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	0018673	A. BUILDING: _____ B. WING _____	R-C 05/03/2024

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MISSION CREEK	3217 FIDDLERS CREEK DRIVE WAUKESHA, WI 53188

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{N 000}	Initial Comments On 04/23/2024, with information obtained through 05/03/2024, the Bureau of Assisted Living, Southern Regional Office, conducted 2 complaint investigations and 2 verification visits for Statement of Deficiency (SOD) 6GWJ11, dated 02/09/2024, and SOD 45ON16, dated 10/19/2023, at Mission Creek, a community-based residential facility (CBRF) located in Waukesha, WI. As a result of the survey, 2 deficiencies were identified. Both deficiencies are repeat deficiencies. See SOD 45ON12, dated 02/16/2022, SOD 5XJJ12, dated 05/18/2022, SOD 45ON13, dated 07/27/2022, SOD 45ON15, dated 04/27/2023, SOD 45ON16, dated 10/19/2023, and SOD 6GWJ11, dated 02/09/2024. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Both complaints were unsubstantiated. Census: 65	{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:	N 352		

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

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Based on record review and interview, the provider did not ensure that Resident 4 received his/her long-acting and rapid-acting insulin on 5 administrations and 4 administrations, respectively, as prescribed by his/her practitioner.

This is a repeat deficiency. See Statement of Deficiency (SOD) 45ON12, dated 02/16/2022, SOD 45ON15, dated 04/27/2023, and SOD 45ON16, dated 10/19/2023.

Findings include:

On 04/23/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 06/22/2022 with diagnoses including diabetes. Resident 4's prescriptions included the following:

- Levemir FlexPen 100 units/mL (start date of 09/12/2023) with instructions to, "Inject 20 units subcutaneously once daily at bedtime (75 days supply). **Discontinue Levemir once facility calls for refills and start Tresiba*"

- Tresiba FlexTouch 100 units/mL pen (start date of 03/14/2024) with instructions to, "*MAR only until requested* Inject 20 units subcutaneously once daily at bedtime...(Please be sure Levemir is discontinued once [patient] starts Tresiba)..."

- Novolog 100 units/mL FlexPen (start date of 07/21/2022) with instructions to, "Inject 5 units subcutaneously three times daily before meals plus sliding scale..."

Surveyor reviewed Resident 4's medication administration records (MARs) from 03/01/2024 - 04/23/2024 and observed the following:

- Blank entries in the administration of Levemir

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from 03/14/2024 through 03/18/2024 (5 total administrations). During that same date range staff documented not administering Resident 4 his/her Tresiba in place of his/her Levemir due to the medication being unavailable.

- Blank entries in the administration of Novolog from the morning of 04/21/2024 through the lunchtime dose on 04/22/2024 (5 total administrations)

At approximately 2:00 p.m., Surveyor interviewed Administrator A and Director of Wellness B. Director of Wellness B clarified the Levemir and Tresiba orders and reported that Resident 4's medical provider instructed for the Tresiba to not be started until all his/her Levemir prescription refills ran out. Director of Wellness B reported that Tresiba was just put on Resident 4's MAR for information only and that it was not yet on hand since staff were still administering Resident 4's Levemir. When asked about the 5-day gap from 03/14/2024 through 03/18/2024 where Resident 4 did not appear to receive either Levemir or Tresiba, Director of Wellness B reported that s/he would look further into it. Regarding the blank Novolog entries, Director of Wellness B reported that Resident 4's Novolog pen was discovered as being out of insulin on the morning of 04/21/2024. Director of Wellness B reported that staff tried to reorder that morning, but the pharmacy did not deliver medications on Sundays and so the pen was not delivered until right before lunch on 04/22/2024. Director of Wellness B reported that staff forgot to fill out the MAR for Resident 4's lunchtime dose on 04/22/2024 but confirmed that s/he him/herself had administered that dose to Resident 4. Director of Wellness B reported that staff should not be waiting until a pen runs out to re-order it, and that the expectation was that staff

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were to reorder insulin pens when they were low or when staff began pulling from the last pen stored in the refrigerator. Director of Wellness B confirmed that multiple staff would have been involved in administering Resident 4's insulin in the days prior to the pen running out and so s/he had addressed the concern with all staff. Director of Wellness B reported that s/he planned to further educate staff.

