STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016351	A. BUILDING: _____ B. WING _____	R-C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN GRAND ASSISTED LIVING SUITES	900 MEADOW LN 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 07/24/2024 with additional information gathered through 07/30/2024, Surveyors conducted 7 complaint investigations and a verification visit. Four of 7 complaints were substantiated. Three complaints were unsubstantiated. Four deficiencies were identified. Two deficiencies were repeat violations, see Statements of Deficiency (SOD) QP0C12, dated 01/19/2021, SOD QP0C13, dated 09/16/2021, SOD QP0C15, dated 10/14/2022, and SOD 8IN911, dated 10/11/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 63	{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: Based on record review and interview, the provider did not ensure residents received medications in the dosage and at intervals prescribed by a practitioner for Resident 1, Resident 2, Resident 3, and Resident 4. Resident 1 had a change in condition resulting in hospice giving direction to staff to administer Resident 1 his/her PRN (as needed) morphine. Resident 1's morphine expired and was	{N 352}		

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

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{N 352}	Continued From page 1	{N 352}		

destroyed on 07/08/2024, but was not reordered from the pharmacy. On 07/20/2024, Resident 1 was sent out to the hospital to receive morphine at the hospital due to the facility not having his/her morphine in the medication cart.
Resident 2 did not receive his/her Senna as ordered due to the medication not being available in the facility.
Resident 3 did not receive 2 separate doses of Buprenorphine, aspirin, humalog insulin, atorvastatin, slow-release iron supplement, and baclofen as ordered due to the medication not being available in the facility.
Resident 4 did not receive his/her alprazolam as ordered 15 of 31 days in December 2023 due to it not being available in the facility.

This deficiency is being cited for a fourth time. See Statements of Deficiency (SOD) QP0C12, dated 01/19/2021, SOD QP0C13, dated 09/16/2021, and SOD 8IN911, dated 10/11/2023.

Findings include:

The provider is licensed to serve up to 72 residents who may be terminally ill, advanced age, developmentally disabled, have a traumatic brain injury, and/or have irreversible dementia/Alzheimer's.

On 12/19/2023, 12/21/2023, and 04/23/2024 the department received complaint information alleging concerns with medication administration and medications not being available at the facility.

On 07/25/2024, Surveyor reviewed provider's "Medication Administration" policy, "The Administrator will ensure each medication is safely administered per written practitioner's order and by staff who have completed the DHS

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{N 352}	Continued From page 2 Chapter 83.20 training." "14) The Administrator or designee will document communication concerning medications with the practitioner, resident, resident legal representative or family in the resident record ... 16) The Administrator or designee will coordinate with the pharmacy to send refills in a timely manner ... 24) Staff will administer all medications following the Six Rights of Medication Administration: Right resident; right medication; right dose; right time; right route; right documentation. 25) Staff will document in the resident permanent medication administration record after each dose is administered. 26) The Administrator or designee will report to the practitioner when a resident has refused a medication for 2 consecutive days or as otherwise directed by practitioner." RESIDENT 1 On 07/25/2024, Surveyor reviewed Resident 1's record and noted s/he had diagnoses of hypertension, chronic pain, and anxiety disorders. Surveyor noted Resident 1 was on hospice services and received assistance from staff for medication administration and management. Surveyor reviewed Resident 1's June 2024 Medication Administration Record (MAR). Surveyor noted an order for Morphine solution 100 mg/5 ML syringe dated 03/04/2024 - "Take 0.25 mL-1 ML (5 mg-20mg) by mouth every hour as needed for pain or shortness of breath." Surveyor reviewed Resident 1's provider observation note dated 07/20/2024 at approximately 6:30 PM. "Resident was found in theater room watching [TV]. Staff noticed resident presented to be shaking and was very	{N 352}		

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{N 352}	Continued From page 3	{N 352}		

pale in color. Staff brought resident to common area office and got a set of vitals bp [blood pressure]-124/74, temp[erature] 98.7, pulse 107, resp[irations] 22. Residents shaking/tremors continued to increase therefore, staff contacted hospice. Hospice advised staff to administer PRN lorazepam and morphine and to call back in an hour if symptoms continue. Morphine was not available in facility; staff was only able to administer PRN Lorazepam. While staff was monitoring resident, [s/he] began clenching [his/her] heart with [his/her] fist. [sic] complaining of chest pain and a burning sensation in [his/her] chest. Staff administered PRN Nitro with no relief. Staff contacted facility nurse and advised staff to contact daughter (POA) [Power of Attorney] and send resident out for further evaluation. 911 contacted and resident sent to ThedaCare ER [emergency room] for evaluation."

On 07/24/2024 at approximately 1:20 PM, Surveyor interviewed Hospice RN D who stated over the weekend, Resident 1 had a change in condition and chest pain. S/he said per protocol the facility was to call hospice, which they did. The on-call hospice nurse directed staff to administer Resident 1's lorazepam, morphine, and nitroglycerin. Hospice RN D stated Resident 1 did not receive morphine as directed due to the facility not having it there. Hospice RN D indicated s/he visited the facility weekly and had asked the charge staff (medication passers) each week whether they needed refills on any of the hospice directed medication. S/he said staff tell him/her no every time. Hospice RN D stated RN B directed staff to send Resident 1 to the hospital because s/he did not have morphine at the facility to treat his/her condition.

