STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 N FRENCH RD APPLETON, WI 54913

(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 08/16/2023, with information gathered through 08/22/2023, Surveyors conducted a verification visit, standard survey, 3 complaint investigations and 1 self report review at Care Partners Assisted Living II in Appleton. Two (2) of 3 complaints were substantiated. As a result of the survey, four (4) deficiencies were identified. One (1) of the 4 deficiencies was a repeat violation (see SOD 3BKN12 dated 01/26/2023 and SOD 3BKN11 dated 09/22/2022). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 36	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department when law enforcement personnel	N 164		

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

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N 164	Continued From page 1	N 164		

were called to the CBRF as a result of an incident that jeopardized the health, safety, or welfare of residents or employees.

On 04/26/2023, law enforcement personnel were called to the facility regarding a theft of a resident's property by a staff member. The department did not receive a report of this incident.

Findings include:

On 06/06/2023, the department received a complaint related to law enforcement personnel being called out to the facility due to concerns related to health, safety and welfare of the residents and staff.

On 08/16/2023, Surveyors conducted an onsite investigation at the facility.

On 08/16/2023 at 10:40 AM, Surveyor interviewed Regional Registered Nurse (RN) B who confirmed law enforcement were at the facility sometime in April or May as well as July 2023 for a theft incident involving Caregiver D and Resident 2. RN B could not recall the exact dates police were at the facility as s/he was not here, but their former director was and was supposed to handle the investigation. RN B was not sure how much information was documented or reported by the former director but would check and let Surveyor know if s/he received any documentation.

On 08/16/2023 at 3:50 PM, Surveyor interviewed RN B who confirmed a self-report was not submitted to the department when law enforcement personnel were called to the facility regarding the theft incident from April 2023. RN B

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N 164	Continued From page 2 confirmed s/he never received a copy from the former director therefore one was never submitted to the department. RN B stated, "I realized it did not get done too late in the game." On 08/17/2023, Surveyor reviewed the department's facility folder and did not locate a facility self-report regarding this incident. On 08/17/2023 at 4:00 PM, Surveyors interviewed Resident 2 who verified several of his/her personal items were stolen from his/her room in April 2023 and s/he called the police. Resident 2 could not remember the exact date s/he contacted the police or when the theft occurred, but s/he confirmed they came to the facility to investigate. On 08/18/2023 at 9:55 AM, Surveyor contacted the local police department and spoke with Police Communication Specialist E who confirmed there was a theft incident reported on 04/26/2023 and law enforcement personnel responded to the facility the same day to investigate. On 08/18/2023 at approximately 4:45 PM, Surveyor received Resident 2's progress notes from Director A. The notes indicated on 04/23/2023, "Called APD at 2 PM to report missing [purse/wallet]. Staff has searched for it many times and so did officer." Cross Reference: N0172 DHS 83.12(6) Documentation Requirements for Written Report	N 164		
N 172	83.12(6) Documentation requirements for written report	N 172		

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N 172	Continued From page 3 All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a written report for 1 (Resident 2) of 1 resident reviewed that included at minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure the resident's health, safety, and well-being. Findings include: On 06/06/2023, the department received a complaint alleging a staff member stole personal items from a resident. On 08/16/2023, Surveyors conducted an onsite investigation at the facility. On 08/16/2023 at 10:40 AM, Surveyor interviewed Regional Registered Nurse (RN) B who confirmed s/he was aware of the theft allegations involving Caregiver D and Resident 2. RN B stated a safe was taken out of Resident 2's room and was found by the police in a parking lot. RN B reported the former director should have handled the investigation, but s/he was not sure what was all documented and/or completed. RN B reported Caregiver D is no longer employed by their facility. S/he confirmed Caregiver D was terminated in June 2023 due to attendance issues. RN B stated, "We had no grounds to terminate [Caregiver D] for the theft as it was all circumstantial." RN B stated s/he was not sure where the investigation documents would be but	N 172		

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N 172	Continued From page 4	N 172		

would look for them and provide Surveyor with any documentation s/he could find.

On 08/16/2023 at approximately 11:30 AM, Surveyor was provided two staff statements from Director A who confirmed this was all the documentation they could find pertaining to the theft incident.

Surveyor reviewed the written statements and noted the following:

On 04/27/2023, Caregiver D stated on 04/26/2023, in the early morning s/he was assisting another resident when Resident 2 pressed his/her call light. Caregiver D reported s/he could hear Resident 2 yelling "get out" and when s/he went to check on him/her Resident 2 asked Caregiver D who was in his/her room. Caregiver D stated s/he told Resident 2, "I don't know no one." Caregiver D confirmed in his/her statement s/he did not see anyone walk by another resident's room and Resident 2 reported to him/her s/he was going to call the police and s/he would lock his/her door.

