident's physical, psychiatric, and social needs are not compatible with the CBRF client group.	Order to discharge resident within 10 days and ensure the safety of residents until discharge occurs.	Appealed
Jackson					
Western					
Jackson House	10/28/02	83.33(2)(a)	Facility self-report. Resident with behavior of self-injury (had inserted knife in rectum on and was hospitalized 11-9-01 to 3-13-02) was not adequately supervised on 3-24-02 and injured self with coat hanger.	$500 (date of violation: 3-24-02)	SOD #10005990
Milwaukee					
Milwaukee					
Southeastern					
Friendship Haven	10/25/02	83.14(1)(c)	Universal Precautions (3 of 8 not trained)	$100	SOD #10006153. Paid
Waupun			Fire Safety (3 of 8 not trained)	$100	SOD #10006153. Paid
Dodge		82.14(2)	Dietary (2 of 8 not trained)	$100	SOD #10006153. Paid
Southern		83.43(3)(b)1	Testing by a Service Company. Testing had not occurred in 2001 or 2002 (as of 9/25/02).	$100 and an order to test within ten days. (second violation)	SOD #10006153. Paid
Golden Years	10/24/02	83.15(1)(a)	Facility did not follow Dept. order to ensure adequate staff (2 caregivers, 24 hrs. per day) to meet the needs of a resident requiring two to transfer, 9-9-02 through 9-18-02)	$2400 (160 hours @$15/per hour - potential negative outcome.)	Appealed.
DeForest					
Dane					
Southern					
Morning Star 2	10/23/02	83.07(10)(a)1	Facility did not provide a plan of correction for 3 SODs. Second violation issued on 9/5/02.	REVOKE LICENSE $280 forfeiture ($10/day from 9/5/02 to 10/3/02 - when last residents were discharged.)	
Merrill		83.14(1)(a)	Client Related Training. 3 of 5 staff were not trained	$100	
Lincoln		83.14(1)(b)	Needs Assessment/ISP. 3 of 5 staff were not trained	$100	
Northern		83.14(1)(c)	Universal Precautions. 1 of 5 were not trained	$100	
		83.14(1)(d)	Fire Safety, First Aid & Choking. 2 of 5 were not trained	$100	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Morning Star 2 (cont.)	10/23/02	83.15(1)(a)	Resident #8 required two caregivers for transfers from 1/31/02 to 3/20/02. There were 48 days when staff did not ensure 2 caregivers were available.	REVOKE LICENSE. $1,440 forfeiture ($10 per shift x 48 days ($30/day)	
		83.21(4)(1)	Telephone was taken from residents #4&5 without consent from 9/1/02-9/11/02. Staff took cigarettes and personal items from residents.	$200	
		83.21(4)(p)	Resident #8 did not receive prompt/adequate tx for pressure sores, weight loss (22# in 7 weeks). Resident #3 did not receive prompt/adequate tx for head injury.	REVOKE LICENSE $1000 forfeiture	
		83.42(3)(d)	Staff did not know how to respond to death of resident; failed to call 911. Called her mother (who is not a facility employee) for help.	$200	
		83.33(2)(c)	Facility did not schedule, provide, or promote daily activities.	$400	
The Whitney Lodge	10/17/02	83.14(1)(c)	3 of 5 staff not trained - Universal Precations	$150	
Madison		83.14(1)d)	1 of 5 staff not trained - first aid	$50	
Dane		83.14(2)	1 of 5 staff not trained - dietary	$50	
Southern		83.14(7)(3)	1 of 5 staff not trained - medication administration	$50	
		83.43(7)(a) 83.51(3)	83.43(7)(a) & 83.51(3)(a) Sprinkler System and Smoke Separation	Order: Comply with requirement and no new Class C admissions until installed.	
Altercare	10/16/02	83.05(2)(d)	Facility is licensed as Class C Ambulatory (CA). Two residents have walkers and difficulty with ambulation.	Order to discharge residents or upgrade licensure class.	