On 07/24/2024 at approximately 1:30 PM,

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{N 352}	Continued From page 4 Surveyor interviewed Caregiver F who stated s/he was present over the weekend when Resident 1 did not get his/her morphine and was sent to the hospital. S/he said Resident 1 was administered Lorazepam, but they did not have morphine in the cart. Surveyor reviewed the medication cart with Caregiver F and noted Resident 1's morphine syringes were now available in the medication cart. Caregiver F stated Resident 1 did not have morphine at the facility on 07/20/2024. On 07/25/2024 at approximately 10:56 AM, Surveyor interviewed Power of Attorney for Healthcare (POAHC) E who stated if Resident 1 were to be having a heart attack and pain that the facility was supposed to have Resident 1's PRN medications onsite per hospice orders. POAHC E stated Resident 1 was sent out on 07/20/2024 due to there not being morphine on site and Resident 1 was experiencing chest pain. POAHC E indicated s/he now had a large medical bill to pay for the ambulance ride, ER visit, and electrocardiogram, which s/he would not have if the morphine had been onsite at the facility as directed by hospice and physician. On 07/29/2024 at approximately 1:00 PM, Surveyors interviewed Registered Nurse (RN) B who stated s/he reviewed the provider's record of medications destroyed in July 2024. S/he said Resident 1's 3 syringes of morphine were destroyed on 07/08/2024 due to them being expired. RN B stated the morphine was not reordered following destroying them. RN B acknowledged Resident 1 was not administered morphine over the weekend as ordered due to there not being any in the facility. RESIDENT 2 On 07/29/2024, at 8:02AM, Surveyor reviewed	{N 352}		

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{N 352}	Continued From page 5 Resident 2's May 2024 MAR. The key located on the MAR identified "OTH" is an abbreviation for "other please note why." Review of the record revealed instances when caregivers documented "OTH" with a corresponding reason why it was not administered. Surveyor noted "OTH" was documented on Resident 2's MAR for the following: Senna\e\dss tablet - take one tablet by mouth every other day for constipation. 05/14/2024: "none in cart" 05/18/2024: "no senna in cart" 05/22/2024: "finished with med" Note: According to the MAR there was a current order dated 05/12/2024) 05/22/2024: none in cart RESIDENT 3 On 07/29/2024, at 11:55AM, Surveyor reviewed Resident 3's March, April and May 2024 MAR. The key located on the MAR identified "OTH" is an abbreviation for "other please note why." Review of the record revealed instances when caregivers documented "OTH" with a corresponding reason why it was not administered. Surveyor noted "OTH" was documented on Resident 3's MAR for the following: Buprenorphine 2mg tablet - Place 1 tablet under the tongue and allow to dissolve twice daily. >1st dose 4/11/2024: "waiting on doctor to see if [s/he] is able to get more refills" Note: According to the MAR, there was a current order dated 04/09/2024 through 04/19/2024. 04/12/2024: "no longer gets medication" (see note above)	{N 352}		

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{N 352}	Continued From page 6 04/13/2024: "waiting on dr approval for more refills" (see note above) 04/14/2024: "done with med" (see note above) 04/16/2024: "waiting on dr approval" (see note above) 04/17/2024: "waiting on doctors order" (see note above) 04/18/2024: "does not have anymore call dr to dc" (see note above) 04/19/2024: "called mortons, denied." Note: According to the MAR, there was a current order dated 04/19/2024 through 05/02/2024. 05/06/2024: "out of med, contacting mortons" 05/07/2024: "no more narcs" 05/08/2024: "out of stock" 05/09/2024: "not in cart" Note: According to the MAR, there was a current order dated 05/02/2024 through 05/09/2024. >2nd dose 03/03/2024: "not in cart" 04/09/2024: "not in cart" 04/10/2024: "waiting on doctor signature" Note: According to the MAR, there was a current order dated 04/09/2024 through 04/19/2024. 04/11/2024: "waiting on doctor order" (see note above) 04/12/2024: "waiting for doctor script (see note above) 04/13/2024: "waiting on dr approval for new script" (see note above) 04/14/2024: no reason documented (see note above) 04/15/2024: "waiting on doctor" (see note above) 04/16/2024: "d/c" (see note above) 04/17/2024: "does not have anymore call dr to dc" (see note above) 04/18/2024: "waiting for doctor" (see note above) 05/04/2024: "couldn't find in cart" 05/05/2024: "out of med need reorder"	{N 352}		

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{N 352}	Continued From page 7 05/07/2024: "not in cart" 05/08/2024: "waiting on pharmacy" Note: According to the MAR, there was a current order dated 05/02/2024 through 05/09/2024. Aspirin 81mg Ec Tablet - Take 1 tablet by mouth daily. 03/26/2024: on order 04/03/2024: "needs more will order" 04/07/024: "waiting on mortons" 04/17/2024: "out of med, ordered" 04/19/2024: "med still not in" 04/24/2024: "resident is out of med [s/he] has need notified" 04/26/2024: "out of supply" 04/27/2024 "out of supply" 05/02/2024: "no supply" 05/03/2024: "out of supply" 05/06/2024: "out of med need reorder" 05/07/2024: "no more supply" 05/09/2024: "no more in cart" 05/11/2024: "no longer in cycle" 05/12/2024: "out of supply" 05/13/2024: "no in cart" Humalog Kwikpen 100units/ml (Lispro) - Prime with 2units. Inject 30u+ ss subcutaneously 3x daily with meals. 151-200 = 6 units, 201-250 = 7 units, 251-300 = 10 units, 301-350 = 12 units, 351-400 = 14 units, 401-450 = 16 units, >450 = 16 units and call the doctor. >2nd dose 03/08/2024: "on order, will arrive tonight" Atorvastatin 80mg Tablet - take one tablet by mouth every morning. 04/07/2024: "is out will contact mortons" Slow-release iron 160 (50mg) - take 1 tablet by	{N 352}		

