STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018769	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN ACRES ASSISTED LIVING	10214 ROCK CREEK RD HAYWARD, WI 54843

(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 06/13/2024, the Department conducted a verification visit and standard licensing survey at Aspen Acres Assisted Living. Data collected through 06/17/2024. Eight violations were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 23	{N 000}		
N 218	83.16(2) Resident care staff at least 18 years old Resident care staff shall be at least 18 years old. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident care staff was at least 18 years old. Findings include: On 6/13/2024, Surveyor reviewed employee files. Caregiver D was hired 2/28/2024. According to his/her employee record, his/her birthdate was 11/22/2006. Caregiver D was 17 years old. On 6/13/2024, at approximately 1:35 pm, Surveyor interviewed Administrator A. Administrator A explained that Caregiver D was employed at the facility prior to 02/28/2024 as a volunteer support staff, and s/he assumed caregiver responsibilities on 02/28/2024. Surveyor asked if they received a waiver for Caregiver D to work under 18 years of age. Administrator A acknowledged that Caregiver D did not have a waiver on file and acknowledged	N 218		

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

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N 218	Continued From page 1 that he/she needed one.	N 218		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 employees sampled obtained all department approved training as required. Caregiver D did not have training in fire safety	N 239		

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N 239	Continued From page 2 and first aid and choking within 90 days of starting employment. Findings include: On 6/13/2024, Surveyor reviewed employee files. The record for Caregiver D, hired 02/28/2024, did not contain evidence of fire safety and first aid and choking training or evidence of exemptions from training. Caregiver D's employee record included a note indicating s/he would complete training after the school year ended in June. On 6/13/2024, Surveyor verified that Caregiver D was not on the Community-Based Care and Treatment training registry for first aid and choking, or fire safety. On 6/13/2024 at approximately 11:22 AM, Surveyor interviewed Administrator A. Administrator A stated Caregiver D was in high school. Administrator A acknowledged Caregiver D had not completed first aid and choking or fire safety within 90 days of hire because of his/her school schedule. Administrator A believed the note in Caregiver D's record explaining the reason s/he had not completed training yet was sufficient until s/he was able to complete the courses.	N 239		
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	N 352		

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N 352	Continued From page 3	N 352		

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 Resident 2 received his/her prescribed medications as ordered. Resident 2 did not receive his/her scheduled melatonin tablets as ordered by his/her provider.

Findings include:

On 6/13/2024, Surveyor reviewed Resident 2's records. Resident 2's progress notes indicated "med (medication) not available" or "med not in cart" multiple times throughout March and April 2024. Surveyors reviewed the medication administration record (MAR). The MAR indicated Resident 2 had an order for 2 tablets (6mg) of melatonin at bedtime. The March and April 2024 MAR indicated "11 = Med not available" for melatonin on the following 2024 dates: March 1, 3-20, 22-26 and April 13-23, 25-29.

On 6/13/2024, Surveyors reviewed Resident 2's individual service plan (ISP), dated 12/26/2023. The ISP read, "Requires assistance for medication administration; ordering of medication; communication with pharmacy, lab appointments, special preparation of crushing medication if he/she is receiving them when in bed."

On 6/13/2024 at approximately 1:58 p.m., Surveyor interviewed Caregiver H. Surveyor asked Caregiver H to explain why Resident 2's progress notes stated "Med not available" for multiple days during March and April. Caregiver H stated, "It was probably [his/her] melatonin, this

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N 352	Continued From page 4 happens often with [him/her]." Caregiver H stated med passers were responsible for ordering medication when it was low. On 6/13/2024 at approximately 2:45 p.m., Surveyor interviewed Administrator A and Area Director (AD) B about their medication ordering protocol. Administrator A explained medications were ordered on the electronic medication administration record. (EMAR). All scheduled meds were sent on auto ship unless awaiting a new script. Surveyor asked the timeline expectation to reorder a low supply medication. Administrator A stated staff should reorder when 1 week of medication is left. Surveyors asked Administrator A and AD B if there were any issues with medications coming in timely. AD B stated, "I would say most of the time they do, sometimes we wait due to needing a script." AD B stated Resident 2 had an issue where pharmacy sent the script for his/her melatonin to the wrong provider. AD B acknowledged this could have been avoided if the medication was ordered sooner.	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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N 381	Continued From page 5 This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 was assessed when s/he experienced changes in condition in August 2023 and in May/June 2024. Findings include: On 06/13/2024 at 7:50 AM, Surveyors interviewed Caregiver G. Caregiver G stated Resident 1 had a change of condition within the last 2 weeks. According to Caregiver G, Resident 1 went from using a sit-to-stand to requiring Hoyer lift (mechanical lift) for all transfers. From 8:07 AM to 8:30 AM, Surveyors observed Resident 1's morning care routine. Resident 1 required full assistance of 2 staff to transfer via Hoyer lift. At 8:15 AM, Caregiver H informed Surveyors that Resident 1 began using the Hoyer lift for all transfers about 1 week ago. On 06/13/2024, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/24/2018. His/her individual service plan (ISP), dated 08/28/2023, read, "Staff will monitor and assist with transferring by using a hoyer [sic] lift due to not following verbal cues to stand and [his/her] body becomes rigid when transfer is done. [S/he] does not bear weight." Resident 1's record included a more current ISP, created on 10/01/2023. This ISP included undated handwritten updates. One of these updates read, "2 assist transfer - Hoyer."	N 381		

