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	0018103	A. BUILDING: _____ B. WING _____	R 12/04/2023

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DRUMLIN RESERVE	111 EAST REYNOLDS AVENUE COTTAGE GROVE, WI 53527

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{N 000}	Initial Comments On 12/04/2023, Surveyor conducted a verification visit and self-report review at Drumlin Reserve. Two deficiencies were identified. All previous violations from statement of deficiency (SOD) 6MT212, dated 01/25/2023 were substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 24	{N 000}		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 4's legal representative within 72 hours when there was an allegation of misappropriation of his/her medication. Findings include: On 11/28/2023, Surveyor reviewed Resident 4's record. Resident 4- was admitted 07/24/2023 with diagnoses including cognitive decline, alcohol dependence, and chronic pain syndrome. Resident 4 had an activated healthcare power of	N 170		

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

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attorney that made decisions on his/her behalf. Resident 4 was a hospice patient.

Resident 4's progress notes documented:
"07/26/2023-Resident arrived at community at approximately 10am. Resident's primary diagnosis CHF and dementia. Resident was living at home prior to move in, receiving 24-care. Resident has had a recent significant physical and cognitive decline and is slowly transitioning to EOL ....Resident has chronic pain treated with scheduled hydromorphone and Pregabalin. PLEASE BE PROMPT WITH PAIN MEDS TO KEEP PAIN UNDER CONTROL. Lorazepam is scheduled every 6 hours for anxiety.
07/31/2023 completed by Caregiver J: Resident received 30 hydromorphone in. LPN and TN was notified.
07/31/2023 completed by Nurse I: Called placed to hospice requesting to reduce narcotics that are not in use to prevent errors. Hospice RN stated that case manager would need to follow up.
08/04/2023: Call placed to hospice requesting nurse manager to follow up with writer [Nurse I] requesting review of narcotics and to discontinue amount of narcotics. Hospice primary RN will follow up on 8/7."

A review of the provider's investigation documented:
Completed by Nurse I-"7/31-it was discovered that a full card of 30 hydromorphone 8 MG tabs was missing. This RN had called Guardian pharmacy to follow up on [Resident 4's] scheduled hydromorphone, as it was currently scheduled to give 2 tabs of 4 MG, where this order is typically difficult in an assisted living setting, as some caregivers forget to give 2 tabs vs one tab. I [Nurse I] requested from pharmacy if we could get 8 MG tabs instead. The tech on the

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N 170	Continued From page 2 phone states that a card of 30 was delivered on 7/28 and [Caregiver J] signed for it. Upon looking through both medication carts, I [Nurse I] could not find the packaging slip for the facility, where staff sign they received the medications, including narcotics. The card of 30 was missing. A copy of the packaging slip is kept by the facility and copy back to the pharmacy. The other medications on the packing slip were accounted for, but not the scheduled card of 30 hydromorphone 8MG tabs. I [Nurse I] requested the packaging slip from the pharmacy, where they faxed me a copy, that did have [Caregiver J's] signature on it, and dated for 7/28. Upon asking [Caregiver J] , [s/he] did not know what happened to the missing card, although [s/he] signed for the medication and was held responsible for receiving narcotics that evening. Completed by Administrator A-It was brought to my [Administrator A] attention on 8/1/23 from the nursing team that [Resident 4] had a card of 30 tablets of hydromorphone missing. The nursing team called the pharmacy to see if they had a copy of the packing slip which is typically left with the medication. The pharmacy provided a copy of the packing slip showing [Caregiver J] had signed for this medication on 7/28/23 at 9pm. I [Administrator A] met with every medication administrator from 7/28/23 at 9pm to the time I was notified to see if they knew of where the medication was. -[Caregiver J]: [s/he] stated [s/he] signed for medication on Friday night but didn't know exactly what the medication was and put the medication on top of the cart and shut the doors. [S/he] needed to attend to a resident who needed assistance and forgot to come back to take care of the medication." Other caregiver's were interviewed. "I	N 170		

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N 170	Continued From page 3 [Administrator A] did call police and filed a case. There was no conclusive evidence that the medication was stolen." Resident 4's record did not contain evidence Resident 4's legal representative was notified of the above allegation. On 12/04/2023 at 9:45 AM, Surveyor interviewed Administrator A. Surveyor asked if Resident 4's legal representative was notified by him/herself or any other staff after misappropriation allegation was made. Administrator A reported s/he did not notify Resident 4's representative but thought a nurse told him/her. Surveyor noted after reviewing documentation no evidence was present in Resident 4's record his/her legal representative was notified. Administrator A stated it would be an expectation whoever made the call to document in Resident 4's progress notes a call was made to the legal representative. Administrator A stated s/he could not comment why Resident 4's record was missing notification to his/her legal representative after the misappropriation allegation was made regarding the 30 tabs of hydromorphone medication.	N 170		
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.	N 348		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 residents were free of mistreatment.

Resident 2 had his/her medication misappropriated by Caregiver J.

Resident 3 was mistreated by Caregiver E and Caregiver H.

83.02(1) defines "Emotional Abuse" as language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.