On 05/02/2023, Caregiver F stated on 04/24/2023 at approximately 10:00 AM Resident 2 called him/her to his/her room and when s/he got there Resident 2 was crying and yelling his/her safe was missing. Caregiver F stated Resident 2 reported to him/her s/he saw a shadow in his/her room the previous night and it woke him/her up and s/he yelled "get the hell out" and the person left. Caregiver F's reported Resident 2 stated s/he rang his/her call light and Caregiver D came into his/her room "pretty quickly." Resident 2 stated to Caregiver F his/her change jar and a few other items were also missing. Caregiver F reported Resident 2 called the police.

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N 172	Continued From page 5 On 08/17/2023 at 4:00 PM, Surveyors interviewed Resident 2 who confirmed his/her lock box, jewelry, silver coins, pictures of his/her family and purse/wallet were all stolen. Resident 2 reported, "There was so much I can't remember it all." Resident 2 stated the estimated value of the items stolen was over $1,000. S/he stated, "I went out of my mind. That stuff was my life and all that I had. I don't feel safe here anymore." Resident 2 reported s/he had been working with the police and there was a court date scheduled in October 2023. According to the Wisconsin Circuit Court Access Program (CCAP), Caregiver D has pending charges for Theft-Movable Property-Special Facts with an offense date of 04/25/2023. His/her next Court date is scheduled for October 2023. Source: https://wcca.wicourts.gov/caseDetail.html?caseNo=2023CF000616&countyNo=44&index=0&mode=details, retrieval date 08/18/2023. In conclusion, there was not complete written documentation of the theft incident for Resident 1 including the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents health, safety and well-being. Cross Reference: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called	N 172		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when	N 389		

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N 389	Continued From page 6 there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not review and revise the individual service plan (ISP) on an annual basis for 2 of 2 (Residents 1 and 2) residents reviewed. Resident 1's most recent ISP was dated 10/20/2020. Resident 1's ISP was not updated annually. Resident 2's most recent ISP was dated 02/2022. Resident 2's ISP was not updated annually. Findings Include: On 08/15/2023, Surveyor conducted an onsite visit to the facility. A sample of resident files were selected, including Residents 1 and 2. Resident 1 was admitted to the facility on 12/07/2019 with diagnoses to include hypothyroidism, hyperlipidemia, depression, anxiety, cardiomyopathy, congestive heart failure and stroke with hemiparesis. Resident 1's most recent ISP was dated 10/20/2020.	N 389		

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N 389	Continued From page 7 Resident 2 was admitted to the facility on 07/31/2021 with diagnoses to include hypertension, phantom limb pain, chronic pain, gastroesophageal disease (GERD), anxiety, hyperlipidemia, pacemaker, arthritis, dysphagia with esophageal strictures, esophageal, spasm, history of cerebral vascular accident, polypharmacy, premature ventricular contractions and dry eyes. Resident 2's most recent ISP was dated 02/2022. On 08/15/2023 at approximately 11:30 A.M., Surveyor interviewed Director A. Director A indicated s/he just started at the facility in July 2023. Director A stated s/he was aware the ISPs were not updated annually and was in the process of reviewing all of them and revising as needed. Director A stated s/he was working to get the ISPs updated to reflect current needs for each resident.	N 389		
{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.	{N 415}		

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{N 415}	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, at the time of administering medications, staff members did not document in the resident record the name, dosage, date and time of the medication taken or treatments performed and initial the medication administration record for 1 of 1 (Residents 1) residents reviewed. Resident 1 had orders for Warafin Sodium (blood thinner) 2mg (milligrams) tablet to take 1 tablet on Monday, Wednesday and Friday and a Warafin Sodium 2.5mg tablet to be taken Sunday, Tuesday, Thursday and Saturday. Resident 1's MAR on 08/13/2023 (Sunday) showed Resident 1 received a 2mg tablet instead of the 2.5mg tablet as prescribed. Additionally, Resident 1's July 2023 Medication Administration Record (MAR) contained 6 days where staff did not document if Resident 1 refused/received medications or treatments. Resident 1's August 2023 MAR contained 7 days where staff did not document if Resident 1 refused/received medications or treatments. This is a repeat citation. See Statement of Deficiency (SOD) 3BKN11 dated 09/22/2022 and SBKN12 dated 01/26/2023. Findings Include: On 08/16/2023, Surveyor conducted an onsite visit to the facility for a verification visit. A sample of resident records were requested, including the resident records of Resident 1. Resident 1 had orders starting 08/11/2023 to receive Warafin Sodium 2mg tablet on Monday, Wednesday and Friday and to receive Warafin Sodium 2.5mg	{N 415}		

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{N 415}	Continued From page 9	{N 415}		

tablet on Sunday, Tuesday, Thursday and Saturday.