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{N 352}	Continued From page 8 mouth twice daily (iron deficiency with anemia) >2nd dose 04/24/2024: "waiting on pharmacy" Baclofen 10mg tablet - take one tablet by mouth three times daily. >1st dose 05/12/2024: "out of cycle" On 07/24/2024 at approximately 2:26 PM, Surveyor interviewed RN-B. RN-B stated s/he just got off the phone with Morton's pharmacy regarding Resident 3's buprenorphine. RN B reported on 04/01/2024, the facility requested a refill of the pain medication as it was running low. On 04/04/2024, the facility called Morton's again to request a refill of the medication. Morton's contacted the physician for an order for a refill. Resident 3 ran out of the medication on 04/09 and Morton's did not receive an order for a refill until 04/19/2024. RN B stated Resident 3 went from 04/09/2024-04/19/2024 without receiving buprenorphine for pain as the medication was not in the facility. RESIDENT 4 On 07/25/2024, Surveyor reviewed Resident 4's record and noted s/he had diagnoses of Parkinson's disease and anxiety. Surveyor reviewed Resident 4's December 2023 MAR and noted an order for Alprazolam 0.25 mg tablet - Take 1 tablet by mouth nightly at bedtime. Surveyor noted "OTH" listed with staff initials on the following days: 12/04, 12/05, 12/06, 12/07, 12/11, 12/12, 12/13, 12/15 REF 12/16, 12/18, 12/19, 12/20, 12/21, 12/24, 12/26, and 12/27 (15 days). Surveyor noted 14 days of December where the medication was listed with "OTH" with staff initials and 1 day with "REF" with staff initials. Staff	{N 352}		

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{N 352}	Continued From page 9 documented the following notations: 12/04, 12/06, 12/12, 12/19, and 12/27 - no notation included as to why the medication was not administered 12/05, 12/11, 12/13, 12/15, 12/16, 12/18, 12/20, 12/21, 12/24, 12/26 "awaiting delivery" 12/14 "REF" - "awaiting delivery" 12/07 "none in facility" 12/19, 12/26 "awaiting pharmacy delivery" On 07/29/2024, at approximately 1:00PM, Surveyors interviewed Operations Administrator A and RN-B regarding missed administration from the remaining sample of MARs. Operations Administrator A and RN-B acknowledged the findings of medications not being administered and stated they will ensure issues with medication refills were addressed. Cross Reference: N0415 83.37(2)(d) Documentation of Medication	{N 352}		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide a written summary of the findings, conclusions, and any action taken to Resident 1's legal representative.	N 362		

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N 362	Continued From page 10 This is a repeat violation. See Statement of Deficiency (SOD) QP0C15, dated 10/14/2022. Findings include: On 12/21/2023, the department received complaint information alleging written findings and conclusions of grievances were not provided. On 07/24/2024 at approximately 10:30 AM, Surveyors interviewed Operations Administrator A who stated s/he received multiple written grievances from Resident 1's legal representative. S/he said s/he addressed all of them and had put actions in place for each of them. Surveyor inquired whether written correspondence regarding the grievance was provided to Resident 1's legal representative and Operations Administrator A stated "I did not write anything down, but I addressed them. I did not provide a written response." On 07/24/2024, Surveyor reviewed 5 written grievances regarding Resident 1 dated 03/08/2024 through 06/18/2024. No additional written documentation was available related to the grievances. On 07/29/2024 at approximately 1:00 PM, Surveyors interviewed Operations Administrator A who verified awareness of needing to provide written conclusion and action of grievances, and that s/he did not provide it following Resident 1's grievances.	N 362		
N 415	83.37(2)(d) Documentation of medication administration.	N 415		

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N 415	Continued From page 11 Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the person administering medications initialed the medication administration records (MAR) for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6. Findings include: On 12/19/2023, 12/21/2023, and 04/23/2024, the department received complaint information alleging issues with medication administration. On 07/25/2024, Surveyor reviewed provider's "Medication Administration" policy: "The Administrator will ensure each medication is safely administered per written practitioner's order and by staff who have completed the DHS Chapter 83.20 training." "24) Staff will administer all medications following the Six Rights of Medication Administration: Right resident; right medication; right dose; right time; right route; right documentation. 25) Staff will document in the resident permanent	N 415		

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N 415	Continued From page 12	N 415		

medication administration record after each dose is administered."

RESIDENT 1
On 07/25/2024, Surveyor reviewed Resident 1's March-July 2024 MAR and noted several days that were not documented with staff initials for administration of the medications. The medication and dates were as follows:

Estradiol 0.01% Cream - Apply (genitally) twice weekly on Monday and Thursday (urinary tract infection):
03/18/2024, 03/25/2024, 04/11/2024, 04/15/2024, 05/17/2024, 07/22/2024, and 07/26/2024.