83.02(30) defines "Misappropriation of property" as the intentional taking, carrying away, using, transferring, concealing or retaining possession of a client's movable property without the client's consent and with the intent to deprive the client of possession of the property.

Findings include:

The provider is licensed to care up to 20 residents in the following client groups: terminally ill, irreversible dementia/Alzheimer's, physically disabled, and advanced age.

Example 1-Resident 2

On 09/27/2023, the Department received a self-report alleging concerns with theft of narcotic.

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N 348	Continued From page 5 On 11/28/2023, Surveyor reviewed the provider's investigation and identified the following: Resident 2 was admitted on 04/12/2021. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Caregiver J was hired on 1/16/2023. A review of the provider's investigation documented: "On 09/24 at approximately 6:40 PM, [Caregiver K] calls [Nurse I], RN on call for provider. [S/he] notifies that something suspicious was noted on a narcotic card. [Caregiver K] states that [s/he] noted that someone had punches on tablet of hydrocodone-8 PM dose and initialed [his/her] name for the 24th. [Caregiver K] worked on the 23rd PM shift, where [s/he] does not remember this being punched out, nor was the initials noted on the card were not [his/hers]. [Caregiver K] was just getting ready to give the medication on the 24th, where I [Nurse I] also observed initials, and medication was punched out from 8 PM hydrocodone card. I [Nurse I] asked [Caregiver K] if [s/he] performed narcotic count at the beginning of [his/her] pass, where [s/he] confirmed, and that count was correct, at this point count was 21. [Caregiver K] states that [s/he] always initials and dates the blister card upon punching a narcotic, where [s/he] states this is not [his/her] writing. [Nurse I] states to go ahead and give [Resident 2] scheduled dose for the 8 PM pass, and would investigate this further. Same evening on the 24th, this RN [Nurse I] looks into the medication/inventory/narcotic count history and observed that [Caregiver J] had made additional deductions from the count for [Resident 2] 8 PM hydrocodone pass on 9/23 at 12:58, and	N 348		

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on 09/24 at 1:13 PM. I [Nurse I] also observed a suspicious sign out on 9/16 at 6:10 PM and omission of the medication on 9/17.
....Conflicts with administration record and count records on 9/16, 9/23, 9/24 don't match , where these two records coincide with each other, when a narcotic medication is administered it deducts automatically from the count record. These dates have [Caregiver J] attached.
On 9/25, [Caregiver J] was interviewed with findings, where [s/he] could not justify what had happened and why [his/her] name was in the count record. Only the nurse should be adjusting count, and questioned about the 8 PM hydrocodone card, as the initials were not from [Caregiver K], and did resemble [Caregiver J's] penmanship. [Caregiver J] was not able to give an answer, only, 'I don't know, can I be taken off the med cart?"
It was recognized by corporate follow up that [Caregiver J] had additional access to the facility electronic software with admin settings as [s/he] was previously worked at the facility in a director role. Upon re-employment, those settings were never reset/updated to reflect resident assistant settings.
...In conclusion it is noted from evidence about that [Caregiver J] taken at least 2 full tabs of hydrocodone from 9/23 and 9/24 and ½ tab of hydrocodone on 9/25, based on information above, evidence by the counts being short, after [Caregiver J] deducts [his/her] entries, and after abruptly having to leave [his/her] shift after [his/her] suspension."

A review of Caregiver J's termination report dated 09/28/2023 documented: "Terminate Reason-Misconduct, Notes-Medication diversion."

On 11/28/2023 at 2:35 PM, Surveyor interviewed

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N 348	Continued From page 7 Nurse I. Nurse I confirmed s/he was contacted on 09/24/2023 about Resident 2's narcotic count being off for his/her hydrocodone. Nurse I stated s/he conducted the above investigation and learned Caregiver J had admin access to the provider's electronic software and made multiple edits during the month of September that were suspicious. Nurse I stated Caregiver J was suspended on 09/25/2023 at approximately 12:00 PM. Nurse I stated s/he was contacted by another caregiver on the evening of 09/25 about Resident 2's narcotic count being off again. Nurse I noted the provider's IT department was able to see on their end Caregiver J accessed an IP address from the provider's address between 5:09 pm and 5:52 pm on 09/25/2023. Nurse I stated after further investigation, it was discovered Caregiver J had deleted his/he entries from 9/23 and 9/24. Nurse I stated during the month of September, Resident 2 had received 3 additional orders addressing symptoms of increased pain that was assessed by his/her hospice nurse. Nurse I noted Caregiver J was dismissed from his/her position on 9/26. Nurse I stated Caregiver J was suspected in July of taking a full medication card-30 tabs of hydromorphone for Resident 3 after pharmacy had delivered the medication and s/he had signed for the medication. Nurse I noted after investigation, the provider was unable to determine exactly what had happened to the medication. On 11/28/2023 at 2:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he reported the above incident to police and also to the Department. Administrator A confirmed Caregiver J was suspended on 9/25 and later came back to the facility in the evening to access the provider's electronic software. Administrator A	N 348		

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noted another staff member in the assisted living saw someone who resembled Caregiver J use the public restroom and leave the facility without engaging with staff.

