| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018200 | A. BUILDING: _____ B. WING _____ | R 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE COMMONS II | W195N9550 ROLLING MEADOWS CIRC MENOMONEE FALLS, WI 53051 |

| (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 |
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| {N 000} | Initial Comments<br><br>On 06/05/2024, Surveyor conducted 2 verification visits at Grace Commons II.<br><br>Three deficiencies were identified.<br><br>Two of 3 deficiencies were repeat violations. See Statement Of Deficiency C1Y311, dated 11/03/2023.<br><br>Seven of 9 deficiencies from Statement Of Deficiency C1Y311, dated 11/03/2023 were substantially corrected.<br><br>The 1 deficiency from Statement Of Deficiency XQ5W11, dated 02/06/2024 was substantially corrected.<br><br>Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 23 | {N 000} | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the resident right to receive medications in dosage and intervals as prescribed by the physician. | N 352 | | |

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

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| N 352 | Continued From page 1<br><br>Resident 5 had a physician order for Midodrine 5 MG 1 tablet 3 times daily before meals, hold for systolic (top number) blood pressure > (greater than) 120. Staff administered Midodrine 5 MG when blood pressure >120.<br><br>Findings include:<br><br>On 06/05/2024, Surveyor reviewed Resident 5's record. S/he was admitted 08/24/2020. Physician orders included Midodrine 5 MG 1 tablet three times daily before meals- hold for systolic blood pressure >120 (start date 08/23/2023).<br><br>From 05/01/2024- 06/04/2024 staff documented on Resident 5's medication administration record that Midodrine 5 MG was administered when systolic BP was >120 following dates:<br>05/01/2024 at 11:50 AM-BP 133/73<br>05/05/2024 at 4:01 PM-BP 127/84<br>05/09/2024 at 8:01 AM-BP 121/71<br>05/11/2024 at 4:09 PM-BP 127/62<br>06/01/2024 at 3:51 PM-BP 134/72 (Photo 2)<br>06/04/2024 at 11:31 AM-141/91 (Photo 3)<br><br>Individual Service Plan (not dated or signed):<br>In the area of Medications: " ...STAFF ADMINISTER ...Resident requires staff to manage/administer medications ...to receive assistance from staff with managing/administering medications per prescriber orders ..."<br><br>On 06/05 2024 at 2:32 PM, Surveyor observed Resident 5's Midodrine bubble packs with Caregiver L. One tablet remained in the 06/01/2024 evening slot (Photo 2) when BP was 134/72 and 1 tablet remained in the 06/04/2024 noon slot (Photo 3) when BP was 141/91. | N 352 | | |

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| N 352 | Continued From page 2<br><br>On 06/05/2024 at 2:32 PM, Surveyor interviewed Caregiver L who stated staff held Resident 5's midodrine when systolic BP was >120.<br><br>On 06/05/2024 at 4:30 PM, Surveyor discussed concern Resident 5's Midodrine with Operations Specialist C, Nurse Manager I, and Intern J. Nurse Manager I stated a staff meeting was held 05/30/2024 regarding hold parameters and discussions were held and education provided during shift-to-shift reports. Nurse Manager I stated hands-on training for staff was scheduled in 2 weeks.<br><br>In 06/06/2024 at 2:12 PM, Surveyor interviewed Resident 5 who stated s/he never refused or declined Midodrine 5 MG. Tenant 5 stated when systolic blood pressure was over 120 it was held because his/her blood pressure was too high to take it.<br><br>Cross Reference:<br>N0415 DHS 83.37(2)(d) Documentation of Medication administration | N 352 | | |
| {N 381} | 83.35(1)(a) Pre-admission and ongoing assessments.<br><br>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 3<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure an assessment for the use of siderails was completed.<br><br>Resident 8's use of siderails was not formerly assessed or addressed on his/her individual service plan (ISP).<br><br>This is a repeat deficiency. See Statement Of Deficiency C1Y311, dated 11/03/2023.<br><br>Findings include:<br><br>According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment.<br>2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patient's medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patient's assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care | {N 381} | | |

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| {N 381} | Continued From page 4 | {N 381} | | |

interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patient's assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 06/06/2024)).

