STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018315	A. BUILDING: _____ B. WING _____	C 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERSTONE ASSISTED LIVING	751 DEERWOOD NEENAH, WI 54956

(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 07/01/2024, Surveyor conducted 3 complaint investigations and 3 self-report reviews at Copperstone Assisted Living. Four deficiencies were identified. Two of 3 complaints were substantiated. Census: 58	N 000		
N 309	83.29(1)(c) 30 day written notice of changes Services and charges. Written notice of any change in services or in charges. The CBRF shall give the resident or the resident ' s legal representative a 30-day written notice of any change in services available or in charges for services that will be in effect for more than 30 days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a resident (Resident 1) or their legal representative, was given a 30-day written notice of a change in charge for services that would be in effect for more than 30 days. Findings include: On 06/19/2024, the Department received a concern that alleged residents were not given a 30-day notice when there was a change in service fees. On 07/01/2024, at approximately 1:00 PM, Surveyor interviewed Administrator A and Licensed Practical Nurse B. Surveyor was informed that service fees are discussed during	N 309		

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

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N 309	Continued From page 1	N 309		

care conferences with the resident and/or resident representative. If a change in service fee is determined, the resident is given a 30-day notice. Administrator A stated, "If the resident has a major change of condition, then the service fee increase goes into effect immediately after the care conference." Surveyor requested Resident 1's record.

Resident 1 was admitted to the facility 01/03/2024.

- Resident 1 had a "Comprehensive Assessment," dated 12/29/2023, that indicated s/he would be admitted at a Level V, charged $8353 for services.
- Resident 1 had a "30-day Assessment," dated 01/30/2024, that indicated s/he was a Level VII and would be charged $8839 for services.
- Resident 1 had a "Change in Condition Assessment," dated 05/28/2024, that indicated s/he was a Level X and would be charged $10,068 for services plus $750/month for a WanderGuard.

Resident 1's invoice statements documented:
02/01/2024 $8351 plus $487 for a fee increase
03/01/2024 $8838
04/01/2024 $8838
05/01/2024 $8838. WanderGuard charge on 05/20/2024 for $290.28 (pro-rated).
06/01/2024 $10,818

Resident 1 was not given a 30-day notice when service fees were increased.

Resident 1's "Residency and Services Agreement," dated 01/03/2024, documented: "Change in Condition. If Resident has a change in condition or engages in behavior that Facility

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N 309	Continued From page 2 deems detrimental to Resident's health or safety, or the health or safety of any other facility resident or staff member, Facility may modify the services provided to Resident and the corresponding fees without advance notice to Resident. Resident shall agree to change his or her Individualized Service Plan to reflect such changes." On 07/01/2024, at approximately 1:15 PM, Surveyor interviewed Administrator A and Licensed Practical Nurse B. Surveyor was informed that the owners of the facility would be made aware that residents are to always be given a 30-day notice.	N 309		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer,	N 310		

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N 310	Continued From page 3 death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) admission agreement included the rate being charged for services not covered under basic services, such as a WanderGuard. Findings include: On 02/15/2024, the Department received a concern that expressed concerns of the cost associated with a resident being equipped with a WanderGuard. On 06/19/2024, the Department received a concern that alleged residents were not given a 30-day notice when there was a change in service fees. On 07/01/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility 01/03/2024.	N 310		

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N 310	Continued From page 4 Resident 1 had a "Change in Condition Assessment," dated 05/28/2024, that indicated s/he was a Level X and required the WanderGuard system, due to eloping behaviors, which was an additional $750 month fee. Resident 1's "Residency and Services Agreement," dated 01/03/2024, did not document what the additional fees were with the WanderGuard system. On 07/01/2024, at approximately 1:15 PM, Surveyor interviewed Administrator A and Licensed Practical Nurse B. Administrator A explained that the WanderGuard system was new to the provider about a year ago and the admission agreements will need to be updated. Cross Reference: N0309 DHS 83.29(1)(c) 30 Day Written Notice of Changes	N 310		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when 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.	N 389		

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N 389	Continued From page 5	N 389		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not update 1 of 1 resident's Individual Service Plan (ISP) when there was a change in the resident's needs, abilities or physical or mental condition.

Resident 3's ISP was not updated to reflect his/her aggressive behaviors.

Findings include:

On 07/01/2024, Surveyor reviewed Resident 3's record.

Resident 3 was admitted to the facility in 2022 with diagnoses including severe psychotic disturbance, schizoaffective disorder, and anxiety.