Example 2-Resident 3

On 09/06/2023, the Department received a self-report alleging Caregiver E and Caregiver H mistreated Resident 3.

On 11/28/2023, Surveyor reviewed the provider's investigation and identified the following:

Resident 3 was admitted on 10/05/2021. Family Member L is Resident 3's activated healthcare power of attorney.

On 11/27/2023 at 12:14 PM, Surveyor interviewed Family Member L. Family Member L stated s/he visited in the afternoon on 8/25/2023 and found Resident 3 very agitated and rocking back and forth, which was new. Family Member L found a large bruise on Resident 3's right arm and left hand. Family Member L stated s/he asked Resident 3 what happened, and s/he noted the staff were rough with him/her while getting dressed. Resident 3 reported they hurt me and the aide said s/he was sorry and won't do it again. Family Member L stated Resident 3 used to live in the provider's assisted living before moving to the memory care and had a camera in the room, but the provider discouraged a camera in the memory care. Family Member L noted s/he was worried about Resident 3's care, so s/he put a video camera under a dresser on 8/26. Family Member L stated the camera was under a dresser so you could not see faces but could hear the caregiver's voices. Family Member L stated on 8/26, the camera recorded a couple of

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situations 1 at 7:50-staff was heard calling Resident 3 a "complainer" and "to be nice." 2 at 7:53-Resident asked the staff to leave and one caregiver said "[s/he] is always mean." 2 at 1:07-Resident 3 told staff they were dismissed of their duties and one caregiver said "no one else would take this job" and Resident 3 complained about his/her wrist and staff said "we didn't touch you." 4 at 1:14-One staff said "by you [expletive]." 8/30-Resident 3 said "stop it to someone." 8/31 at 7:55-someone hit Resident 3 and you could hear him/her say "ouch.". 7:55-aide said "[s/he] would knock [Resident 3] the [expletive] out." 7:57-Resident 3 said "[s/he] hit me and the aide said no I didn't but you would know if I did because you would be knocked the [expletive] out. Aide said [Resident 3] was mean and then [Resident 3] said stop it." Family Member L stated on 8/31, s/he emailed Nurse I and Administrator A to talk about the abuse. Family Member L noted Administrator A had him/her come in and talk to him/her. Family Member L noted Administrator A went over incident and said Caregiver H had been terminated.

A review of the provider's investigation documented:
"On 08/25/2023, [Family Member L] notice bruising on right side of mid-section of body + bruising on right hand.
8/26/2023-[Family Member L] came into visit. Staff in nursing station that [Resident 3] had a bandage on [his/her] hand because [s/he] was flinging [his/her] arms. [Resident 3] said someone's nails clawed [him/her] than clammed up and said [s/he] didn't want to talk about it.
On 08/31/2023 at 12:10 PM met with [Family Member L] to review and shared videos."

A review of the provider's self-report dated

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N 348	Continued From page 10 09/06/2023 submitted to the Department documented: " ....[Family Member L] had placed a camera in [Resident 3's] apartment on 08/25/2023, on the floor, under a table stand and that there were videos that [Family Member L] wanted to share with [Administrator A] when meeting on 08/31/2023. In the video from 08/31/2023, [Resident 3] says "don't hit me." Provider staff [Caregiver H] replies "if I hit you, you would be knocked the [expletive] out." In the second video that was shared from 08/26/2023, provider staff [Caregiver H] walks out of [Resident 3's] room and says "bye [expletive]." On 09/01/2023, [Family Member L] sent more video footage from [Resident 3's] apartment from dates 08/26/2023 and 08/31/2023 ....[Administrator A] and [Nurse I] listened to the videos together that were sent by [Family Member L]. Both [Administrator A] and [Nurse I] continued their investigation based on the videos. In the video dated 08/31/2023, provider staff [Caregiver E] tells [Resident 3] "stop being rude, you need to be nice to us." Provider staff [Caregiver E] also tells [Resident 3] "to say please." During the time of [Administrator A] and [Nurse I] reviewing the videos, it was noticed that [Caregiver E] was in [Resident 3's] apartment when [Caregiver H] says "if I hit you, you would be knocked the [expletive] out." After reviewing the videos, [Resident 3] says to [Caregiver E] "you're the one who hit me." On 09/05/2023, investigation completed, and updates to [Family Member L], a skin check was performed by [Nurse I], where no other bruising was noted on bode. Except on right forearm bruise. [Resident 3] has been experiencing chronic pain, as [s/he] has a long history , where [s/he] was followed up by [his/her] primary care physician and admitted to hospital with sepsis on 09/05/2023."	N 348		

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N 348	Continued From page 11 A review of Caregiver E's and Caregiver H's termination report dated 09/05/2023 documented: "Termination reason-verbal abuse to resident, Notes-misconduct." On 11/28/2023 at 2:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he reported the above incident to police and also to the Department. Administrator A confirmed s/he listened to the videos and Caregiver E and Caregiver H were identified as verbal abusing Resident 3. Administrator A noted after the above incident all staff were retrained on preventing abuse/neglect and misappropriation.	N 348		