On 06/05/2024 at 1:41 PM, Surveyor observed bilateral ¼ siderails attached to Resident 8's bed in the up position (Photo 1). Resident 8 was seated in his/her chair. Surveyor interviewed Resident 8 who stated the siderails were on his/her bed since admission in April 2021. Resident 8 stated the siderails remained in the up position all the time, even when s/he was in bed and s/he used them to help position his/herself in

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| {N 381} | Continued From page 5<br>bed and sit up on the edge of the bed.<br><br>On 06/05/2024, Surveyor reviewed Resident 8's record. S/he was admitted 04/09/2021. Diagnoses included: multiple sclerosis; paraplegia, unspecified; quadriplegia, unspecified; and unspecified abnormal involuntary movements, neuropathy and legal blindness.<br><br>Assessment dated 12/20/2023 signed and dated by Nurse Manager I:<br>In the area of Mobility, Transport and Escort- " ...2. Have you experienced a fall in the past six (6) months?...No ...3. Do you use a bedside mobility device ...No ..."<br>The assessment did not address siderails.<br><br>ISP (not dated or signed):<br>In the area of Mobility, Transport and Escort- " ...Requires a mechanical lift for transfers ..."<br>The ISP did not address the use of siderails.<br><br>On 06/05/2024 at 3:48 PM, Surveyor interviewed Caregiver K who stated Resident 8's siderails were in the up position whenever Resident 8 was in bed since s/he began employment 4-5 months ago. Caregiver K stated Resident 8's siderails were used to prevent Resident 8 from rolling out of bed and Resident 8 hung onto them when sitting up at edge of bed.<br><br>On 06/05/2024 at 4:30 PM, Surveyor discussed concern Resident 8's siderails not assessed or addressed on his/her ISP with Operations Specialist C, Nurse Manager I, and Intern J. Nurse Manager I stated s/he was not aware that Resident 8 had siderails. | {N 381} | | |

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| {N 415} | Continued From page 6 | {N 415} | | |
| {N 415} | 83.37(2)(d) Documentation of medication administration.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure staff documented medication administration correctly on the medication administration record (MAR).<br><br>Resident 5 had a physician order for Midodrine 5 MG 1 tablet 3 times daily before meals, hold for systolic (top number) blood pressure > (greater than) 120.<br><br>Staff documented Resident 5's Midodrine was declined by Resident 5 when it was held.<br><br>This is a repeat deficiency. See Statement Of Deficiency C1Y311, dated 11/03/2023.<br><br>Findings include:<br>On 06/05/2024, Surveyor reviewed Resident 5's record. S/he was admitted 08/24/2020 .Diagnoses included orthostatic hypotension. | {N 415} | | |

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| {N 415} | Continued From page 7<br><br>Physician orders included Midodrine 5 MG 1 tablet three times daily before meals- hold for systolic blood pressure >120 (start date 08/23/2023).<br><br>From 05/01/2024- 06/04/2024 staff documented on Resident 5's medication administration record that Midodrine 5 MG was declined by Resident 5 when held on the following dates:<br>05/06/2024 at 1:07 PM- BP 148/68<br>05/07/2024 at 7:48 AM- BP 180/58<br>05/07/2024 at 12:57 PM-BP 120/68<br>05/19/2024 at 8:36 AM- BP 144/68<br>05/19/2024 at 1:23 PM- BP 143/67<br><br>Individual Service Plan (not dated or signed):<br>In the area of Medications: " ...STAFF ADMINISTER ...Resident requires staff to manage/administer medications ...to receive assistance from staff with managing/administering medications per prescriber orders ..."<br><br>On 06/05/2024 at 2:32 PM, Surveyor interviewed Caregiver L who stated staff held Resident 5's midodrine when systolic BP was >120.<br><br>On 06/05/2024 at 4:30 PM, Surveyor discussed concern of staff's documentation of Resident 5's Midodrine with Operations Specialist C, Nurse Manager I, and Intern J. Nurse Manager I stated a staff meeting was held 05/30/2024 regarding hold parameters and discussions were held and education provided during shift-to-shift reports. Nurse Manager I stated hands-on training for staff was scheduled in 2 weeks.<br><br>In 06/06/2024 at 2:12 PM, Surveyor interviewed Resident 5 who stated s/he never refused or declined Midodrine 5 MG. Tenant 5 stated when | {N 415} | | |

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| {N 415} | Continued From page 8<br>systolic blood pressure was over 120 it was held because his/her blood pressure was too high to take it.<br><br>Cross Reference:<br>N0415 DHS 83.37(2)(d) Documentation of Medication administration | {N 415} | | |