Madison					
Dane					
Southern					
Comforts of Home	10/16/02	83.15(1)(a)	Facility did not have sufficient staffing on the night shift on 9/7 and 9/8/02. Only one caregiver was available for residents currently requiring 2-person transfers.	$160 (two 8 hr shifts @ $10/hr assessed)	
Black River Falls		83.07(7)	Facility had not submitted license renewal application as of 10/3/02. License expired on 8/1/02.	$630 ($10/day from 8/2-10/3/02. Cont. $10 per day until application is received.)	
Jackson		83.43(2)(a)1	Facility did not provide fire dept with updated plan indicating which residents required point of rescue. Facility had not submitted an update since Jan. 2002 and changes in residents and room locations occurred.	Issue an order to provide updated information within 5 days.	
Western					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
HiL Fox Mead Waterford Racine Southeastern	10/15/02	83.21(4)(p)	Facility did not ensure a resident received services to prevent severe sunburn. Resident was sunburned on 6/30/02 and again on 7/11/02 sustaining 2nd degree burns. Facility did not seek tx until 7/19/02 and did not ensure the resident received acetaminophen for sunburn pain.	$250 (not preventing 7/11 burn or providing tx for burn/pain)	
Hampton Supportive Care Milwaukee Milwaukee Southeastern	10/14/02	83.15(1)(a)	Facility did not comply with Department directive to staff minimum 4 resident assistants per shift. One resident assistant was assigned to the second floor where 19 residents resided including residents requiring monitoring for behavioral concerns (smoking in bedroom, exiting facility unattended, combativeness) and assistance with activities of daily living. RFOS recommends continuing directive to require a minimum of 4 caregivers per shift.	$4,230 ($10/day from July 1, 2001 to August 27, 2002. Continue order for 4 caregivers per shift.	Facility is appealing. (SOD #10005985).
		83.41(2)(c)	Facility did not supply sufficient, clean towels in good repair for resident use. Linen closets and bathrooms did not contain towels for resident use. Staff used an 8" piece of fabric as a towel to provide foot care to a resident.	$100 and an order to supply sufficient, clean towels in good repair to meet resident needs.	Paid
		83.43(1)	Facility did not have a fully interconnected smoke detection system. Thirty-two bedrooms had single-station smoke detectors. (Plans were received on 1/3/02 and approved on 4/9/02.)	$1,430 ($10/day) 1/1-1/2/02 = $20. 4/10-8/28/02 = $1,410. $10/d until installed.	Paid
Little Pine Valley Mauston Juneau Southern	10/11/02	83.33(2)(a)	3rd cite. Facility has not properly supervised a DD resident who was protectively placed because the resident's immaturity and impulsivity precluded caring for himself without supervision and without creating a substantial risk for harm. Resident was taken to and dropped off at a dance without supervision on 8/7/02 (returned 8/8 at 1:45 AM), at a fair on 8/16 (returned 4:22 PM on 8/17), and in Wis. Dells on 9/15 (returned 1:15 PM on 9/16 after turning himself into the police).	$2400 ($800 x 3)	Appealed.

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
REM - Eponymous Portage Columbia Southern	10/10/02	88.05(2)(a)	Facility has residents who require assistance with ambulation but does not have two exits ramped to grade.	Order to ramp to grade 2 exits and not to admit residents requiring assistance with ambulation until installed.	