Surveyor then reviewed an incident report provided by Director of Wellness B. The incident report was filled out for a medication error on 04/21/2024 and documented the following:

"It was discovered during medication audit Monday morning resident did not receive insulin on 04/21 at 8AM, 12PM, and 5PM. [S/he] did not receive insulin 4/22 at 8AM and 12PM. Medication had been depleted and was not reordered from pharmacy or delivered in a timely manner. It was reordered by staff 4/21 at 8AM. Pharmacy does not deliver on Sundays. Pharmacy did not deliver until 4/22 PM. Resident was out with [family member] on 4/21 for several hours during which time the PM dose would have been ordered to be administered. [Family member] stated resident appeared 'normal' and showed no signs or symptoms of being hypo/hyperglycemic that evening. Staff did not contact [Director of Wellness B] to inform insulin had not been given because there was none at the community so it could have been administered from backup pharmacy."

Under the "Immediate Action Taken" heading of the incident report, the following was documented: "Resident observed for signs and symptoms of hypo/hyperglycemia. Supply of insulin checked to ensure it had been refilled and

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N 352	Continued From page 4 was at community and able to be administered. [Power of attorney] and [primary care provider] notified of incident." Surveyor reviewed a "Reorder History" document for Resident 4's Novolog, which showed that a refill request of his/her Novolog was sent on 04/21/2024 at 8:17 a.m. At approximately 3:10 p.m., Surveyor interviewed Administrator A and Director of Wellness B to follow up on the Levemir/Tresiba interview earlier. Director of Wellness B reported that the discontinuation of Resident 4's Levemir had been approved by Resident Care Coordinator F on 03/14/2024 because s/he thought Resident 4's Tresiba was going to start. Director of Wellness B reported that it wasn't until later that Resident Care Coordinator F recognized that Resident 4's Tresiba wasn't starting and after this s/he restarted the Levemir. Director of Wellness B confirmed that Resident 4's Tresiba would not be ordered until his/her Levemir completely ran out, and s/he still had several refills of the Levemir. On 04/25/2024, at approximately 8:45 a.m., Surveyor interviewed Pharmacy Technician G, from the pharmacy that refilled Resident 4's prescriptions. Pharmacy Technician G confirmed that a Novolog refill request for Resident 4 was received on 04/21/2024 at 8:17 a.m. and was signed for as received on 04/22/2024 at 12:37 p.m. Pharmacy Technician G confirmed that the pharmacy was not open on Sundays and that the provider should have known that and accounted for that when requesting medication refills.	N 352		
{N 389}	83.35(3)(d) Service plans updated annually or on changes	{N 389}		

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{N 389}	Continued From page 5 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plan (ISP) for Resident 5 was updated when his/her incontinence care needs increased. This is a repeat deficiency. See Statement of Deficiency (SOD) 5XJJ12, dated 05/18/2022, SOD 45ON13, dated 07/27/2022, SOD 45ON15, dated 04/27/2023, and SOD 6GWJ11, dated 02/09/2024. Findings include: On 04/23/2024, at approximately 9:03 a.m., Surveyor interviewed Medical Provider I. Medical Provider I reported that s/he had some concerns regarding the cares that residents were receiving, especially for those who had wounds and were incontinent. Medical Provider I reported that s/he specifically had concerns that Resident 5, who had pressure wounds, was not being changed after his/her incontinence episodes as frequently	{N 389}		

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as s/he should have been.

At approximately 12:27 p.m., Surveyor attempted to interview Resident 5. Resident 5 was observed laying in his/her hospital bed. A fall mat was observed at the side of his/her bed and a Hoyer lift was observed in his/her room. Resident 5 briefly roused upon Surveyor entering the room but did not reply to conversation.

At approximately 12:35 p.m., Surveyor interviewed Caregiver J. Caregiver J reported that Resident 5 had been declining. Regarding Resident 5's condition and needs, Caregiver J reported that Resident 5 was nonverbal, bedbound, and totally dependent for all cares. Caregiver J reported that Resident 5 had wounds which were completely managed by his/her hospice agency. Caregiver J reported that staff were supposed to be repositioning Resident 5 every 2 hours, but that the overnight (NOC) shift staff were not doing this. Caregiver J reported that s/he typically worked first shift and when s/he came in there were instances where s/he found him/her soaked and unchanged. Caregiver J reported that s/he brought up his/her concerns to Administrator A during the day of the survey, who said that s/he would discuss the concerns with staff.