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N 381	Continued From page 6 At 12:40 PM, Surveyors interviewed Administrator A. Administrator A stated Resident 1 had become more rigid within the last 2 weeks, which led to needing the Hoyer lift for transfers. Administrator A stated Resident 1 was able to pivot transfer with the assistance of 2 staff and gait belt before the change in condition. Administrator A explained s/he had printed all resident ISPs from the provider's electronic system about 1 month ago and s/he had been making handwritten changes to these hard copy ISPs. Administrator A stated s/he was doing this in anticipation of an upcoming electronic charting system transition. Administrator A stated s/he did not date his/her handwritten updates so s/he was unsure when Resident 1 began using the Hoyer. Resident 1's record included an assessment, dated 08/23/2023. The assessment read, "Transferring... Requires monitoring and assistance to transfer. [Resident 1] is transferred by two team members and the hoyer [sic] due to not following verbal cues to stand and [his/her] body becomes rigid when transfer is done. [S/he] does not bear weight." At 1:25 PM, Administrator A informed Surveyors that Resident 1's most recent assessment was on 08/28/2023. At 1:58 PM, Surveyors interviewed Caregiver H. Caregiver H stated s/he was hired in December 2023, and s/he was not aware of Resident 1 needing a Hoyer lift prior to 2 weeks ago. Caregiver H stated that prior to this change in condition, Resident 1 was able to stand independently. At 2:25 PM, Surveyors interviewed Administrator A and Area Director (AD) B. Administrator A	N 381		

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N 381	Continued From page 7 stated they should have assessed Resident 1 when s/he experienced a change in condition 2 weeks ago. Administrator A said Resident 1 used a Hoyer lift in the past briefly when s/he was ill, but it was only for a day or 2. Surveyor discussed concern that the August assessment indicated Resident 1 was non-weight bearing and needed a Hoyer lift. AD B reviewed the record and stated, "We didn't do a new assessment when [s/he] no longer needed the Hoyer."	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents sampled (Resident 1 and Resident 2) had signed individual service plans (ISP). Resident 1's ISP was not updated with changes in condition. Findings include:	N 389		

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N 389	Continued From page 8 The provider is licensed to care for 28 residents in the client groups terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease. RESIDENT 2 On 06/13/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 11/29/2021. Resident 2 had a healthcare power of attorney (POA). Resident 2's record included his/her initial ISP and multiple revisions. The most current ISP was updated on 12/26/2023. None of ISPs included evidence (i.e., signature) that Resident 2 and/or his/her POA reviewed and agreed to the terms in the plans. RESIDENT 1 On 06/13/2024, from 8:07 AM to 8:30 AM, Surveyors observed Resident 1's morning care routine. Resident 1 required full assistance of 2 staff to reposition, dress, and transfer. Resident 1 was not able to self-propel his/her wheelchair or assist with grooming cares. At 8:15 AM, Caregiver H informed Surveyors that Resident 1 began using a Hoyer lift for all transfers about 1 week ago. At 11:22 AM, Surveyors interviewed Area Director (AD) B. AD B stated the provider used to have an electronic charting system called Extended Care Professional (ECP). They decided to switch to another system called Point Click Care (PCC) in October 2023, but they were switching back to ECP soon. At 12:40 PM, Surveyor interviewed Administrator A. Administrator A explained that s/he printed all resident ISPs from the provider's electronic	N 389		

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N 389	Continued From page 9 system (PCC) about 1 month ago and s/he had been making handwritten changes to these hard copy ISPs. Administrator A stated s/he was doing this in the interim until they reimplemented ECP. Administrator A stated s/he did not date his/her handwritten updates. Administrator A stated s/he updated Resident 1's ISP sometime in the last 2 weeks to include the need for a Hoyer lift. Administrator A stated Resident 1 was able to pivot transfer with the assistance of 2 staff and gait belt before the change in condition. On 06/13/2024, Surveyors reviewed Resident 1's record provided by Administrator A. Resident 1 was admitted to the facility on 08/24/2018. Resident 1 had a healthcare POA. Resident 1's record included an ISP, created on 10/01/2023. The ISP was not individualized or complete as many sections read, "Requires Assistance," but did not identify the type or frequency of assistance needed. This ISP included undated handwritten updates. Based on the interview with Administrator A above, these updates were made within the past month. The section titled "Transferring" read: "Requires Assistance for: (specify: getting in and out of bed, chair, car. Requires use of railing or devices) Date Initiated: 10/01/2023" A handwritten addition read, "2 assist transfer - Hoyer" Resident 1's previous ISP, dated 08/28/2023, read, "Staff will monitor and assist with transferring by using a hoyer [sic] lift due to not following verbal cues to stand and [his/her] body becomes rigid when transfer is done. [S/he] does not bear weight."	N 389		

