| 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 _____ | R-C 05/06/2025 |

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

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| {U 000} | INITIAL COMMENTS<br><br>On 05/06/2025, Surveyors conducted an onsite visit to investigate 3 complaints and complete a verification visit.<br><br>Two (2) of 3 complaints were substantiated.<br>Two (2) of 4 previous citations were corrected.<br>A total of 2 new deficiencies were identified. Two of 2 deficiencies were repeat violations.<br><br>Census: 36<br><br>Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed. | {U 000} | | |
| {U 129} | 89.23(4)(a)2. SERVICES<br><br>PROVIDER QUALIFICATIONS.<br><br>Service Providers.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Caregiver F and Caregiver I, who administered medications, including injectable medications, were delegated to do so by a registered nurse (RN.) | {U 129} | | |

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

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| {U 129} | Continued From page 1<br><br>This is a repeat deficiency. See SOD # 6RJV11, dated 07/12/2024.<br><br>Findings include:<br><br>The Department received complaints alleging the provider was not utilizing a nurse to delegate medication services including insulin injections.<br><br>According to s. N 6.03(3), SUPERVISION AND DIRECTION OF DELEGATED ACTS.<br>In the supervision and direction of delegated acts an RN (registered nurse) shall do all of the following:<br><br>(a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.<br><br>(b) Provide direction and assistance to those supervised.<br><br>(c) Observe and monitor the activities of those supervised.<br><br>(d) Evaluate the effectiveness of acts performed under supervision.<br><br>On 05/06/2025 at 8:01 AM, Surveyor interviewed Assistant Manager (AM) B. S/he identified Caregiver F as a medication passer and said s/he administers injections. During a follow up interview at 11:15 AM, s/he said Caregiver I also was a medication passer who administered injections.<br><br>AM B said the facility does not have a current nurse on staff but has contracted with RN G since January of 2025. S/he said RN G had only been | {U 129} | | |

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| {U 129} | Continued From page 2 | {U 129} | | |

at the facility twice during 2025 and s/he could not initially recall his/her name. AM B said former RNs were RN H and RN C, but they had not provided services to the facility since the end of 2024.

On 05/06/2025 at 10:00 AM, Surveyor reviewed the records for Caregiver F and Caregiver I and noted the following:

Caregiver F was hired on 05/05/2021.

-- Former RN C delegated medication administration 08/02/2024.
-- There was no delegation to administer injections. (Subsequently at 4:19 PM, [Executive Director A] emailed surveyor documentation of "instruction" for the injection of insulin.)

Caregiver I was hired on 03/26/2025.

-- There was no delegation to administer medications.
-- Current RN G "completed instruction" for the injection of insulin on 01/22/2025.

Surveyor noted the documentation indicating "instruction" for injections did not specifically indicate the task was delegated.

Surveyor interviewed AM B and Executive Director A on 05/06/2025 at 12:23 PM. AM B confirmed Surveyor's review of the record. The managers verified RN C had not worked at the facility since November of 2024, and was not currently performing delegation tasks, or supervising the staff s/he formerly delegated to administer medications, including injectable medications.

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| {U 225} | Continued From page 3 | {U 225} | | |
| {U 225} | 89.29(2)(b) 2. ADMISSION & RETENTION OF TENANTS<br><br>(2) RETENTION.<br><br>(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:<br><br>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 activated power of attorney for health care or durable power of attorney shall, either or together, substantially cover the person's areas of incapacity.<br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the provider retained a tenant who became incapacitated and was unable to recognize danger or summon assistance without ensuring the activated power of attorney (POA) substantially covered the person's area of incapacity or ensuring the facility staff provided adequate oversight, protection or services.<br><br>Tenant 5 was admitted on 09/09/2024 and his/her POA was activated on 10/22/2024, after a determination s/he was incapacitated. Between 02/26/2025 and 05/06/2025, Tenant 5 experienced consistent episodes of confusion, | {U 225} | | |

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| {U 225} | Continued From page 4 | {U 225} | | |

wandering and unsafe transfers resulting in unwitnessed falls with injury. The provider retained Tenant 5 at the facility without ensuring adequate oversight, protection or services and Tenant 5's POA was not directly involved in providing care or otherwise covering Tenant 5's areas of incapacity.