Cedar Crossing Elder Services	10/9/02	83.21(4)(r)	Facility did not give the 4:30 PM dose of insulin on 8/21, 8/26, 8/31, and 9/10. Facility did not give sliding scale insulin on 10/6, when blood sugars were high, because the dose needed was not drawn up. Facility did not monitor blood glucose levels as frequently as ordered, on 9/5, 9/11, 9/18, 9/20, 9/21, 9/29, 10/1, 10/2, 10/4, and 10/6/02.	$510 forfeiture ($50/day when 4:30 insulin not given; $200 on 10/6; $10/day when blood glucose levels not monitored.)	Paid
Baraboo Sauk Southern		83.33(3)(e)2b	An RN had not delegated authority to give injections to caregivers	$100 forfeiture	Paid
Gardens at Bayside North Bayside Milwaukee Southeastern	10/4/02	83.41(9)	Facility had an odor, particularly bad in one area, that smelled like sewer gas or rotten cabbage. Licensing specialist stated it was "nauseating" and staff and residents complained of burning eyes and headaches from the smell. The smell had been present at varying degrees for four months.	$500 forfeiture	Paid
Hammersley Place Madison Dane Southern	10/4/02	88.05(2)(a)	Only 1 of the facility's 3 exits is ramped to grade even though all 3 residents require assistance with ambulation (walker or quad cane).	Order to ramp exits to grade.	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Sunny Ridge LLC	10/4/02	83.14(1)(d)	3 of 5 staff have not completed training in fire safety and 1 of 5 has not completed training in first aid.	$100 forfeiture	Paid
Marshall		83.33(3)(e)2b	3rd cite. Staff administer an insulin injection to a diabetic resident. This task has not been delegated to staff by an RN who has also assumed responsibility for supervision and oversight.	$400 forfeiture. Order for RN to delegate in writing responsibility for giving injections and to provide supervision or to discharge the resident.	Paid
Dane					
Southern					
Waunakee Manor CBRF	9/27/02	83.14(1)(d)	2nd cite. 1 of 8 staff had not been trained in fire safety and first aid.	$50 forfeiture	Paid
Waunakee		83.43(4)(b)3	2nd cite. Facility did not have an interconnected smoke detection system in 10 resident bedrooms, the office, and both sides of the chapel. The facility had single-station battery-operated smoke detectors in these areas.	$10/day from 1/1 - 9/25 - 10/10/02 (date installed) = $2780	Paid
Dane					
Southern					
Family Faith Group Home	9/25/02	83.43(4)(b)2a	Facility had only single smoke/fire alarms in 8 bedrooms and did not have alarms that were part of its interconnected smoke detection system.	$2540 forfeiture ($10/day from 1/1 - 9/11/02 + $10/day until plans are submitted + $10/day from approval date until installation date.	Appealed. Forfeiture assessment withdrawn per JQ letter 10/15/02
Milwaukee					
Milwaukee					
Southeastern					
RFDF Strathmore	9/25/02	88.05(2)(a)	Facility has a resident who requires a walker, or the assistance of another person, to ambulate. Neither exit from the facility has a ramp to grade. Front exit has six steps and the rear exit has two.	Order to upgrade facility, including two ramped exits to grade.	
Madison					
Dane					
Southern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Oakwood House East	9/24/02	88.05(2)(a)	Facility has one resident who requires assistance with ambulating, as verified through observation and record review. Neither exit from the facility is ramped to grade - one exit has nine steps, another has five.	Order to install ramps	
Waukesha		88.07(1)(a)	2nd cite. On 2/9/02, manager found the house empty and in disarray that evening when reporting to work. Through the police, the manager learned that the staff person working the dayshift had taken the facility's three residents on an unauthorized outing. The staff member had been involved in a car accident and had been charged with driving while intoxicated. None of the residents were hospitalized but were placed on a watch for possible head injuries. The manager had previously directed the staff person not to drive residents because of insurance concerns. The manager had had other concerns with this staff person because of finding a beer bottle cap in the facility and missing items after this person had worked. The manager, however, had not communicated these concerns to the licensee.	Continue no new admissions (from Jan. 2002 survey when staff person was charged with drug dealing). Referral to CRIS.	Order lifted 12/19/02 per PB; corrected.
Waukesha Southeastern					
Windsor House Glendale East	9/24/02	83.21(4)(p)	Resident had a second fall from bed on 7/22/02. (Facility had not used a mattress on the floor as identified in the ISP but was using a side rail designed for children up to 36 months.) Resident complained of shoulder pain throughout the day, telling the surveyor it was an "8" on a scale of 1-10, and later as a "9." Facility did not give any pain medication from 6:10 AM until 4:35 PM.	$400 forfeiture	Paid. Appealed citation 10/8/02. Appeal withdrawn 10/31/02
Glendale		83.32(2)(a)	Resident wandered out of the facility, unbeknownst by staff, crossed a busy two-lane street and was found sitting on the ground after a neighbor notified the facility.	$300 forfeiture	Paid
Milwaukee		83.21(4)(n)4	Facility restrained a resident with a history of wandering by placing him next to the table and locking his wheelchair. This was done because there weren't enough staff to supervise him. Facility used a side rail (designed for children up to 36 months) for a resident with a history of falling out of bed, without department approval.	$500 forfeiture	Paid
Southeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Bluffview Meadows	9/19/02	83.14(1)(a)	3rd cite. 4 of 4 staff had not completed training in residents' rights, managing behaviors, and client-group specific training. (SOD: 10006491)	$600 forfeiture ($150 x 4)	Appealed. SOD re-issued, forfeiture withdrawn. Per JG, appeal will be wd.
