STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015172	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK ON WEST PROSPECT	2601 TOUCHMARK DR APPLETON, WI 54914

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/28/2024, Surveyor conducted 2 complaint investigations at Touchmark on West Prospect, a CBRF located in Appleton, WI. As a result of the investigation, 2 violations of Chapter DHS 83 were issued. Both complaints were substantiated.	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from misappropriation of property. Sixty pills of hydrocodone prescribed to Resident 1 were stolen from the facility on 12/19/2023. Findings include: On 01/08/2024, the Department received a complaint that alleged residents' medications were stolen. On 05/28/2024, Surveyor reviewed the documented facility investigation regarding the alleged medication theft on 01/08/2024.	N 348		

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

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N 348	Continued From page 1 On 05/28/2024 at 9:15 AM, Surveyor observed the blister pack prescribed for Resident 1. The blister pack medication card appeared to have been tampered with. The medication card identified hydrocodone as the medication contained in the blister pack prescribed for Resident 1. All 60 pill pockets had been torn. It appeared the original pills had been removed and replaced by a different medication. The pills that were in the blister pack had been broken in half and were not uniform in size or shape. The back of the blister pack had all 60 slots broken and then covered with tape. On 05/28/2024 at 9:30 AM, Surveyor reviewed the Police Report dated 12/20/2023. According to the Police report, Former Caregiver B had re-ordered 60 pills of hydrocodone prescribed to Resident 1 on 12/19/2023. The report indicated that when the hydrocodone was re-ordered, Manager C was suspicious as to why the medications were ordered early. Manager C checked the blister pack medication card and found that it had been tampered with. The medication card was found with all 60 pills removed and replaced with another medication identified as Excedrin migraine, which was not prescribed to Resident 1, and the back of the card had been taped. The Police report indicated Former Caregiver B had left early on 12/19/2023, the day the medication went missing. On 05/28/2024 at 9:45 AM, Surveyor reviewed Police Detective E's report. Police Detective E's report indicates that there was a high probability that Former Caregiver B was involved in the medication diversion that occurred on 12/19/2024.	N 348		

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N 348	Continued From page 2 On 05/28/2024 at 10:00 AM, Surveyor interviewed Nursing Manager D. Nursing Manager D confirmed that 60 pills of hydrocodone prescribed for Resident 1 had gone missing as of 12/19/2023. Nursing Manager D stated that Manager C had reported the missing medication to him/her and an investigation was started immediately. Nursing Manager D stated that Former Caregiver B had been on duty on 12/19/2023 and was the medication passer. Nursing Manager D stated that Former Caregiver B had re-ordered hydrocodone on 12/19/2023 and then left early (10 AM). The re-order of hydrocodone was suspicious and the medication card was checked and found to have been tampered with. All 60 pills of hydrocodone had been removed and replaced with a different medication. Nursing Manager D stated s/he researched the medication that had been replaced and identified it as Excedrin migraine, which was not prescribed to Resident 1. Nursing Manager D stated that Former Caregiver B was asked to complete a drug test, which s/he declined. Former Caregiver B was then suspended immediately and employment was terminated as of 01/04/2024. On 05/28/2024 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated that s/he was alerted that there was a possible medication theft of hydrocodone. Administrator A stated that s/he was alerted on 12/20/2024 and that Nursing Manager D had already started an investigation. Administrator A stated that Former Caregiver B had been on duty as the medication passer on 12/19/2023, the day the hydrocodone went missing. Administrator A stated that Former Caregiver B refused a drug test and refused to give a written statement regarding the misappropriation of hydrocodone.	N 348		

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N 348	Continued From page 3 Administrator A stated that Former Caregiver B had re-ordered hydrocodone on 12/19/2023 even though the count of hydrocodone on hand was sufficient, which raised suspicion. Administrator A stated that Former Caregiver B also left early on 12/19/2023, which was also suspicious. Administrator A stated that the facility investigation indicated that 60 pills of hydrocodone had been stolen and it was probably that Former Caregiver B was involved. On 05/28/2024 at 12:00 PM, Surveyor discussed the above concern with Administrator A and Nursing Manager D. Both Administrator A and Nursing Manager D acknowledged that 60 pills of hydrocodone prescribed for Resident 1 had been misappropriated. Administrator A and Nursing Manager D acknowledged that it was probable that Former Caregiver B was involved in the misappropriation of the hydrocodone.	N 348		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a safe environment appropriate for resident needs. Former Caregiver	N 358		

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N 358	Continued From page 4	N 358		

B let 2 unknown persons into the building on the evening of 01/22/2024 resulting in theft from the building.

Findings include:

The facility serves up to 52 residents with primary diagnoses that include but are not limited to: Advanced Age and Irreversible Dementia/Alzheimer's.

On 01/30/2024, the Department received a complaint that alleged 2 unknown people entered the building during the night of 01/22/2024 and constituted a risk to the residents that live at the facility.

On 05/28/2024 at 10:15 AM, Surveyor reviewed the documented investigation regarding the events of 01/22/2024. Documentation dated 01/23/2024 indicated that Former Caregiver E allowed 2 unknown people into the facility. The unknown people removed a nightstand, dresser and a trash can from the facility. This incident was captured via security cameras mounted above the entry/exit doors. The document indicated that Former Caregiver E gave the unknown people the entry code so they could enter/exit the building on their own.

On 05/28/2024 at 11:15 AM, Surveyor interviewed Administrator A. Administrator A confirmed that 2 unknown people had entered the facility and removed furniture and other items. Administrator A stated that the furniture and items had belonged to a former resident that had passed away. Administrator A acknowledged that Former Caregiver E had given the unknown people the entry code which put all residents in the facility at risk. Administrator A acknowledged that the

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N 358	Continued From page 5 population that lives in the facility are vulnerable and need to be protected.	N 358		