At approximately 1:15 p.m., Surveyor interviewed Caregiver K. Caregiver K reported that staff were expected to reposition Resident 5 every 2 hours because s/he was bedbound. Caregiver K reported that Resident 5 was dependent for cares. Caregiver K reported that NOC shift staff were not doing this or performing other cares for Resident 5. Caregiver K reported that Resident 5 needed to be checked for incontinence at least every 2 hours. Caregiver K reported s/he could

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{N 389}	Continued From page 7 tell when NOC shift staff were not changing Resident 5 as often as s/he needed because when arriving to work and checking in on him/her, s/he would see urine soaked through his/her chuck pad and bed. Caregiver K reported that this typically only happened if Resident 5 was left to sit in his/her soiled briefs for an extended time period. Caregiver K reported that NOC shift staff had been double briefing Resident 5 about 2-3 months ago, and that his/her hospice agency had to intervene to tell staff to stop doing it. On 04/23/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 08/01/2022 with diagnoses including chronic kidney disease and benign prostatic hyperplasia. Resident 5's current ISP had individual sections that were dated as reviewed at various points from 2022 - 2024. Resident 5's ISP documented the following: - Under the section labeled "[Resident 5] has an [activities of daily living] self-care performance deficit": "MOBILITY: Resident is able to ambulate with one care team member, resident will typically want to sit in wheelchair for mobility...TRANSFER: The resident requires assistance with transfer with 2 of care team members for assistance with transfers using hoyer." - Under the section labeled "[Resident 5] has bladder incontinence": "[Resident 5] will use [his/her] urinal or call for assistance to be continent during waking hours through next review...Encourage and assist resident with cleansing perineal area after each incontinence episode...TOILETING PROGRAM: Resident uses [his/her] urinals for bedtime and wake hours."	{N 389}		

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{N 389}	Continued From page 8 - Under the section labeled "[Resident 5] has bowel incontinence": "[Resident 5] will use [his/her] urinal or call for assistance to be continent during waking hours through next review...Assist resident with toileting and allow resident adequate time to toilet." - Under the section for Resident 5's skin concerns, the following wounds were documented: Stage 1 wound to his/her right outer foot, unstagable wound to his/her left heel, stage 1 wound to his/her left inner foot, stage 3 wound to his/her bottom, stage 2 wound to his/her coccyx, and a deep tissue injury to his/her right inner foot. Within this section, it was documented that staff were to turn or reposition Resident 5 "every two hours while in bed and chair." Resident 5's ISP also documented that staff were to follow both his/her facility care plan and hospice care plan. Surveyor did not observe a toileting schedule or documented frequency that staff were directed to check Resident 5 for incontinence episodes. At approximately 4:00 p.m., Surveyor interviewed Administrator A and Director of Wellness B. Both reported that no concerns regarding Resident 5's cares had previously been brought up to them. Administrator A reported that earlier during the survey, a staff had brought up concerns about NOC shift staff to him/her but it was the first time s/he heard about these concerns. Administrator A clarified that the specific concerns were that the NOC shift staff on the unit Resident 5 lived on was leaving residents unchanged. On 04/25/2024, at approximately 9:30 a.m., Surveyor interviewed Manager of Clinical Services (Manager) L, from Resident 5's hospice	{N 389}		

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{N 389}	Continued From page 9	{N 389}		

agency. Manager L reported that there have been concerns that Resident 5 had been wet when hospice staff arrived first thing in the morning. Manager L reported that hospice staff brought up concerns to him/her that Resident 5 on occasion has been left soiled for long periods of time, with urine and feces soaked through his/her pants. Manager L reported that when this happens, hospice staff then have to work on changing all Resident 5's bedding and giving him/her a shower. Manager L reported that these occasions have occurred approximately 1x/week since his/her significant decline starting a month ago. Manager L reported that Nurse M, who was Resident 5's hospice nurse case manager, has brought up concerns both to Director of Wellness B and Resident Care Coordinator F via in-person conversations in the last month that Resident 5 needed to be changed more frequently than s/he was. Manager L reported that on 04/11/2024, there was a care conference with Resident 5's hospice team, Resident 5, Resident 5's power of attorney, Director of Wellness B, Resident Care Coordinator F, and Licensed Practical Nurse (LPN) H, in which hospice staff discussed the concerns regarding Resident 5's frequency of incontinence cares.