North Freedom		83.14(1)(c)	3rd cite. 7 of 8 staff had not completed training in universal precautions.	$1050 forfeiture ($150 x 7)	Appealed. SOD re-issued, forf. Withdrawn; per JG appeal will be withdrawn.
Sauk		83.14(1)(d)	2nd cite. 3 of 7 staff had not completed training in fire safety and 6 of 7 had not completed training in first aid.	$150 forfeiture	Appealed SOD re-issued, forf. Withdrawn; per JG appeal will be withdrawn.
Southern		83.14(2)	2nd cite. 7 of 7 staff had not completed dietary training.	$150 forfeiture	Appealed. SOD re-issued, forf. Withdrawn; per JG appeal will be withdrawn.
		83.14(3)	7 of 8 staff had not completed medication administration training.	$100 forfeiture	Appealed. Cite/forfeiture remains; appeal to be withdrawn.
Sunny Spring Corporation	9/19/02	83.14(1)(c)	5 of 5 employees had not completed training in universal precautions prior to beginning work.	$100 forfeiture	Paid
Port Washington					
Ozaukee					
Southeastern					
Agape Acres Supportive Living	9/18/02	83.21(4)(h)	One two-bed room did not have a bathroom door, exposing whichever resident used the toilet.	Order to replace bathroom door.	
Warrens		83.32(2)(a)	3rd cite. Facility had not developed complete and up-to-date ISP's for 3 of 3 residents reviewed.	$450 forfeiture ($150 x 3)	
Monroe		83.33(2)(a)	Resident wandered 1/2 mile away down a county road when staff forgot to activate the door alarm.	$200 forfeiture	Appealed
Western		83.33(3)(c)2	Facility did not have a system for maintaining proof-of-use records and for auditing controlled medications. A bottle of 27 doses of Lortab and 90 tablets of propoxyphene were missing and unaccounted for.	Order to develop a system for maintaining proof-of-use records and for auditing controlled medications.	
		83.33(4)(h)	Facility did not have activities for dementia residents on 2 of 2 days of survey.	$400 forfeiture ($200 x 2)	

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Alterra Sterling Manitowoc	9/18/02	83.13(7)(b)	Facility did not provide the personnel records for one staff person from 9/9 until 9/16. On 9/10, corporate staff stated the request needed to be made in writing on State of Wisconsin letterhead.	$200 forfeiture	Appealed. Per stipulation, forfeiture withdrawn.
Manitowoc			Resident developed open areas and blackened toes following admission to the CBRF on 6/9/02. The resident's family and physician were not notified of the resident's changing condition. Arrangements were not made for needed health services. Resident was admitted to the hospital on 8/13/02 and was noted to have numerous open areas and blackened toes on her right foot. The physician was not notified of the pressure sores prior to admission to the hospital, and the resident's leg was amputated above the knee as a direct result of the ischemic ulcers on the toes. A second resident experienced a decline in her medical condition including problems with swallowing, decline in food and fluid intake, suspected weight loss, development of skin breakdown, and pain. The CBRF did not notify the resident's physician and family members promptly of changes in her medical condition. The CBRF did not arrange for needed health services such as an evaluation of her swallowing deficits, proper thickening of food and fluids, weight monitoring, pain management and necessary interventions to prevent and treat open areas.	$4500 forfeiture. Probationary and conditional license for new owner if CHOW occurs on 9/26/02. All violations to be corrected within 30 days.	Appealed. Case No. ML-02-0223 settled by stip.