The following medications were not documented with staff initials for administration of the medications on 05/01/2024:
Aspirin 81 mg chewable tablet - Take 1 tablet by mouth daily
Clopidogrel 75 mg tablet - Take 1 tablet by mouth once daily
Losartan Potassium 25 mg tab - Take ½ tablet (12.5 mg) by mouth every morning Hold if SBP (systolic blood pressure) less than 100
Metoprolol Succ ER 25 mg tab - Take ½ tablet (12.5 mg) by mouth every morning hold for SBP <100
Rosuvastatin Calcium 20 mg tablet - Take 1 tablet by mouth daily in the morning
Polyethylene Glycol (over the counter) Mix 17 gm in 4-8 ounces of liquid and drink by mouth every other day for constipation
Cranberry 450 mg tab - Take 1 tablet by mouth daily (UTI prevention)

Surveyor reviewed Resident 1's provider observation note dated 07/20/2024 at approximately 6:30 PM. "Resident was found in

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theater room watching [TV]. Staff noticed resident presented to be shaking and was very pale in color. Staff brought resident to common area office and got a set of vitals bp [blood pressure]-124/74, temp[erature] 98.7, pulse 107, resp[irations] 22. Residents shaking/tremors continued to increase therefore, staff contacted hospice. Hospice advised staff to administer PRN lorazepam and morphine and to call back in an hour if symptoms continue. Morphine was not available in facility; staff was only able to administer PRN Lorazepam. While staff was monitoring resident, [s/he] began clenching [his/her] heart with [his/her] fist. [sic] complaining of chest pain and a burning sensation in [his/her] chest. Staff administered PRN Nitro with no relief. Staff contacted facility nurse and advised staff to contact daughter (POA) [Power of Attorney] and send resident out for further evaluation. 911 contacted and resident sent to ThedaCare ER [emergency room] for evaluation."

Surveyor noted Resident 1's July 2024 MAR did not include staff initials for administration of Lorazepam 0.25 mg tab or Nitroglycerin tab on 07/20/2024.

On 07/24/2024 at approximately 2:26 PM, Surveyor interviewed Registered Nurse (RN) B who verified the MAR did not include initials identifying Resident 1 was administered Lorazepam and Nitroglycerin and listed in observation notes.

RESIDENT 2
On 07/29/2024, at 8:02AM, Surveyor reviewed Resident 2's June and July 2024 MAR and noted several dates that were not documented with the initials of the caregiver administering the medications. The medications and dates were as

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N 415	Continued From page 14 follows: One Daily WMN Multivitamin - take 1 tab by mouth at bedtime: 06/13/2024, 07/05/2024, 07/07/2024, 07/09/2024, 07/16/2024 and 07/17/2024. Docusate sod 100mg tablet - take 1 tablet by mouth once daily at noon: 06/28/2024, 07/05/2024, 05/07/2024, 07/09/2024, 07/16/2024 and 07/17/2024. RESIDENT 3 On 07/29/2024, at 11:55AM, Surveyor reviewed Resident 3's May 2024 MAR and noted several dates that were not documented with the initials of the caregiver administering the medications. The medications and dates were as follows: Gabapentin 300mg capsule - take 3 capsules by mouth 3 times daily: >2nd dose 05/02/2024 and 05/07/2024 Metoprolol succ er 50mg tablet - take 1 tablet daily every morning: 05/01/2024 Humalog Kwikpen 100units/ml (Lispro) - Prime with 2units. Inject 30u+ ss subcutaneously 3x daily with meals. 151-200 = 6 units, 201-250 = 7 units, 251-300 = 10 units, 301-350 = 12 units, 351-400 = 14 units, 401-450 = 16 units, >450 = 16 units and call the doctor. >3rd dose 05/02/2024, 05/03/2024, 05/09/2024 and 05/12/2024. RESIDENT 4	N 415		

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N 415	Continued From page 15 On 07/29/2024, Surveyor reviewed Resident 4's December 2023 MAR and noted several dates that were not documented with the initials of the caregiver administering the medications. The medications and dates were as follows: Pramipexole 0.25 mg tablet - Take 1 tablet by mouth 3 times daily at 7 AM, 2 PM, 7 PM: 12/01/2023 7:00 AM 12/02/2023, 12/05/2023, 12/07/2023 2:00 PM Carbidopa Levidopa 25/100 tablet - Take 2 tablets (50/200 mg) by mouth 4 times daily (7:30 AM, 11 AM, 3 PM, 7 PM): 12/01/2023 7:30 AM 12/01/2023 & 12/08/2023 11:00 AM 12/07/2023 3:00 PM One Daily Sentry Woman 50+ Tab - Take 1 tablet by mouth daily: 12/01/2023 7:00 AM Fluticasone 50 mcg Nasal spray - Instill 1 sprays into each nostril daily: 12/01/2023 7:00 AM Vitamin B12 500 mcg tab - Take 1 tablet by mouth every day: 12/01/2023 7:00 AM Lidocaine 4% Patch (Aspercreme) - Apply topically to right shoulder once daily: 12/01/2023 7:00 AM 12/01/2023, 12/12/08/2023 12:00 PM Flutic-Salm 250-50 mcg (advair 250/50 diskus) - inhale 1 puff into lungs twice daily: 12/01/2023 7:00 AM Metoprolol Tartrate 25 mg tab - Take 3 tablets-	N 415		

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N 415	Continued From page 16 (75 mg) by mouth twice daily for atrial fibrillation: 12/01/2023 7:00 AM Eliquis 5 mg tab - Take 1 tablet by mouth twice daily for blood clot prevention in lung: 12/01/2023 7:00 AM Estradiol 0.01% Cream - Insert 1 gm intra(genitally) twice weekly on Monday and Friday: 12/04/2023, 12/15/2023, 12/18/2023, and 12/22/2023 at 6:00 AM Potassium CL 20 Meq ER tablet - Take 1 tablet by mouth twice daily: 12/01/2023 7:00 AM Polyethylene Glycol - Mix 8.5 gm in 4-8 ounces of liquid daily: 12/01/2023 8:00 AM Fentanyl 25 mcg/hr patch - Apply one patch transdermally to intact skin and change every 3 days for pain: 12/25/2023 8:00 PM Tramadol HCl 50 mg tab - Take 1 tablet by mouth 4 times daily at 6:30 AM, 10:30 AM, 2:30 PM, and 6:30 PM: 12/02/2023, 12/03, 12/04, 12/05, 12/06, 12/07, 12/12, 12/15, 12/16, 12/18, 12/22, 12/23, 12/24, 12/29 6:30 AM 12/01/2023, 12/03, 12/07, 12/08, 12/13, 12/30 10:30 AM 12/02/2023, 12/04, 12/05, 12/06, 12/07 2:30 PM 12/01/2023, 12/02, 12/03, 12/04, 12/07, 12/08, 12/14, 12/17, 12/21, 12/23 6:30 PM Gabapentin 100 mg capsule - Take 1 capsule by mouth 3 times daily 1 hour before meals:	N 415		

