STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016627	A. BUILDING: _____ B. WING _____	C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP GRAND VILLAGE INC	1400 24TH ST S WISCONSIN RAPIDS, WI 54494

(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
U 000	INITIAL COMMENTS On 07/12/2024, Surveyor conducted a complaint and abbreviated survey at Hilltop Grand Village Inc. The complaint was unsubstantiated. Four deficiencies were identified. One of 4 deficiencies was a repeat deficiency. See Statements of Deficiency (SOD) N73211, dated 05/11/2022 and SOD D6K212, dated 05/17/2019. Census: 41 Tenants; 39 Apartments	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on observation and interview, the provider	U 118		

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

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U 118	Continued From page 1 did not provide nursing services related to medication management for 3 tenants that required insulin medication. Findings include: "All insulins must be stored with care to ensure that they remain safe and effective. Improper storage could result in the breakdown of insulin, affecting its ability to effectively and predictably control your blood sugar level... Once you open a new vial (meaning once you stick a needle in the vial) or pen, use a Sharpie to note the date you opened it right on the packaging. This will help you remember when to stop using it ..." (Source: Harvard Health Blog, Safe and Effective Use of Insulin Requires Proper Storage, 12/04/2018, https://www.health.harvard.edu/blog/safe-and-effective-use-of-insulin-requires-proper-storage-2018120415486 , retrieved 07/12/2024.) On 07/12/2024 at approximately 11:50 a.m., Surveyor observed the medication carts with Resident Assistant (RA) E. Tenant 2 had a Humalog insulin pen and a Toujeo insulin pens in the medication cart. The pens did not have a date documented as to when they were opened or when they could be used by. Humalog may be used for 28 days after opened and stored at room temperature. (Retrieved from: https://uspl.lilly.com/humalog/humalog.html#pi, retrieval date: 07/12/2024.) Toujeo may be used for 56 days after opened and stored at room temperature. (Retrieved from: https://products.sanofi.us/toujeo/toujeo.pdf, retrieval date: 07/12/2024.)	U 118		

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U 118	Continued From page 2 Tenant 3 had a Humalog insulin pen that was not dated. Tenant 4 had a Semglee insulin pen that was not dated. Semglee may be used for 28 days after opened and stored at room temperature. (Retrieved from: https://www.semglee.com/, retrieval date: 07/12/2024.) On 07/12/2024 at 11:55 a.m., Surveyor interviewed RA E. RA E told Surveyor they were supposed to write the open date on the insulin pens. S/he said that if another staff does not write the date on the insulin pens, s/he does not put the date as s/he would not know for sure the exact date the insulin pens were open.	U 118		
U 129	89.23(4)(a)2. SERVICES PROVIDER QUALIFICATIONS. Service Providers. Nursing services and supervision of delegated nursing services shall be provided consistent with the standards contained in the Wisconsin nurse practice act. Medication administration and medication management shall be performed by or, as a delegated task, under the supervision of a nurse or pharmacist. This Rule is not met as evidenced by: Based on record review and interview, the	U 129		

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U 129	Continued From page 3	U 129		

provider did not ensure Resident Assistant (RA) D and RA E, who provided medication services were delegated to provide the nursing task.

Findings include:

According to s. N 6.03(3), SUPERVISION AND DIRECTION OF DELEGATED ACTS.
In the supervision and direction of delegated acts an RN (registered nurse) shall do all of the following:
(a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.
(b) Provide direction and assistance to those supervised.
(c) Observe and monitor the activities of those supervised.
(d) Evaluate the effectiveness of acts performed under supervision.

On 07/12/2024 at approximately 11:00 a.m., Surveyor interviewed RA D and RA E. RA D and RA E told Surveyor they administered medications.

On 07/12/2024, Surveyor reviewed the employee records for RA D and RA E.

RA D was hired 04/22/2024. Surveyor could not locate delegation from a registered nurse (RN) or pharmacist to allow RA D to administer medications.

RA E was hired 09/08/2021. RA E had medication administration observation and delegation forms, signed 10/20/2021.

On 07/12/2024 at approximately 12:50 p.m., Surveyor interviewed Executive Director (ED) A.

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U 129	Continued From page 4 ED A told Surveyor RA E's medication delegation form was signed by their previous RN. ED A told Surveyor s/he was unable to locate a delegation form for RA D to administer medications. ED A explained to Surveyor their current RN, RN C, had not delegated medication administration to the staff. Surveyor explained to ED A that delegation was specific to the RN and the staff, it does not transfer to a different RN.	U 129		
U 134	89.23(4)(d)1. SERVICES PROVIDER QUALIFICATIONS. Staff training. All facility staff shall have training in safety procedures, including fire safety, first aid, universal precautions and the facility's emergency plan, and in the facility's policies and procedures relating to tenant rights. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident Assistant (RA) D received training in all required topics, for 1 of 2 staff reviewed. RA D did not have training in tenant rights. The is requirement is being cited for the third time. See Statement of Deficiency (SOD) N73211, dated 05/11/2022 and SOD D6K212, dated 05/17/2019.	U 134		