Manitowoc Northeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Mill Pond Senior Living #513 (cont.)	9/18/02	83.21(4)(h)	2nd cite. Staff did not respect the privacy of residents in that they brought their children and, during one observation, their disabled spouse to work with them. One resident stated that the children's noise bothered her.	$100 forfeiture	Appealed. Per stipulation dated 10/21/02, total forf. Reduced to $5950. Pd
		83.21(4)(p)	Resident had a medication change by the resident's physician on 06/13/02. Following the medication change, the resident had fluctuating blood sugars on a daily basis for the next month and a half. On 6/17 and 6/18 the resident did not feel good and was confused. Staff did not check blood sugar aside from a 210 reading at 1:15 AM on 6/17. On 7/16, blood sugar was 441 and later was 294. No MD contact. On 07/18/02 the resident's blood sugar level on the P.M. shift was 351. Administrator was contacted by the facility staff on duty, and instructed the facility staff to give 1/2 tab (5 mgs) of Glucotrol to the resident. On 7/20, blood sugar was not recorded even though the resident had "lots of confusion." On 07/28/02 on the P.M. shift, the resident's blood glucose level was 432. Administrator again instructed the facility staff to give the resident 1/2 tab. (5 mgs.) of Glucotrol. The resident's family or physician were not notified of these changes in the resident's condition, nor had the physician given the facility an order to give these medications related to those blood sugars levels.	$700 forfeiture ($50/day for 6/17, 6/18); $100/day for 7/16, 7/20; $200/day for 7/18, 7/28)	Appealed. Paid
		83.33(3)(a)1	2nd cite. Facility did not have MD written orders for the prescriptions of 6 of 6 residents.	$150 forfeiture	Appealed. Paid

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Mill Pond Senior Living 513 (cont.)	9/18/02	83.07(11)(d)	Facility has a probationary license. At survey in March 2002, facility had 12 citations. At revisit in May, there were 12 additional citations. At current survey, there are 11 repeat and 10 new citations. Of the repeat deficiencies, two deficiencies related to training, and 4 related to medication issues. One repeat deficiency related to the cleanliness of the rooms and one repeat deficiency related to the lack of privacy for the residents. Out of the 10 new deficiencies, 3 related to proper documentation, 1 related to training, 2 related to staff background checks, and 1 related to not posting the plan of correction. Two of the new deficiencies had a direct impact on the health, safety and welfare of the residents residing at the facility. One of these deficiencies related to prompt and adequate treatment and the other deficiency related to medical services. SOD #10006127	NON-RENEWAL OF LICENSE	Appealed. Per stipulation 10/21/02, total forf. Reduced to $5950. Paid
		83.14(1)	2nd cite. 1 of 8 staff had not completed 45 hours of initial training.	$50 forfeiture	Appealed. Paid
		83.14(1)(d)	2nd cite. 4 of 5 staff had not completed training in fire safety, first aid, and choking.	$150 forfeiture	Appealed. Paid
		83.14(3)	2nd cite. 2 of 8 staff had not completed training in medication administration.	$150 forfeiture	Appealed. Paid
		83.15(1)(c)1	2nd cite. One resident's condition had changed such that the resident needed two staff for transfers. Facility was staffed with only one person, who requested the assistance of the licensing specialist to transfer the resident. Staff had approached the licensee about purchasing a lift but the licensee had told staff to make do with what they had.	$250 forfeiture	Appealed. Paid

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Mill Pond Senior Living 515	9/18/02	83.07(11)(d)	Facility has failed to comply with ch. 50 and HFS 83 as evidenced by 21 citations served in May 2002, 14 citations served in July 2002, and 16 citations served in August 2002, 7 of which were repeat violations. SOD #10006128	NON-RENEW LICENSE	Appealed. Per stipulation dated 10/21/02, total forf. Reduced to $5950
Westfield		83.19(3)(c)	Facility did not investigate two allegations of theft from a resident, of approximately $200 (charge for 3 shaves given to the resident) and $500 (overcharge of "keep the change" for several errands that were run for the resident) by a caregiver's fiance.	$200 forfeiture	Appealed. Paid