Resident 3's "Individualized Service Plan (ISP)," dated 01/29/2024, documented:
"Behavior Monitoring: Staff to monitor resident's behavior each shift. Document any s/sx (signs/symptoms) of anxiety, continually calling [son/daughter], and pacing. Staff to redirect resident. Staff to notify nurse of changes or concerns."
"Interaction - Staff Assistance: Staff assistance to have a pleasant and positive interactions with others."
"Mental Illness: To have behaviors at a minimum and MD (medical doctor) updated on any behaviors that continue with the use of interventions,"

Resident 3's "Incident Reports" documented:
"08/21/2023 - Another resident continuously kept going into resident's room. Other resident started

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to knock down resident's belongings and yelling. Resident got up from [his/her] bed and grabbed other residents right arm and punched [him/her] once."
"09/24/2023 - Staff was coming out from assisting another resident when staff noticed [Resident 3] was by a resident, [s/he] been having altercation with. As staff was approaching [Resident 3] to remove [him/her] from the area, [Resident 3] hit the other resident while [s/he] was on the couch sleeping staff intervene and [Resident 3] hit resident again."
"09/24/2023 - When Writer exited the kitchen writer saw resident walking very fast to [other resident] laying on the couch sleeping. Writer ran and slide in-between resident and [other resident]. Resident began charging at writer, pushing, shoving, grabbing, and hitting. Resident pushed writer enough to slide by and punch [other resident] in the face once, [other resident] stayed still and did not move ...Writer redirected resident away ... As writer was documenting this incident, writer noticed resident standing up. ... Resident began walking fast towards [other resident]. Writer ran and attempted to again redirect resident, [s/he] started to dig [his/her] nails into writer as [s/he] was trying to move and yanking at writer's arm. Resident fell onto the couch [other resident] was laying on. Resident grabbed [other resident] ankles and began digging [his/her] nails into them. Writer tried to pull [his/her] hands off and resident would not stop. ..."
"01/23/2024 - While seated in activity area resident threw bar (snack) on ground and stomped on it. When writer began picking it up off ground resident started kicking writer. Writer and staff redirected writer back to room when resident began ramming writer with [his/her] walker and trying to hit writer ..."

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N 389	Continued From page 7 "01/26/2024 - While [s/he] was sitting with staff and other residents at the dining tables, [s/he] started to kick staff multiple times. [S/he] would stand up from wheelchair and staff charging [sic] at staff and other residents. [S/he] was then pushing the table into other residents and staff. ... 20 minutes later resident was walking done [sic] with the wheelchair. Staff approached resident. Resident then put [his/her] fist up and started to charging at staff for 10 minutes till another staff member was able to help ..." "01/31/2024 - Writer heard staff call for help d/t (due to) resident to resident altercation. Writer observed [Resident 3] in [other resident's] room. When writer attempted to redirect and coax resident out of room, resident stated, "that is [explicative word]" and charged at writer with fist in air. Resident attempted to swing at writer. ..." "02/01/2024 - ...While waiting resident just started to get more and more agitated while med tech was getting the PRN (as needed) ready. Resident started to scoot in wheelchair closer and closer to residents playing bingo while holding water getting more agitated. Resident started swinging and hitting staff while trying to keep resident back from other residents. Multiple staff came and assisted staff with resident ..." "02/02/2024 - Writer went down to check on resident and found resident on the floor in front of the recliner. Writer and the two other staff members assisted getting resident up off the floor and in [his/her] bed with the Hoyer lift. [S/he] was very combative and was hitting, grabbing and trying to bite staff. On 07/01/2024, at approximately 1:15 PM, Surveyor interviewed Administrator A and Licensed Practical Nurse B. Surveyor reviewed Resident 3's ISP with Administrator A and Licensed Practical Nurse B. Licensed Practical	N 389		

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N 389	Continued From page 8 Nurse B stated s/he would review all resident ISPs to ensure behavior guidelines are adequately documented.	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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N 431	Continued From page 9	N 431		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed received appropriate health monitoring to meet his/her needs.

This is a repeat deficiency. See Statement of Deficiency (SOD) FPRQ11, dated 02/03/2023.

Resident 2's urine sample for a urine analysis (UA) was delayed.

Findings include:

On 02/15/2024, the Department received a concern alleging resident treatment for a urinary tract infection was delayed due to urine sample not being obtained timely.

On 07/01/2024, Surveyor reviewed Resident 2's record.

Resident 2 admitted to the facility, 01/19/2022.