Surveyor reviewed Resident 1's August 2023 MAR. The MAR contained staff initials on 08/13/2023 (Sunday) by the Warafin Sodium 2mg dose.

On 08/16/2023 at 3:30 P.M., Surveyor interviewed Director A and Regional Registered Nurse (RN) B. Director A stated staff must have initialed the wrong box. RN B stated s/he discussed during medication class the importance of Warafin dosage and to "x" out the dates on the MAR that the dose is to not be given so staff do not mix up the days/dosage.

On 08/17/2023 at 2:30 P.M., Surveyor interviewed Medication Tech G. Medication Tech G verified s/he worked the evening of 08/13/2023 and passed medications to Resident 1. Medication Tech G stated, "I must have just initialed the wrong box. The person putting the medication on the MAR didn't "x" out the dates its not to be given so I got Monday, Wednesday, Friday days confused and initialed the wrong one. I'm fairly certain I gave [him/her] the correct dose."

On 08/17/2023, Surveyor requested a picture of the Warafin Sodium 2.5mg tablet blister pack from Director A. Director A immediately sent a picture to Surveyor. Surveyor verified the 2.5mg dose was administered on 08/13/2023.

Additionally, Surveyor reviewed Resident 1's MAR for July 2023 and August 2023. Review of the MARs showed days where medication administration was not documented as indicated by no medication passer's initials on specific

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{N 415}	Continued From page 10 dates. RESIDENT 1: Missing Documentation on MARs: Furosemide 20mg (milligrams) take 1 tablet by mouth daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Nystatin Powder apply topically to groin area daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Senna Laxative take 1 tablet by mouth daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/20232, 08/15/2023 Spironolactone 25mg take 1/2 tablet once daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Levothyroxine 75mcg(micrograms) take 1 tablet by mouth daily: 6AM dose on 07/23/2023, 08/05/2023, 08/06/2023 Potassium Chloride 20 MEQ(milliequivalents) take 2 tablets every morning with breakfast: 8AM dose on 07/03/2023, 0723/2023, 08/05/2023, 08/06/2023, 08/15/2023 Potassium Chloride 20 MEQ(milliequivalents) take 1 tablet daily with supper: 4PM dose on 07/05/2023 Omeprazole 20mg take 1 capsule daily in the morning: 7AM dose on 07/23/2023, 08/05/2023, 08/06/2023	{N 415}		

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{N 415}	Continued From page 11 Acetaminophen 325mg tablet take 2 tablets three times daily: 8AM dose on 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 2PM dose on 07/03/2023, 07/04/2023, 07/08/2023, 07/23/2023, 08/02/2023, 08/05/2023, 08/06/2023, 08/09/2023, 08/14/2023, 08/15/2023 Calcium 600mg plus D 400 IU(international unit) take 1 tablet daily: 8AM dose on 07/03/2023, 07/23/20232, 08/05/2023, 08/06/2023, 08/15/2023 Chlorhexidine 0.12 % rinse mouth with 15ml(milliliters) three times daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 4PM dose on 07/05/2023 Clonazepam 0.5mg take 1/2 tablet twice daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 4PM dose on 07/05/2023, 08/10/2023 Entresto 24mg-26mg tablet take 1 tablet twice daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 4PM dose on 07/05/2023 Loratadine 10mg take 1 tablet daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Metoprolol 25mg take 1/2 tablet daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Polyethylene Glycol mix 17grams in 4-8 ounces	{N 415}		

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{N 415}	Continued From page 12 of liquid and drink by mouth daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Pregabalin 100mg take 1 capsule daily in the morning: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Venlafaxine 150mg take 2 capsules once daily: 8AM dose on 07/03/2023, 07/23/2023, 08/05/2023, 08/06/2023, 08/15/2023 Warafin Sodium 2.5mg take 1 tablet once daily: 8PM dose on 07/25/2023 On 08/16/2023 at approximately 1:45 P.M., Surveyor interviewed Med (Medication) Tech C. Med Tech C explained that when passing medications, the Med Tech is to initial the MAR after giving the resident his/her medications. On 08/16/2023 at 3:30 P.M., Surveyor interviewed Director A and Regional RN (Registered Nurse) B. Director A stated s/he just started at the facility around early July 2023. Director A and Regional RN B verified the missing initials on the July and August 2023 MARs for Resident 1. Regional RN B stated there was a medication class scheduled for the following day in which s/he would stress the importance of making sure staff initial the MAR passing out resident medications.	{N 415}		