Marquette		83.21(4)(o)	3 residents had not received their medications as ordered by the physician on 12 different dates because the facility did not have the medications on hand.	$300 forfeiture ($25/day x 12)	Appealed. Paid
Northeastern		83.21(4)(p)	Beginning in mid-July, a resident began having symptoms of worsening congestive heart failure (swollen feet and ankles and weight gain of 10 lbs.). MD, on 7/30/02, said, "needs to take in less fluids and salt." Between 7/30 and 8/18, when the resident died of congestive heart failure, the facility did not contact the physician when the resident had changed symptoms, such as "frequent thirst and urination with foul smelling urine" (7/31), "ankles and feet hot and big" (8/3), difficulty breathing and "acting strange" (8/6), "confused and disoriented, aggressive" (8/7), "ankles really swollen" (8/8), and "feet badly swollen" (8/14).	$1500 forfeiture	Appealed. Paid
		83.33(2)(c)	2nd cite. On 8/27 and 8/28, three residents stayed in their rooms all day except to smoke. No activities were provided. One of these resident's annual CBRF evaluation had stated, "needs more activities."	$600 forfeiture ($300 x 2 days)	Appealed. Paid
Mill Pond Senior Living 515 (con't)	9/18/02	83.33(3)(a)1	2nd cite. Facility did not have written physician orders for the medications being given to 2 of 3 residents.	$225 forfeiture ($75 x 3)	Appealed. Per stipulation dated 10/21/02, total forf. Reduced to $5950. Pd
		83.35(1)(f)	2nd cite. Facility did not provide 3-5 servings of vegetables on 19 of 48 days. There were no vegetables served on one date, one serving of vegetables on another date, and 2 servings of vegetables on 17 dates.	$245 forfeiture ($50 x 1; $25 x 1; $10 x 17 days)	Appealed. Paid
		50.03(5g)	Facility, even though it was under a No New Admissions order, admitted a respite resident off and on throughout August 2002.	$600 forfeiture ($100 x 6 days)	Appealed. Paid

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Tender Elder Care I	9/13/02	83.21(4)(p)	Resident complained throughout November 2000 that her eyes were bothering her (itching). Staff did not notify MD. It wasn't until 11/29, when the resident was admitted to the hospital with a broken arm, that conjunctivitis was identified and medication started.	$200 forfeiture	
Ashland		83.33(2)(c)	No activities were observed during two days of survey from 1-4:45 PM on 4/8 and 6:30 - 6:00 on 4/9.	$300 forfeiture	
Ashland		83.33(3)(e)3a	Resident was given PM insulin dose in the morning (32 U NPH and 10 u regular) rather than the AM dose. Staff identified the error when it was time to give the PM dose. Licensee instructed staff person to give the morning dose, with some squirted out, at 4 PM (12 u NPH, 4 u Reg.) Staff persn complied rather than disobey the licensee. Resident was "shaky" that evening and "not herself." Resident was given a snack and observed 1:1 for half an hour.	$300 forfeiture	
Northern					
Oak Grove	9/12/02	88.05(3)(a)	Hot water temperatures at the sinks in 2 bathrooms and in the kitchen sink were 140 and 141 degrees. At this temperature, scalding could occur within 6 seconds.	Order to maintain hot water temperature at 120 degrees.	
Fort Atkinson					
Jefferson					
Southeastern					
West Allis Castle, LLC	9/12/02	83.14(1)(d)	4 of 6 staff had not completed training in fire safety.	$100 forfeiture	
West Allis		83.21(4)(p)	Resident fell in the bathroom at 3:15 AM. Caregiver could not get the resident up. She called the licensee who instructed her to make the resident comfortable with blankets and pillows and to get her up when the dayshift caregiver arrived - which was three hours later.	$300 forfeiture	
Milwaukee					
Southeastern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Haven House	9/11/02	88.04(2)(a)	Third citation. Licensee has not ensured compliance with HFS 88 as demonstrated by 15 citations of noncompliance, 14 of which are being cited for the third time since April 2002 and one which is being cited for the second time. Citations include no personnel records, no medication orders for one resident, no ISPs, no semi-annual fire drills, no monthly testing/servicing of smoke detectors, no evacuation plan for a nonambulatory resident, no evacuation evaluations, no DOJ and IBIS check on employees, and blocked egress. Licensee had 27 citations in April (including refusal to admit licensing specialist), 24 uncorrected citations in July, and 15 uncorrected citations at this survey.	REVOKE LICENSE	Appealed (Prehearing scheduled for November 13.)