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N 415	Continued From page 17 12/01/2023 7:00 AM 12/01/2023, 12/08/2023 11:00 AM 12/07/2023 4:00 PM Alprazolam 0.25 mg tablet - Take 1 tablet by mouth daily in the morning at 11:00 AM: 12/01/2023, 12/08/2023 11:00 AM Culturelle Capsules (15 bil) - Take 1 capsule by mouth daily: 12/01/2023 8:00 AM RESIDENT 5 On 07/29/2024, Surveyor reviewed Resident 5's June 2024 MAR and noted several days that were not documented with staff initials for administration of medications. The medication and dates were as follows: Xarelto 2.5 mg tablet - Take 1 tablet twice daily: 12/16/2023, 12/23/2023 8:00 AM 12/01/2023 8:00 PM Furosemide 20 mg tab - Take 1 tablet every other day: 12/23/2023 Ferrous Sulfate 325 mg tab - Take 1 tablet daily in the morning: 12/16/2023, 12/22/2023 Culturelle Capsules - Take 1 capsule by mouth in the morning: 12/16/2023, 12/23/2023 Vitamin C 500 mg tab - Take 1 tablet by mouth twice daily: 12/16/2023, 12/23/2023 8:00 AM Acetaminophen 325 mg tablet - Take 1 tablet by	N 415		

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N 415	Continued From page 18 mouth 3 times daily: 12/16/2023, 12/23/2023 8:00 AM Sertraline HCl 100 mg tablet - Take 1 tablet by mouth daily: 12/16/2023, 12/23/2023 Methenamine HIpp 1 gm tablet - Take 1 tablet by mouth twice daily: 12/16/2023, 12/23/2023 8:00 AM Famotidine 20 mg tablet - Take 1 tablet by mouth twice daily: 12/16/2023, 12/23/2023 8:00 AM Nutritional Supplement (Eg. Ensure) 8 ounces - Provide nutritional supplement 8 oz with each meal: 12/16/2023, 12/23/2023 8:00 AM 12/01/2023, 12/04/2023, 12/17/2023, 12/21/2023, 12/22/2023, 12/23/2023 12:00 PM 12/01/2023, 12/06/2023, 12/10/2023, 12/16/2023, 12/20/2023, 12/24/2023, 12/26, 12/30/2023 5:00 PM RESIDENT 6 On 07/29/2024, Surveyor reviewed Resident 6's May 2024 MAR and noted several days that were not documented with staff initials for administration of medications. The medication and dates were as follows: Aspirin 81 mg EC tab - Take 1 tablet by mouth twice daily: 12/19/2023 Fluoxetine HCl 20 mg capsule - Take 3 capsules (60 mg) by mouth every morning: 12/19/2023	N 415		

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N 415	Continued From page 19 Levothyroxine 50 mcg tablet - Take 1 tablet by mouth daily on empty stomach: 12/02/2023, 12/03/2023, 12/09/2023, 12/14/2023, 12/15/2023, 12/16/2023, Aripprazole 10 mg tab - Take 1 tablet daily: 12/19/2023 Famotidine 10 mg tab - Take 1 tablet by mouth twice daily: 12/19/2023 8:00 AM Carvedilol 25 mg tab - Take 1 tablet by mouth twice daily: 12/19/2023 8:00 AM Diltiazem CD 300 mg cap - Take 1 capsule once daily: 12/19/2023 8:00 AM Additionally, Surveyor noted Resident 6's MAR lists Diltiazem as being administered at 8 AM and 8 PM although the order says once daily. Novolog Flexpen 100 unit/mL - (sliding scale): 12/05/2023 12:00 PM 12/14/2023, 12/15/2023, 12/17/2023, 12/20/2023, 12/21/2023 4:00 PM Cyclobenzaprine 5 mg tab - Take 1 tablet by mouth twice daily at 6 AM and 11 PM: 12/02/2023, 12/03/2023, 12/09/2023, 12/14/2023, 12/15/2023, 12/16/2023 6:00 AM 12/01/2023, 12/02/2023, 12/03/2023, 12/04/2023, 12/06/2023, 12/07/2023, 12/10/2023, 12/14/2023, 12/15/2023, 12/17/2023, 12/18/2023, 12/19/2023 11:00 PM Bupropion HCl XL 150 mg tab - Take 1 tablet by mouth daily:	N 415		

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N 415	Continued From page 20 12/19/2023 Clotrimazole 1% Cream - Apply topically to affected area twice daily: 12/19/2023 8:00 AM 12/19/2023 8:00 PM Atorvastatin 20 mg tab - Take 1 tablet once daily: 12/19/2023 Metformin HCl 1,000 mg tab - Take 1 tablet once daily with breakfast: 12/14/2023, 12/15/2023, 12/17/2023, 12/20/2023 4:00 PM On 07/29/2024, at approximately 1:00PM, Surveyors interviewed Operations Administrator A (OA-A) and RN B regarding the missing documentation on the MARs. OA-A and RN-B reported in the past they reviewed MARs for missed documentation. OA-A and RN-B reported they will begin reviewing MARs to ensure accurate documentation and will be holding a staff training. Cross Reference: N0352 83.32(3)(h) Rights Of Residents: Receive Medication	N 415		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the	Y3244		