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N 389	Continued From page 10 The ISP that replaced the 08/28/2023 ISP was not complete or individualized. Resident 1 did not have a comprehensive ISP between 10/01/2023 to May 2024, when Administrator A began making handwritten updates. Based on staff interview, Resident 1 experienced a change in condition at least twice since 08/28/2023 (improving from needing a Hoyer lift to pivot transfer and declining from pivot transfer to needing a Hoyer lift again), and his/her ISP did not reflect this change. Neither ISP included evidence (i.e., signatures) that Resident 1 and/or his/her POA reviewed and agreed to the terms in the plans. On 06/13/2024 at 2:25 PM, Surveyor interviewed Administrator A and Area Director (AD) B. Administrator A stated s/he recently completed the administrator course offered through their provider association. AD B stated they were not aware they needed to obtain legal representatives' signatures on ISPs prior to Administrator A completing the administrator course.	N 389		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 2 residents sampled (Resident 1 and Resident 2) were evaluated for their ability to respond to a fire alarm annually or when there was a change in	N 394		

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N 394	Continued From page 11	N 394		

condition, using the Department's form.

Findings include:

According to DHS 83.35(5)(a), form F62373, titled, Resident Evacuation Assessment, shall be used to evaluate a resident's ability to evacuate in an emergency.

The provider is licensed to care for 28 residents in the client groups terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease.

On 06/13/2024, from 8:07 AM to 8:30 AM, Surveyors observed Resident 1's morning care routine. Resident 1 required full assistance of 2 staff to reposition, dress, and transfer. Resident 1 was not able to self-propel his/her wheelchair or assist with grooming cares.

On 06/13/2024, Surveyor reviewed resident records.

Resident 1 was admitted to the facility on 08/24/2018. Resident 1's initial evacuation assessment, dated 01/10/2018, indicated Resident 1 was physically able to start and complete an evacuation without physical assistance. Resident 1's record included a 1-page document titled Evacuation/Safety Assessment, dated 05/13/2024. The assessment indicated Resident 1 required full assistance of 2 or more staff to evacuate the building.

Resident 2 was admitted to the facility on 11/29/2021. Resident 2's initial evacuation assessment, dated 11/29/2021, indicated Resident 2 was physically able to start and complete an evacuation without physical

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N 394	Continued From page 12 assistance. Resident 2's record included a 1-page document titled Evacuation/Safety Assessment, dated 05/13/2024. The assessment indicated Resident 2 required limited assistance from up to 2 staff to transfer to a wheelchair and needed to be wheeled out of the building. On 06/13/2024 at 2:25 PM, Surveyor interviewed Administrator A and Area Director (AD) B. Administrator A discussed their policy to evaluate evacuation capabilities within 3 days of admission, annually, and when residents experience a change in condition. AD B stated they were not aware that the electronic charting program they implemented in October 2023 had 2 different evacuation assessment forms in it. AD B stated they had been using the incorrect one, and going forward they would utilize the Department's evacuation assessment form F62373.	N 394		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible material was at least 3 feet away from the furnace and water heater. Findings include: On 6/13/2024, Surveyor observed multiple combustible items within 3 feet of the facility furnace, including 5 cardboard furnace filter boxes, paper towels, 4 cloth rags, and a 1 x 8 wood board.	N 507		

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(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 507	Continued From page 13 On 6/13/2024 at approximately 2:30PM, Surveyors discussed the observations with Administrator A, Area Director B, and Administrative Assistant C. Administrator A stated s/he would have the items removed.	N 507		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that at least two emergency evacuation drills (other than fire) were conducted annually with residents and staff. Findings include: On 6/13/2024, Surveyor reviewed facility's emergency evacuation drills for 2022 and 2023, and did not find record of two "other" evacuation drills. Records showed the facility completed one tornado drill each year on 4/24/2022 and 6/21/2023. On 6/13/2024 at approximately 10:43 AM, Surveyor interviewed Area Director B. Area Director B stated that the corporate office required staff to complete a monthly missing persons drill and one tornado drill a year. Area Director B believed that the missing person drill was a sufficient evacuation drill. Area Director B acknowledged they needed two "other" evacuation drills.	N 526		