Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
701012701	or dorate of the transfer of t	IDENTIFICATION TO COMBETA	A. BUILDING: _			
		0011819	B. WING		C 01/16/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SPRINGB	ROOK COMMUNITY ASS	SITED LIVING LLC	TER COURT KA, WI 54650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
U 000	INITIAL COMMENTS		U 000			
	Springbrook Communum 1/13/2020, with further	tion was conducted at nity Assisted Living on er information received on lt, 1 violation of DHS 89 was				
	Census: 66	abstantiated.				
U 238	89.29(3)(c)1.a. ADMI TENANTS	SSION & RETENTION OF	U 238			
	(3) TERMINATION OF CONTRACT.					
	(c) Procedures for termination.					
		I care apartment e 30 days advance to the tenant gnated . If there is entative, the e county or human services e or 46.23, as evidenced by: ew and interview, the facility notice before discharging a				
	written by the facility was addressed to Ternotice of immediate of 12/31/2019. The notice	rveyor reviewed a letter dated 12/31/2019. The letter nant 1 and gave Tenant 1 discharge effective ce stated Tenant 1 had three e last month, as well as acute				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		0011819	B. WING		01/16/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
SPRINGR	ROOK COMMUNITY ASS	SITED LIVING LLC 861 CRITTI	ER COURT			
SFININGE	KOOK COMMONITT ASS	ONALASK	A, WI 54650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
U 238	Continued From page	e 1	U 238			
U 238	colitis and rectal bleed medically unstable and uncontrolled internal I had tested positive for (C-Diff) and airborne Staphylococcus aurent the facility could not resituations as they do monitor for internal blueded to issue an interviction notice effective. The surveyor interview A regarding the notice e-mailed the letter to sent one to Tenant 1's Tenant 1 was not at the hospital. ED A state facility address with the family member would. The surveyor interview member who stated his was spending time at and they had no reas picked up before Tenant 1. Tenant 1 state is the tenant 1. Tenant 1 state is the tenant 1. Tenant 1 state is the emergency discontinuation of the discharge. The of the emergency discontinuation of the discharge I not realize Tenant 1 his the surveyor reviewer.	ding, and that Tenant 1 was and posed a risk for bleeding. It stated Tenant 1 in Clostridium Difficile Methicillin-resistant aus (MRSA). It further stated manage these medical not have licensed staff to eeding and therefore mediate emergency we that day. Wed Executive Director (ED) is ED A stated he/she Tenant 1's case worker and is address at their facility. Tenant 1 was in the he/she sent it to the me thought that Tenant 1's pick up Tenant 1's family me/she works full time and the hospital with Tenant 1 on to think the mail would be ant 1 returned from the member stated he/she was never staff and never received the enant 1 only became aware charge when he/she was by a hospital nurse who did and not been informed.	U 238			
	On 12/3/2019, Tenan	t 1 told staff he/she had Staff B observed in the				
		ith blood in it and suggested				
	Tenant 1 go by ambu	lance to the hospital. Tenant an appointment that day with				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011819	B. WING		C 01/16/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-
SPRINGBROOK COMMUNITY ASSITE	ED LIVING LLC 861 CRITTE ONALASKA	ER COURT A, WI 54650		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE COMPLETE
phone with the triage nurse asked to speak with the triage nurse agreed Ten Tenant 1 agreed. The arranant 1 was admitted transtraint 1 was taken to the facility on 12/6/20. Tenant 1 was taken to the family member was consequently member was consequently member was consequently member was admitted to the hose active bleeding was four by physical therapy and and they indicated he/shassisted living. Tenant 1 was admitted to 12/27/2019, with abdomediagnosed with C-Diff. To note dated 12/31/2019, in Tenant 1's stool. The Tenant 1 tested positive state Tenant 1 had an arranstraint 1 had three hose in the last month. Hospit Tenant 1 was only admit GI bleed one time and the Tenant 1 brought it to the The emergency letter of	d inform him/her. Staff B saure cuff and when coom Tenant 1 was on the curse. Staff took vitals and a nurse. Staff B and the nant 1 should be seen, and mbulance was called. to the hospital with a n 12/3/2019 and returned on 19. The physician on amily member as the neerned about Tenant 1's to the physician's red 12/23/2019, Tenant 1 spital for anemia. No nd and Tenant 1 was seen to occupational therapy, the was stable to return to to the hospital on ninal discomfort and was the physician progress stated there was no blood laboratory tests showed a for MRSA but did not not not not not not not not of the hospital on the total composition. The physician progress stated there was no blood laboratory tests showed a for MRSA but did not	U 238		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			/ 20122to. <u>-</u>		С
		0011819	B. WING		01/16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE	
SPRINGB	ROOK COMMUNITY ASS	SITED LIVING LLC	TER COURT		
0/0.15	STIMMADY ST.	ATEMENT OF DEFICIENCIES	KA, WI 54650	PROVIDER'S PLAN OF CORRECT	ION OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
U 238	Continued From page	e 3	U 238		
	12/17/2019 and 12/27 did not have active bl	7/2019, both stated Tenant 1 eeding.			
	1 was, "Now positive MRSA." Tenant 1 was	of discharge stated Tenant for both C-Diff and airborne s treated for C-Diff and there how Tenant 1 had active			
		er of emergency discharge, wed to return to the facility or over 3 years.			
	criteria for emergency	monstrate Tenant 1 met the discharge and did not have to serve Tenant 1 with a 30 discharge.			