Sun Prairie					
Dane					
Southern					
Golden Oaks Home	9/9/02	83.14(1)(c)	2nd cite. 2 of 8 staff had not completed training in universal precautions.	$150 forfeiture	Appealed. Dismissed due to no show.
New Berlin		83.14(1)(d)	3 of 8 staff had not completed training in fire safety, first aid, and/or choking and 1 of 8 had not completed this training within 90 days of hire.	$150 forfeiture	Appealed. Dismissed
Waukesha		83.14(3)(a)	1 of 8 staff had not completed training in medication administration training.	$50 forfeiture	Appealed. Dismissed
Southeastern		83.33(2)(a)	Resident had a history of eloping or attempting to elope (64 times between 5/4/01 and 9/27/01). On 2/26/02, staff forgot to alarm the back door. Resident wandered out shortly after 12:10 AM and was brought back by police about half hour later. Resident was found in the middle of the road approximately 3/10's of a mile from the facility wearing pajamas, a robe, and slippers. Outside temperature was 29 degrees.	$250 forfeiture	Appealed. Dismissed
		50.065(2)(b)	2nd cite. DRL background checks were not documented for 4 of 8 staff. This was completed within two weeks following the end of the survey.	$100 forfeiture	Appealed. Dismissed
Huntington Residence	9/9/02	83.14(4)	3 of 5 staff had been trained by a part-time RN through a facility-sponsored program. The RN had not been approved as a trainer by the department.	$100 forfeiture	Paid
Janesville					
Rock					
Southern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Women in Transition - Halfway Madison Dane Southern	9/9/02	83.13(3)	1 of 8 staff had not completed training in fire safety and first aid, universal precautions, client-specific training, dietary training, and medication administration.	$100 forfeiture	Paid
Countryview	9/6/02	83.14(1)	Licensee's husband, who functions alone as a careigver at times, did not have block 1 training, dietary training, or med. administration training.	$100 forfeiture	Appeal rec'd 9/17/02
Germantown		83.15(1)(b)	When the licensee went out of the country from 5/27 through 6/10, they assigned as backups two staff who had previously been fired. One of these staff worked 5/27. Another back up worked from 10:30 PM on 6/9 to 2:30 PM on 6/10. She stated she had never worked dayshifts before and didn't know what to do. On 6/10, one resident lay on the floor for 20 minutes until the caregiver secured additional help getting up the resident, ran out of food serving breakfast, and had one resident with rib pain go unassessed for over four hours.	$700 forfeiture ($200 for 5/27 and $500 for 6/10)	Appeal rec'd 9/17/02
Washington Southeastern		83.33(2)(h)	Resident who was to have accuchecks done twice weekly, had 1 of 4 the last two weeks in February, 3 of 8 done in March, 3 of 8 done in April, 3 of 10 done in May, and 3 of 8 done in May.	$250 forfeiture ($10 per missed accucheck)	Appeal rec'd 9/17/02
Heavenly Care Group Home	9/4/02	83.41(5)(d)2	Facility water temperature at one of the tubs was 140 degrees, a temperature at which scalding can occur in six seconds. A non-verbal developmentally disabled resident sustained severe second-degree burns to the tops of both feet when she stepped into the tub. Resident is temporarily unable to walk because of the burns.	$800 forfeiture	Payment extension granted until 10/31/02
Milwaukee Milwaukee Southeastern		83.21(4)(p)	Facility delayed for almost 12 hours before the burns sustained by a resident were assessed by a licensed professional. Caregiver called the LPN on duty at 11 PM concerning the burns and was told to "assess" them (which she was not qualified to do) and to call back if the blisters worsened. Doctor's office states they were called and told the resident had a rash, for which treatment was ordered, but facility staff deny having made such a call.	$800 forfeiture	Payment extension granted until 10/31/02. Late notice sent 11/6/02