STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017307	A. BUILDING: _____ B. WING _____	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS TOUCH ASSISTED LIVING	400 ANGELS TOUCH CT DE PERE, WI 54115

(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 08/31/2023, Surveyor conducted a complaint investigations at Angels Touch Assisted Living. Two deficiencies were identified. Complaint was substantiated. Census: 20	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 2 of 3 residents reviewed (Resident 1, Resident 2). This is a repeat deficiency. See Statement of Deficiency (SOD) GD0J12, dated 10/11/2021. Resident 1's Fentanyl (pain patch) was not administered at the prescribed times. Resident 2's Lispro (insulin) and Pregabalin (pain medication) were not administered at the prescribed times. Findings Include: On 05/09/2023, the department received a concern that alleged there were medication administration errors.	N 352		

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

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N 352	Continued From page 1 On 08/31/2023, Surveyor reviewed Resident 1's, Resident 2's and Resident 3's record. Example 1: Resident 1 Resident 1's April and May 2023 Medication Administration Records (MAR) documented: "Fentanyl 25 MCG (microgram) - Apply One Patch Onto the Skin Every 3rd Day for Pain." The April MAR did not document that his/her 8:00 AM dose of Fentanyl had been administered on 04/01/2023, due to 'Not in Med Cart,' and 04/04/2023, due to 'Wrong Day to Administer,' and then there was a 4-day gap before the next dose on 04/08/2023. The May MAR did not document that his/her 8:00 AM dose of Fentanyl had been administered on 05/05/2023, due to 'Only 2nd day,' and 05/08/2023, due to 'Wrong Day to Apply.' Surveyor noted that the Fentanyl had been administered on 05/02/2023; 05/05 would have been the 3rd day. Example 2: Resident 2 Resident 2's May 2023 MAR documented: "Insulin Lispro Kwikpen - Inject Subcutaneously 32 Units at Supper - 4:00 PM. Hold if B/S (blood sugar) <100." The MAR did not document that his/her 4:00 PM dose was administered on 05/06/2023 and 05/09/2023 due to 'No Pass Per Vitals.' Resident 2's BS was documented as 182 on 05/06/2023 and BS was not documented on 05/09/2023. "Insulin Lispro Kwikpen - Correction Dose: B/S 150-175 = 1 Unit, B/S 176-200 = 2 Unit, B/S 201-225 = 3 Unit, B/S 226 - 250 = 4 Unit, B/S 251-275 = 5 Unit" The MAR did not document a BS level on 05/04	N 352		

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N 352	Continued From page 2	N 352		

or 05/05 at 4:00 PM and no corresponding Lispro administration.
"Pregabalin 300 MG (milligram) - Take One Capsule by Mouth 2 Times a Day for Epilepsy. Scheduled at 5:00 AM and 5:00 PM."
The MAR did not document administration on 05/10/2023 at 5:00 PM and 05/11/2023 at 5:00 AM due to 'Resident Out of Medication.'

Resident 2's June 2023 MAR documented:
"Insulin Lispro Kwikpen - Inject Subcutaneously 32 Units at Lunch and Supper - Hold if B/S (blood sugar) <100."
"Insulin Lispro Kwikpen - Correction Dose: B/S 150-175 = 1 Unit, B/S 176-200 = 2 Unit, B/S 201-225 = 3 Unit, B/S 226 - 250 = 4 Unit, B/S 251-275 = 5 Unit"
The June MAR documented:
06/04 12:00 PM - BS 275 - 36 Units (32 + 5 correction [sic] dose = 37)
06/05 12:00 PM - BS 260 - 34 Units (32 + 5 correction [sic] dose = 37)
06/18 12:00 PM - BS 326 - 37 Units (32 + 8 correction [sic] dose = 40)

06/09 4:00 PM - BS 167 - 32 Units (32 + 1 correction [sic] dose = 33)
06/21 4:00 PM - BS 201 - 36 Units (32 + 3 correction [sic] dose = 35)

"Pregabalin 300 MG (milligram) - Take One Capsule by Mouth 2 Times a Day for Epilepsy. Scheduled at 5:00 AM and 5:00 PM."
The MAR did not document administration on 06/12 at 5:00 PM due to 'Out.'