On 04/26/2024, at approximately 9:45 a.m., Surveyor interviewed Medical Provider I again. Medical Provider I reported that s/he worked closely with Resident 5's hospice team and the hospice aide had voiced concerns to him/her that Resident 5 has been in the same brief that s/he had placed the previous morning. Medical Provider I reported that s/he had personally heard caregiving staff say, "That's not my job" when asked to perform cares. Medical Provider I reported that approximately 1 month ago, Nurse M had discussed concerns with him/her that

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{N 389}	Continued From page 10 Resident 5's pressure injuries were worsening and that the lack of his/her incontinence cares were contributing to this. On 05/03/2024, Surveyor reviewed Resident 5's hospice notes, obtained by his/her hospice agency, and observed the following: - 01/26/2024 visit note by Nurse M: "Upon arrival patient is sitting a [sic] recliner chair watching TV...Patient had urine all over [his/her] clothes. Writer and facility care giver [sic] transferred [sic] patient to bathroom..." - 02/12/2024 visit note by Nurse M: "Writer educated facility staff on making sure patient has thin liquid throughout today and not just with meals and also check on patient [every 2 hours] for incontinent [sic] care." - 02/13/2024 visit note by Nurse M: "...Patient has become more incontinent of both urine and stool. Patient struggles with using [his/her] urinal. - 02/15/2024 visit note by Nurse M: "Writer educated facility staff on making sure patient has thin liquid throughout today and not just with meals and also check on patient [every 2 hours] for incontinent [sic] care." - 02/20/2024 visit note by Nurse M: "Writer educated facility staff on making sure patient has thin liquid throughout today and not just with meals and also check on patient [every 2 hours] for incontinent [sic] care." - 02/22/2024 visit note by Nurse M: "...Writer educated facility caregiver and [Resident Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and	{N 389}		

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{N 389}	Continued From page 11 has increased urination..." - 02/26/2024 visit note by Nurse M: "Writer educated facility caregiver [Caregiver K] and [Resident Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and has increased urination." - 03/01/2024 visit note by Nurse M: "Writer educated caregiver [Caregiver J], [Caregiver N], and [Resident Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and has increased urination and want to prevent skin breakdown." - 03/06/2024 visit note by Nurse M: "Writer educated caregiver [Caregiver J] and [Resident Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and has increased urination and want to prevent skin breakdown." - 03/18/2024 visit note by Nurse M: "Writer educated caregiver [Caregiver O] and [Resident Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and has increased urination and want to prevent skin breakdown." - 04/08/2024 visit note by Nurse M: "Writer educated caregiver [Caregiver K] and [Resident Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and has increased urination and want to prevent skin breakdown...Patient is unable to complete any [activities of daily living (ADLs)] alone. Patient needs assistance with all ADLs..." - 04/15/2024 visit note by Nurse M: "Writer educated caregiver [Caregiver K] and [Resident	{N 389}		

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MISSION CREEK	3217 FIDDLERS CREEK DRIVE WAUKESHA, WI 53188

(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 389}	Continued From page 12 Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and has increased urination and want to prevent skin breakdown." - 04/22/2024 visit note by Nurse M: ""Writer educated caregiver [Caregiver N] and [Resident Care Coordinator F] about incontinent [sic] care [every 2 hours] due to patient being on a diuretic and has increased urination and want to prevent skin breakdown." On 05/03/2024 Surveyor reviewed Resident 5's hospice plan of care, as referenced from the provider's ISP. The hospice plan of care did not provide any information regarding incontinence care needs. On 05/03/2024, at approximately 3:00 p.m., Surveyor interviewed Administrator A and LPN H. Administrator A reported that an investigation was conducted into the lack of cares and that management narrowed down the culpability to one staff member who was not doing cares. Administrator A reported that staff member had been previously warned about not doing cares. Administrator A reported that as a result of the investigation that caregiver was terminated. When discussing care needs, Administrator A acknowledged Surveyor's concern that the lack of Resident 5's incontinence care needs, as recommended by hospice, were not documented in his/her ISP. Administrator A reported that after Surveyor was last on site, Director of Wellness B and LPN H had been working on updating residents' care plans.	{N 389}		