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Y3244	Continued From page 21 facility. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure adequate and appropriate care was provided within the capacity of the facility for Resident 2. Findings Include: On 12/19/2023, the department received a complaint alleging long wait times when requesting assistance with the pendant/call light system. Review of Resident 2's Individual Support Plan (ISP) updated on 06/24/2024, identified the following: MOBILITY: Uses a hoyer lift for all transfers and a wheelchair for mobility. TOILETING: Resident 2 is incontinent of urine and staff should provide incontinence care every two hours and uses a bed pan for bowel movements. MANDATORY CARES/FREQUENT CHECKS: Staff should conduct safety/wellness checks every 2 hours. During these checks, staff should ensure the following: offer fluids, snacks and meals, pendant, phone and remotes are in reach, heels are free floating using a pillow, ensure s/he is not in need of incontinence care and remind	Y3244		

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him/her of any upcoming appointments or visitors.
COMMUNICATION: Resident 2 is alert and can make needs known most of the time but has moments of confusion. Resident 2 can use the call pendant but sometimes has issues pressing or forgetting to press the button. "Staff to answer all calls from [Resident 2] in a timely manner and meet [his/her] needs."

On 07/24/2024, Surveyor interviewed Resident 2. Resident 2 reported "they" do not respond timely when s/he needs help. Resident 2 stated s/he waits for long periods of time before someone comes to see if s/he is ok.

On 07/25/2024 at 10:49AM, Surveyor interviewed Power of Attorney C (POA-C). POA-C identified s/he is the activated power of attorney of healthcare for Resident 2. The power of attorney was activated due to Resident 2's progression of Lewy Body Dementia. POA-C reported s/he is very concerned about the call light response times, particularly on the weekends. POA-C stated sometimes Resident 2 waits up to an hour. POA-C advised s/he lives out of state and Resident 2 will call him/her any time s/he is not assisted and POA-C stays on the phone until help arrives. POA-C explained sometimes, to get assistance, s/he has to call or text the facility's charge phone (cell phone that is with the lead caregiver on duty). POA-C stated s/he is also worried the caregivers are not "rounding" or checking on Resident 2 every 2 hours as it specifies in the individual support plan (ISP). POA-C also expressed concerned of caregivers clearing the pendant without providing any cares. POA-C explained s/he has witnessed this occur when s/he was on the phone with Resident 2 as s/he stays on the phone until assistance is

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Y3244	Continued From page 23	Y3244		

provided. POA-C reported s/he has hired a private home health provider to help with overnight cares as well. POA-C mentioned s/he recognizes how hard the staff work, but feels this is a safety concern.

On 07/29/2024 at 4:10PM, Surveyor reviewed text messages provided by POA-C. The text messages demonstrate how Resident 2 calls POA-C when s/he is not assisted. It further shows how POA-C stays on the phone with Resident 2 while calling and texting the charge phone or Operations Administrator A's phone when there was no success reaching the charge phone.

The text messages from POA-C to the Facility Charge Phone and Operations Administrator A were as follows:

Friday - 11/24/2023 at 8:23PM:
POA-C: " ...I know you are short staffed tonight and I'm sorry to reach out. I've been on the phone with [Resident 2] mom for about 35 minutes to keep [him/] her calm while [s/he] is waiting for someone to take [him/her] to the rest room. I think [s/he] has soiled [his/herself] in [his/her] depends at this point and may need to be cleaned up ..."
CHARGE PHONE: "Yes I sent someone ..."

Friday - 12/01/2023 at 8:14PM:
POA-C: " ...I'm on the phone with [Resident 2] and [s/he] seems to be thinking that [s/he] has been waiting to go to the restroom but I don't know that [s/he] hit [his/her] pendant. I did talk [him/her] through pressing it about 10 minutes ago ...When someone is available, would they be able to help [him/her] to the restroom please?"
CHARGE PHONE: "Yes we will get down there when we can but the pendant didn't go off ....I'm

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Y3244	Continued From page 24 going there right now." POA-C: "Hi again, any idea when someone might be free?... I've been in [sic] the phone with [him/her] about 30 minutes and I can understand [s/he] may be getting close to having an accident since [his/her] button wasn't going through." CHARGE PHONE: "Yes ..." Saturday - 12/02/2024 at 6:09PM: POA-C: "I'm sorry to bother you. [Resident 2] is having trouble today remembering to use [his/her] pendant... [S/he] needs assistance to use the restroom and I tried to talk [him/her through using the pendant. [S/he] thinks the red light was blinking but I'm not sure if it went through?... When someone is available, could you please have them assist [him/her]? I will stay on with [him/her] so she doesn't yell out for people ..." CHARGE PHONE: " ...[girls/boys] said they were in there and that [s/he] just went potty like 20 minutes ago ..." POA-C: "No, I've been on with [him/her] 35 minutes at this point... came in but just took the dishes and left." CHARGE PHONE: "Is [sic] [s/he] still need help" POA-C: "[S/he] does still need help. CHARGE PHONE: "Ok I'll send somebody ....my bad [s/he] went to potty last time you told them ... or asked them I should say ..." POA-C: "No one has taken [him/her] to the restroom since I've been on the phone. [S/he called me at 545" CHARGE PHONE: "[S/he] went potty at 5:53PM the computer says but I'll send somebody" POA-C: "That's definatly [sic] not right since I was on the phone the. With [him/her] [sic]" CHARGE PHONE: "Ok maybe [girls/boys] have times messed up I'm not by them right now" POA-C:" Okay, if we could just send someone, I'd be grateful. I'm trying to tell [him/her] to be	Y3244		