Resident 2's "Observations" documented:
01/30/2024 - UA ordered by PCP (primary care physician). Staff to collect specimen and then POA (Power of Attorney) will be contacted to transport specimen to lab.
01/31/2024 - Writer put brief on resident.
02/01/2024 - Writer and staff obtained the urine sample for resident. It is in the UA fridge.
02/02/2024 - Residents POA picked up UA sample to take it to labs.
02/05/2024 - Resident will need UA recollected. Lab called and stated date/time of collection was not written on the lab requisition form. Please make sure all needed areas are filled out. Staff

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will need to call POA to transport when specimen is collected. POA updated.
02/06/2024 - Resident brushed their teeth. Resident had two pairs of pants in their shower and dirty briefs folded back up and stacked by the other briefs. Resident got agitated when staff took clothes out, but after explaining to resident that they have to be washed so they are clean for them to wear. Resident was also very upset with taking the briefs and putting them in the garbage. Resident was less agitated when they were taken out of their room and a new garbage bag in.
02/07/2024 - Staff heard knocking on the front doors of [facility] at 1am and it was [Resident 2] standing out there, with [his/her] walker and [his/her] coat on. When staff got to the door and asked [him/her] what was going on, [S/he] replied that [s/he] had been downtown and now [s/he] is back. [S/he] told the other staff member that [s/he] went to the store, but they were closed, so [s/he] came back. ... Writer instructed [staff] to place wander guard on resident for now and [s/he] was on hourly checks. ... early MC (memory care) program ...
02/07/2024 - Resident refused multiple times to get dressed into pajamas. Resident allowed writer to put nystatin powder on, but stated they will wash it off after writer was gone. Writer stated that is your choice, but I put it on for you. Resident laughed.
02/09/2024 - Staff informed writer that staff attempted to get resident to go to the bathroom so staff could obtain UA. Resident declined to use the toilet and stated to staff "No, I don't have to go to the bathroom and you guys can't make me. Why do you keep asking me that?" When staff explained the need to obtain UA sample, resident got agitated, staff left room. *Writer updated POA - POA stated [his/her] [wife/husband] will be coming to the facility to visit

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with resident. [S/he] also stated [his/her] [wife/husband] will attempt to help get the UA.
02/11/2024 - UA results faxed to PCP - waiting for any new orders.
02/12/2024 - Resident is positive for UTI. Order for antibiotics will be sent over to [pharmacy] today.

Surveyor noted the second request occurred on 02/05/2024 and the urine was not collected until 02/09/2024; 4 days. Resident 2, who tested positive for a UTI, did not receive his/her antibiotic until 02/12/2024; 13 days since original request, 7 days since second request.

Resident 2's assessment, dated 10/17/2023, documented:
"Toileting - Independent"
"Motivation and Attitude - Always has a positive attitude and is self-motivated."

Resident 2's medical notes, dated 01/29/2024, documented:
"Behaviors have slowly increased. [S/he] is not wanting to change clothes when incontinent, yelling and swinging at staff, starting to wander and going closer to the doors as if wanting to leave the building. I know [his/her] POA contacted you about changing meds to BID (twice a day) instead of TID (three times a day). I feel this has started to impact [him/her] and [his/her] increased behaviors. ..."

On 07/01/2024, at approximately 1:15 PM, Surveyor interviewed Administrator A and Licensed Practical Nurse B. Surveyor was informed that Resident 2 was displaying an increase in behaviors after his/her Buspirone medication was changed to two doses a day versus three times. Licensed Practical Nurse B

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N 431	Continued From page 12 stated Resident 2's POA spouse, who is a nurse, was able to obtain the second urine sample. Licensed Practical Nurse stated, "[Resident 2] was more cooperative with family." Administrator A stated, "Most families switch their loved ones over to our in-house physician service. [Resident 2's] family chose not to, so there was a delay in obtaining the urine sample and receiving the results." Surveyor asked if there was additional documentation to show that attempts had been made to collect the urine sample and/or that the POA had been made aware that staff were unable to collect the urine sample. Surveyor was provided with Resident 2's Care History, dated 02/01/2024 to 02/09/2024, which documented: 02/01 - Resident refused toileting assistance all 3 shifts 02/02 - Resident refused toileting assistance 2 shifts and was documented as independent one shift 02/03 - Resident refused toileting assistance all 3 shifts 02/04 - Resident refused toileting assistance on one shift 02/05 - Resident refused toileting assistance on 2 shifts 02/06 - Resident refused toileting assistance on 2 shifts 02/07 - Resident refused toileting assistance on 2 shifts 02/08 - Resident refused toileting assistance on 2 shifts. One shift documented as incontinent, unable to collect 02/09 - Resident was assisted by [granddaughter/son] on one shift, refused one shift	N 431		