This is a repeat deficiency. See SOD 6RJV11, dated 07/12/2024.

Findings include:

The Department received a complaint alleging the provider retained tenants who needed more care than the facility provided.

OBSERVATIONS and INTERVIEWS with Tenant 5 on 05/06/2025:

On 05/06/2025 at 8:35 AM, Surveyor observed two caregivers providing stand-by assistance as Tenant 5 transferred from his/her recliner to a standing position at his/her walker. Surveyor observed Tenant 5 was very unsteady. Caregiver J needed to remind Tenant 5 how to unlock the brakes on his/her walker. At 8:41 AM, Caregiver F wished Tenant 5 a happy birthday. Tenant 5 responded with confusion about whether it was his/her birthday, even after Caregiver F continued to explain it was. Tenant 5 also said s/he was 30 years younger than his/her actual age.

At 9:10 AM, Surveyor interviewed Tenant 5. S/he told Surveyor s/he does not have access to a call pendant.

During a follow up interview at 10:12 AM, Tenant 5 showed Surveyor s/he wore a pendant under his/her shirt, but said s/he didn't need to use it.

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| {U 225} | Continued From page 5<br><br>Surveyor observed Tenant 5's TV was on, but on a blank screen and asked Tenant 5 what s/he does if s/he wants to watch TV. Surveyor observed the remote control in plain view on the side table between Tenant 5 and Surveyor. Tenant 5 looked around and picked up the cordless phone. S/he said, "Is this the remote? There are missed calls. Let's see." Tenant 5 then tried to use the phone as a remote. Surveyor asked if the remote on the table might work. S/he replied, "There it is," but then picked up a bottle of water next to the remote and said, "This has got to be it."<br><br>RECORD REVIEW on 05/06/2025 beginning at 9:44 AM:<br><br>On 05/06/2025, Surveyor reviewed Tenant 5's file. Tenant 5 was admitted on 09/09/2024 with diagnoses to include dementia. Tenant 5's designated power of attorney (POA) for health care did not reside at the facility and was not activated at the time of admission.<br><br>09/29/2024 incident report - at approximately 8:45 AM during morning medication pass, caregivers couldn't locate Tenant 5. They eventually found him/her laying outside on another tenant's patio. S/he had fallen into some plants, both shoes were off and his/her wallet/purse was laying nearby. S/he was cold and wet. Night shift subsequently reported Tenant 5 asked to go for a walk at midnight and s/he was redirected to his/her room. It was unknown how long s/he had been laying outside. Tenant 5 was admitted to the hospital for treatment of a heart condition and discharged back to the facility on 10/11/2024.<br><br>10/11/2024 - A risk agreement was updated but was not signed. Risks included, "Not asking for | {U 225} | | |

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| {U 225} | Continued From page 6 | {U 225} | | |

guidance or assistance when needed. Not using an assistive device when ambulating. Not pushing call pendant or not aware of where call pendant is." The provider agreed to "observe [his/her] surroundings and redirect often. Will discuss with [Tenant 5] if s/he feels [s/he] needs us to check on [him/her] and how often."

10/14/2024 - The individual service plan (ISP) was updated, but was not signed. It identified "increased confusion & falls recently" and the need for 2 hour checks.

10/22/2024 - Two physicians deemed Tenant 5 incapacitated and unable to receive and evaluate information effectively, and the POA was activated.

10/11/2024 through 12/19/2024 - 2 hour checks were documented. "Stopped 12/20 not trying to leave anymore."