On 08/31/2023, at approximately 3:00 PM, Surveyor interviewed Executive Director A and House Manager B. House Manager B stated s/he would speak with the provider's nurse and

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N 352	Continued From page 3 request additional training be provided to staff. House Manager B stated Resident 2's MAR would be updated to show the correct dosage when BS are higher than 275. House Manager B explained that an additional Unit of insulin should be given for every 25 levels of BS. House Manager B stated s/he would follow up on why medications are not refilled in a timely manner. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 352		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper documentation of the Medication Administration Record (MAR) for 3 of 3 residents reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) GD0J12, dated 10/11/2021.	N 415		

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N 415	Continued From page 4 Resident 1's, Resident 2's, and Resident 3's MAR contained blanks where medication administration should have been documented. Resident 2's blood sugar levels did not correspond with units of Lispro (insulin) administered. Findings include: On 05/09/2023, the department received a concern that alleged there were medication administration errors. On 08/31/2023, Surveyor reviewed Resident 1's, Resident 2's, and Resident 3's record. Example 1: Resident 1 Resident 1's May 2023 MAR documented the following medications were not administered and had not listed a rationale as to why the medication may have been held: -Gabapentin, Acetaminophen, Baclofen, Donepezil - 05/04, 05/05 at 8:00 PM - Preservision Areds 2, - 05/04, 05/05 at 7:45 PM -Soothe XP Lub Eye Drop - 05/04, 05/05 at 4:00 PM and 8:00 PM Example 2: Resident 2 Resident 2's May and June 2023 MARs documented the following medications were not administered and had not listed a rationale as to why the medication may have been held: -Lantus Solo, Clobazam, Atorvastatin, Primidone - 05/04, 05/05, 06/15, 06/18, 06/25 at 8:00 PM -Pregabalin, Lamotrigine - 05/06 at 5:00 AM -Pregabalin - 05/04, 05/05 at 5:00 PM -Levetiracetam, Lamotrigine, Lispro - 05/04,	N 415		

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N 415	Continued From page 5 05/05 at 4:00 PM -Lispro (32 Units plus correction dose), Lantus Solo, Clobazam, Lamotrigine, Levetiracetam - 05/30 at 4:00 PM -Atorvastatin, Primidone - 5/25 at 8:00 PM -Lantus Solo, Atorvastatin, Primidone - 06/15, 06/18, 06/25 at 8:00 PM -Clobazam - 06/15, 06/18 at 8:00 PM -Lispro (32 Units plus correction dose) - 06/23 at 12:00 PM -Lispro (32 Units plus correction dose), Lamotrigine, Levetiracetam - 06/15, 06/18, 06/30 at 4:00 PM -Lamotrigine, Pregabalin - 06/10 at 5:00 AM -Pregabalin - 06/15, 06/18 at 5:00 PM Resident 2's May and June 2023 MARs did not document blood sugar (BS) levels on the following dates: 8:00 AM - 05/01; 12:00 PM - 06/12, 06/23; 4:00 PM - 05/20, 05/30, 06/15, 06/18, 06/23 Resident 2's June 2023 MAR documented: "Insulin Lispro Kwikpen - Inject Subcutaneously 32 Units at Lunch and Supper - Hold if B/S (blood sugar) <100." "Insulin Lispro Kwikpen - Correction Dose: B/S 150-175 = 1 Unit, B/S 176-200 = 2 Unit, B/S 201-225 = 3 Unit, B/S 226 - 250 = 4 Unit, B/S 251-275 = 5 Unit" The June MAR documented uncorrelated Units of Lispro administered based on BS levels at 4:00 PM: 06/01 - BS 135 - 12 Units 06/06 - BS 103 - 133 Units 06/08 - BS 155 - 14 Units 06/16 - BS 143 - 12 Units Example 3: Resident 3	N 415		

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N 415	Continued From page 6 Resident 3's May 2023 MAR documented the following medications were not administered and had not listed a rationale as to why the medication may have been held: -Lorazepam, Oxycodone - 05/23, 05/30 at 6:00 PM -Acetaminophen - 05/30 at 4:00 PM On 08/31/2023, at approximately 3:00 PM, Surveyor interviewed Executive Director A and House Manager B. House Manager B stated s/he would speak with the provider's nurse and request additional training be provided to staff as blanks should not appear on a resident's MAR.	N 415		