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Y3244	Continued From page 25 patient" Saturday - 02/03/2024 at 2:51PM: POA-C: " ...I've been on the phone with [Resident 2] in Room 20 north, since 152pm. [S/he] has been trying to press her button to get help to the rest room [sic]. The charge on north confirmed they would send someone when free at 154pm. No one has arrived and I haven't been able to get a response on the north charge phone. Is there anyway to find out how much longer it may be- [s/he] has been waiting about an hour at this point. Thanks much ..." NOTE: The message noted "Read 2/3/24," which indicated someone read the message. Thursday - 02/29/2024 at 11:49PM: POA-C: " ...I've been on the phone with [Resident 2] for 30 min trying to help [him/her] to get assistance to the restroom. I've tried talking [him/her] through pressing [his/her] pendant, have tried texting the north charge phone (messages remain unread) and have tried calling the north charge phone but there was no answer and the voicemail is full. Would it be possible for you to get word to the north staff that [s/he] needs some assistance please?" CHARGE PHONE: "Yep I'll head over there to check it out." Monday - 03/18/2024 at 4:27PM: POA-C: "I've been on the phone with [him/her] for about 35 minutes trying to help her use [his/her] pendant to get some assistance to the restroom ...I've texted the north charge phone twice and left a voice mail but still have not had a reply. Is there any chance that you could please get word to the north side to ask if they could possibly send someone to assist [him/her]? CHARGE PHONE: "I will try and get ahold of	Y3244		

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	0016351	A. BUILDING: _____ B. WING _____	R-C 07/30/2024

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Y3244	Continued From page 26 them" POA-C: " ...Did you happen to have any success finding someone on the north side? I'm still on the phone with [him/her] trying to get someone in to help [him/her] ...[S/he] has been waiting about 45 minutes and I'm not quite sure what else to do to try to get him/her] some assistance?" Friday - 05/03/2024 at 4:47PM: POA-C: " ... [Resident 2] has been trying to get some help for the last 45 minutes and I've been trying to contact the north charge but can't reach any one ... [S/he] is starting to escalate and is upset and I'd like to avoid [him/her] getting to [sic] emotionally distraught ... Never mind [sic] ... we finally reached someone. Thanks so much" Wednesday - 05/08/2024 at 8:13PM: POA-C: " ... [Resident 2] had been trying to get some assistance for about 1-1/4 hours and we can't reach anyone on the north side to see when someone may be free. Is there any chance that you could please get a message to someone?" CHARGE PHONE: "Yes I will let someone know [s/he's] in need of assistance" Wednesday 05/08/2024 at 8:40PM: POA-C: "Hi [Operations Administrator A] ... "I'm sorry to text late. I wanted to let you know that we have been trying to get [Resident 2] assistance for over two hours tonight. A staff member did come in at 7pm after 39 minutes waiting and stated they were very busy but would be back. [Resident 2] has tried [his/her] pendant several times. I have called the north charge and had to leave messages. I then resorted to trying to call the south charge phone 30 minute [sic] ago ... At this point, we are still waiting and I've been on the phone with [Resident 2] to keep [him/her] calm. I know folks are busy but this is concerning."	Y3244		

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Y3244	Continued From page 27 OPERATIONS ADMINISTRATOR A: "I just called one of the staffs personal phone. They just let me know about 20 minutes ago that they cannot find the facility phone so if [s/he's] trying to call that they don't know where it is, but I did tell [him/her] to go in there and [s/he's] just putting medication on another resident and then [s/he'll] go ..." POA-C: "Thanks so much. I have had [him/her] pressing the pendant about every 20 minutes and [s/he tells me [s/he] sees the red light. I appreciate you reaching someone." Sunday - 05/12/2024 at 6:25PM: POA-C: "Hi [Operations Administrator A] ... I am sorry to text on a Sunday ... I was with [Resident 2] the last few days and am very concerned about the safety of [his/her] care. There do not seem to be sufficient staff on to provide timely assistance and [Resident 2] hasn't been able to leave his/her bed the last three days because there are not enough staff available for [him/her] to use the hoyer lift. [S/he] had to wait over 2 hours on several occasions in the last few days to have his/her depends changed when [s/he] soiled [him/herself] because no one was available to take [him/her] to the restroom. Additionally, it is taking more than 45 minutes repeatedly to have someone even respond to [his/her] call light to see that [s/he] is okay ... I hope you can understand why this is concerning to observe repeatedly when I am there. Thank You." Saturday - 05/25/2024 at 1:49AM: POA-C: " ...I am sorry to send a middle of the night text but am very concerned. I just got a call from [Resident 2] - who is quite distraught. [S/he] is telling me that [s/he] has been pressing [his/her] pendant since about 1045pm and no one came for over 2 hours. [S/he] apparently didn't have [his/her] phone] where [s/he] could see it	Y3244		