02/11/2025 - The ISP was updated to identify increased needs with toileting and the activation of the POA. The 2 hours checks were no longer identified. The ISP was not signed.

A scheduled titled "Daily Duties" for 3rd shift (current as of 04/25/2025) read, "[Tenant 5]...keep apt. door open all shift...make sure legs are elevated 3x/shift."

Incident reports and observation notes documented continued unwitnessed falls, confusion and wandering. Some examples during February - April 2025 included:

02/26 unwitnessed fall - "Said [s/he] slipped...and hit [his/her] head...head was cut and bleeding out." Sent to emergency room.

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| {U 225} | Continued From page 7<br>03/05 unwitnessed fall - AM shift entered for morning cares and found Tenant 5 on the ground near the TV. Tenant 5 said s/he had been knocking on the TV cabinet for help. Complained of pain. Plan to prevent recurrence, "frequent checks, reminders to use call button."<br>03/12 unwitnessed fall - found in his/her kitchen. Complained of pain and finger swollen/bruised.<br>03/13 - complained of "a lot of pain" from the fall the day before. Sent to emergency room. Plan, "check on [him/her] more often."<br>03/16 unwitnessed fall - AM shift entered for morning cares and found Tenant 5 on the ground, unable to bear weight on his/her right leg. Sent to emergency room.<br>03/18 - "walking weird & was unsteady...too confused (and) unsteady to get [him/her] in shower."<br>03/25 - "wandering...looking for [his/her child]...very confused today."<br>03/28 - "wake most of the (overnight). Kept going in hall then back into room."<br>03/30 - "keeps saying [s/he]'s going somewhere & packs..."<br>03/31 unwitnessed fall - self-transferring out of recliner<br>04/03 - "was up and down all night."<br>04/13 - "confused as always...packed up...ready to go home."<br>04/14 unwitnessed fall - "found on living room floor...at 7:30 AM."<br>04/25 - frequent waking and confusion overnight<br>04/27 unwitnessed fall - AM shift found in bathroom, complaining of head, back (and) arm pain. Sent to the emergency room.<br><br>INTERVIEWS with staff on 05/06/2025:<br><br>On 05/06/2025, Surveyor interviewed Caregiver F at 8:48 AM. Caregiver F said Tenant 5 has days | {U 225} | | |

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| {U 225} | Continued From page 8<br>where s/he "doesn't know what the heck is going on." Caregiver F said s/he will wander and look for his/her parent or children and sometimes s/he will pack his/her belongings intending to leave. Caregiver F said, "S/he tries to go out(side), good thing we catch [him/her]...Usually we see [him/her], or other residents will tell us." Caregiver F said Tenant 5 experiences frequent unwitnessed falls with injury and commented, "S/he finally got rid of glue on the back of [his/her] head which [s/he] had for a long time (after) one of [his/her] falls." Caregiver F recalled, [s/he] fell last weekend in [his/her] bathroom. There were two mornings in a row we walked in and [s/he] was on the floor." Caregiver F said Tenant 5 is not steady on his/her feet and tries to self-transfer. Caregiver F added, "[S/he] does not know how to press [his/her] (call) button. [S/he] wears it, but we can tell [him/her] a million times until we are blue in the face and [s/he] won't remember." Caregiver F said there is no prescribed frequency for checking on Tenant 5 but said, "I think [s/he] probably should be" on 2 hour checks.<br><br>Caregiver F said Tenant 5's POA does not visit "very often" and does not participate in providing direct care or supervision.<br><br>Surveyor interviewed Assistant Manager B and Executive Director A at 12:23 PM. They confirmed Surveyor's review of the record. They also confirmed Tenant 5 was very confused, was unable to recognize the dangers associated with self-transferring and was unable to effectively call for assistance. They acknowledged the provider had not been effectively able to meet Tenant 5's needs for fall prevention and did not indicate the POA had any role in providing direct care for Tenant 5. | {U 225} | | |