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U 134	Continued From page 5 Findings include: On 07/12/2024, Surveyor reviewed RA D's employee record. RA D was hired 04/22/2024. RA D's training log did not include training related to tenant rights. On 07/12/2024 at approximately 1:00 p.m., Surveyor interviewed Executive Director (ED) A. Surveyor reviewed RA D's training log with ED A and requested documentation related to tenant rights training. At 1:15 p.m., ED A told Surveyor the training log was changed and tenant rights was removed. ED A told Surveyor s/he would update this form and ensure tenant rights training would be done. ED A did not have documentation to indicate RA D received training related to tenant rights.	U 134		
U 225	89.29(2)(b) 2. ADMISSION & RETENTION OF TENANTS (2) RETENTION. (b) A residential care apartment complex may retain a tenant who becomes incompetent or incapable of recognizing danger, summoning assistance, expressing need or making care decisions, provided that the facility ensures all of the following: 2. That the tenant has a guardian appointed under ch. 880, Stats., or has an activated power of attorney for health care under ch. 155, Stats., or a durable power of attorney under s. 243.10, Stats., or both. The	U 225		

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activated power of attorney for health care or durable power of attorney shall, either or together, substantially cover the person's areas of incapacity.
This Rule is not met as evidenced by:
Based on interview and record review, the provider retained a tenant (Tenant 1) who became incompetent and was no longer able to recognize danger and summon assistance. Tenant 1's activated health care power of attorney (HCPOA) did not substantially cover Tenant 1's areas of incapacity.

Tenant 1's HCPOA did not reside at the facility with Tenant 1 and could not cover Tenant 1's incapacity to recognize danger and summon for help. Tenant 1 had multiple falls.

Findings include:

On 07/12/2024 at approximately 11:15 a.m., Surveyor interviewed Tenant 1 in his/her apartment. Tenant 1 was unable to carry on a sensible conversation. S/he was unable to tell Surveyor where s/he was. Surveyor asked Tenant 1 what s/he would do if s/he needed help. Tenant 1 replied: "Sorry, I can't talk. I like it here. [Spouse] is from here." Resident Assistant (RA) D came in the apartment to get Tenant 1 for lunch. RA D looked all over the apartment for Tenant 1's call pendant. RA D told Surveyor there are multiple places that s/he will put the pendant.

On 07/12/2024, Surveyor reviewed Tenant 1's record.

Tenant 1 was admitted on 02/03/2024. His/her pre-admission assessment, dated 12/27/2023, indicated Tenant 1 had dementia. Tenant 1 had

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multiple falls documented in his/her record.

An incident report, dated 06/26/2024, indicated Tenant 1's neighbor summoned staff to assist Tenant 1. Tenant 1 was having difficulty breathing and was sent to the hospital.

Documentation from the hospital indicated the following: "HPI (history of present illness): [Tenant 1] is a [age] with dementia, hypertension and recurrent falls who presented to the ED (emergency department) with report of left sided abdominal pain, shortness of breath. [S/he] is reported to have recurrent falls and the facility doesn't always note them due to how frequently they occur. [S/he] is a poor historian due to underlying dementia so history obtained from chart review. Initial evaluation in the ED revealed a small pneumothorax (this is a collapsed lung, caused by chest injury), left sided ribs fractured and extensive subcutaneous emphysema. [S/he] was having oxygen requirements after getting pain medication." A chest tube was placed for the pneumothorax and removed on 07/01/2024.

On 06/28/2024, 2 physicians signed determinations of incapacity for Tenant 1, which activated Tenant 1's HCPOA.

On 07/01/2024, the registered nurse, case manager, from the hospital documented: "pt (patient) is ready for dc (discharge) today. Cm (case manager) left vm (voicemail) for [Assistant Manager (AM) B] at Hilltop grand [sic] updating [him/her] on pt return. Cm will need to get ALF (assisted living facility) fax number to fax HCPOA and INCAP (incapacity) to [him/her]."

On 07/01/2024, Tenant 1 returned to the facility. Staff documented the following after his/her

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U 225	Continued From page 8 return: 07/03/2024 - staff found Tenant 1 on the floor in front of his/her couch. 07/04/2024 - unwitnessed fall 07/05/2024 at 3:00 - 4:00 a.m. - unwitnessed fall 07/05/2024 at 10:00 p.m. - Tenant 1 was crawling on the floor in front of his/her apartment. 07/07/2024 - Tenant 1 was found on the floor. On 07/12/2024 at approximately 1:20 p.m., Surveyor interviewed AM B. AM B said Tenant 1 was not given a discharge notice. S/he said Tenant 1's HCPOA visits approximately once a week. AM B told Surveyor Tenant 1 was not appropriate for the facility but family wanted to first try home health before discharging. Surveyor reviewed retention requirements with AM B. Surveyor explained interview with Tenant 1 was nonsensical and staff could not locate his/her pendant. AM B said staff did find Tenant 1's pendant in one of his/her plants. On 07/12/2024 at approximately 2:00 p.m., Surveyor interviewed Executive Director (ED) A. ED A told Surveyor s/he was not aware Tenant 1's incapacity statement was signed. ED A told Surveyor they have not issued Tenant 1 a discharge notice. The provider retained a resident who became incompetent and was no longer able to recognize danger and summon for assistance.	U 225		
L 103	441.301(c)(4)(iii) Ensures Right to Privacy, Respect, Freedom Ensures an individual ' s rights of privacy, dignity and respect, and freedom from coercion and	L 103		

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L 103	Continued From page 9 restraint. All staff (paid and unpaid) need initial and annual training on resident rights. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all staff received annual resident rights training. Executive Director A told Surveyor s/he did not conduct annual tenant rights training.	L 103		