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Y3244	Continued From page 28 and wasn't able to call for help and says [s/he] has been screaming to try to get attention. [S/he] felt completely abandoned and with no recourse to get help ... It sounds like there is only one person covering the entire facility tonight? Are you able to let me know what is going on ..." [OPERATIONS ADMINISTRATOR A]: "There are four people in the building like they're [sic] always is ... I will call there and ask ... what is going on because there are four people in the building ..." Monday - 06/17/2024 at 12:53AM: POA-C: " ...[Resident 2] has been trying to push [his/her] pendant for help since about 12am but no one has come yet. I've tried to text and call the north charge phone but haven't been able to reach anyone. Would it be possible for you to get word to the north side to see if someone could please assist her when free? Thank You!" CHARGE PHONE: "I will call them now" Saturday - 07/13/2024 at 11:10PM: POA-C: " ...[Resident 2] has been waiting over an hour for some assistance. I've texted the north charge phone number but am not getting any reply. I also tried calling but got voicemail. Would it be possible to send someone to assist my mom please? Thank You." CHARGE PHONE: "I just talked to somebody they said they'll check on [him/her]. Saturday - 07/20/2024 at 8:01AM: POA-C: " ...I'm on the phone with [Resident 2] and [s/he] is needing some assistance to have [his/her] depends changed ...Would it be possible to please have someone assist her when someone is available? Thank You!!" CHARGE PHONE: "Yes just a few mins. They are getting people up but as soon as one is done I'll send them your way."	Y3244		

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Y3244	Continued From page 29 POA-C: "Hi again. Sorry to bother you again. Any sense of when someone may be available? I'm trying to manage [Resident 2's] expectations but I've been in [sic] the phone with [him/her] for 45 minutes to keep [him/her] calm while [s/he] has been waiting for someone ..." NOTE: The message read "delivered." On 07/29/2024 at 5:32PM, Surveyor reviewed email correspondence sent by POA-C to the provider. The email demonstrated POA-C's observation of extended wait times for Resident 2's needed cares. The email was dated 06/18/2024 at 10:22AM. Recipients included Operations Administrator A and Registered Nurse B. The email stated: "Hi all- I hope that everyone has enjoyed a great weekend and wonderful start to the week. I was with [Resident 2] this weekend and wanted to follow up on a couple items below to see when we should expect they will start. Specifically, I did not observe the q2 (every 2 hours) hour rounding and repositioning occurring while I was there this weekend ..." On 07/29/2024 at 7:50AM, Surveyor reviewed a sample of call light data for the weekends of 07/06/2024 through 07/07/2024, 07/13/2024 - 07/14/2024 and 07/20/2024 through 07/21/2024. The call light data demonstrated several response times that exceeded 20 minutes. The data was as follows: 07/07/2024 at 6:51PM: 46 minutes and 28 seconds 07/04/2024 at 8:43PM: 29 minutes and 48 seconds 07/07/2024 at 9:56PM: 1 hour 13 minutes 16 seconds	Y3244		

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Y3244	Continued From page 30 07/06/2024 at 9:06AM: 37 minutes 22 seconds 07/06/2024 at 1:41PM: 58 minutes 9 seconds 07/06/2024 at 4:52PM: 56 minutes 29 seconds 07/14/2024 at 5:57AM: 27 minutes 34 seconds 07/14/2024 at 10:01AM: 35 minutes 22 seconds 07/14/2024 at 4:09PM: 35 minutes and 13 seconds 07/14/2024 at 5:57PM: 56 minutes and 4 seconds 07/14/2024 at 8:10PM: 26 minutes 41 seconds 07/14/2024 at 9:25PM: 28 minutes 25 seconds 07/13/2024 at 1:24PM: 31 minutes and 46 seconds 07/13/2024 at 6:27PM: 1 hour 11 minutes 34 seconds 07/13/2024 at 9:55PM; 1 hour 17 minutes 45 seconds 07/21/2024 at 3:14AM: 1 hour 9 minutes 15 seconds 07/21/2024 at 7:01AM: 35 minutes 42 seconds 07/21/2024 at 1:12PM: 30 minutes 41 seconds 07/21/2024 at 7:29PM: 33 minutes 8 seconds 07/20/2024 at 6:13AM: 2 hours 20 minutes 50 seconds 07/20/2024 at 9:21AM: 47 minutes 27 seconds 07/20/2024 at 10:12AM: 41 minutes 39 seconds 07/20/2024 at 12:32PM: 1 hour 13 minutes 21 seconds 07/20/2024 at 4:42PM: 1 hour 5 minutes 52 seconds 07/20/2024 at 6:54PM: 35 minutes 59 seconds 07/20/2024 at 10:00PM: 39 minutes 16 seconds 07/20/2024 at 11:23PM: 46 minutes On 07/24/2024, at approximately 10:00AM, Surveyors interviewed Operations Administrator A (OA-A) reported Resident 2 is checked on frequently. OA-A explained they have replaced Resident 2's pendent with a new one and	Y3244		

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Y3244	Continued From page 31 continue to ensure it is in working condition. OA-A reported Resident 2 has declined and sometimes does not use the pendant correctly. Resident 2 sometimes yells out, uses a bell in his/her room or will call POA-C. OA-A stated, "I am aware of long call wait times and know it's a problem. We have QA [quality assurance] meetings monthly and talk about the call light times." OA-A further stated the expectation for call light wait time was 3 minutes, but they haven't "hit" that in years. OA-A clarified his/her expectation is no more than 5 minutes, but t hats not happening either. OA-A stated, "We're lucky if resident's call lights are answered in 10 minutes." Resident 2 has a diagnosis of Lewy Body Dementia and depends on caregivers for assistance with transfers, mobility and toileting needs. Review of the text messages provided by POA-C and the call light data provided by the facility demonstrate Resident 2 consistently waited over 20 minutes and sometimes over an hour. There were instances when Resident 2 was not able to hold bowel of bladder and became incontinent due to the long wait times. This led to Resident 2 fearing calls for help would not be answered and resulted in many phone calls to POA-C.	Y3244		