STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018417	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT BRENTWOOD	633 CAMERON ROAD RICE LAKE, WI 54868

(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 03/20/2024, Surveyor conducted a complaint investigation at Vista Prairie at Brentwood. Data was collected through 04/04/2024. The complaint was substantiated. Three deficiencies were identified. One of the 3 deficiencies was a repeat violation. See Statement of Deficiency (SOD) J55711, dated 12/14/2021 and SOD J55712, dated 06/21/2022. Census: 19	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an allegation of caregiver misconduct was reported to the Department after they concluded Caregiver C was not administering Resident 1's medications as prescribed. Caregiver C was terminated for resident neglect. Findings include: On 01/24/2024, the Department received a complaint related to resident mistreatment. On 03/30/2024, at 9:45 AM, Surveyor interviewed Executive Director (ED) A. When asked about any recent staff concerns, ED A stated s/he had let a few staff go recently. ED A stated Caregiver C no longer worked at the facility and described him/her as being "rough" with staff and residents. Surveyor requested all internal investigations and staff misconduct reports completed that involved Caregiver C. At 10:35 AM, Surveyor reviewed Caregiver C's records that included the following: -A handwritten note, dated 02/29/2024, that appeared to be signed by Caregiver D and Caregiver E. The note stated concerns with Caregiver C's conduct that read, in part, "[S/he] tends to not give [Resident 1] [his/her] scheduled 2am neb (nebulizer) most mornings until 4am-5am. [Resident 1] has come out complaining about this multiple times while coughing and wheezing." -A document titled, "Performance Management/Corrective Action Form," that included the following summary: "Violated Resident Rights by not giving [Resident 1]	N 158		

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VISTA PRAIRIE AT BRENTWOOD	633 CAMERON ROAD RICE LAKE, WI 54868

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N 158	Continued From page 2 [his/her] Ipratropium - Albuterol neb treatment at 2:00 am, Eldermark shows 25 times from 11-6-23 to 2-22-24, 25 times that it was given 2 to 3 hours late in the shift." Under the section titled, "Expectations and Performance Improvement Plan," it stated, "This is very serious and it is our duty to pass meds (medications) as assigned, if given late there is no documentation to explain why, this goes all against our mission. Termination will be effective as of 2-29-24 for resident neglect." At 12:23 PM, Surveyor interviewed Registered Nurse (RN) B. RN B stated they first became aware Caregiver C was administering late medications when they received the handwritten note from staff with the allegations. RN B stated they identified Caregiver C had been giving the medications late and they addressed it the same day. RD B stated that during the weeks leading up to termination, they had talked to Caregiver C about his/her behavior with staff and residents. RN B stated s/he was not aware if the investigation had been reported to the Department. At approximately 1:17 PM, Surveyor interviewed ED A. When asked if the investigation that led to Caregiver C's termination was reported to the Department, ED A stated s/he did not think s/he reported it. On 03/26/2024, Surveyor requested additional information from ED A via email. When asked about the internal investigations regarding resident neglect allegations made by staff, ED A stated Caregiver C, "never worked alone and was being watched and management was building enough evidence to terminate the employee."	N 158		

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N 158	Continued From page 3 Cross Reference N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 158		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the CBRF (Community Based Residential Facility) immediately notified Resident 1 and Resident 3's legal representatives when there was an allegation of physical, sexual or mental abuse, or neglect. Findings include: On 03/30/2024, at 9:45 AM, Surveyor interviewed Executive Director (ED) A. When asked about any recent staff concerns, ED A stated s/he had let a few staff go recently. ED A stated Caregiver C no longer worked at the facility and described him/her as being "rough" with staff and residents. Surveyor requested all internal investigations and staff misconduct reports completed that involved Caregiver C. At 10:35 AM, Surveyor reviewed Caregiver C's records that included the following:	N 170		

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N 170	Continued From page 4 -Caregiver C was hired on 09/13/2021 and rehired on 12/15/2022. -A typed document, dated 02/17/2023, that read, in part, "We also had complaints from the AM staff today that there were some cares not done and also toileting that didn't get done. Resident neglect was very evident with [Resident 3]." -A document titled, "Vista Prairie Counseling/Disciplinary/Performance Improvement Plan," dated 02/24/2023, that read, in part, "Staff reported there were some cares and toileting not done with Resident [sic] neglect was very evident with [Resident 3]." -A handwritten note, dated 02/29/2024, that appeared to be signed by Caregiver D and Caregiver E. The note stated concerns with Caregiver C's conduct that read, in part, "[S/he] tends to not give [Resident 1] [his/her] scheduled 2am neb (nebulizer) most mornings until 4am-5am. [Resident 1] has come out complaining about this multiple times while coughing and wheezing." -A document titled, "Performance Management/Corrective Action Form," that included the following summary: "Violated Resident Rights by not giving [Resident 1] [his/her] Ipratropium - Albuterol neb treatment at 2:00 am, Eldermark shows 25 times from 11-6-23 to 2-22-24, 25 times that it was given 2 to 3 hours late in the shift." Under the section titled, "Expectations and Performance Improvement Plan," it stated, "This is very serious and it is our duty to pass meds as assigned, if [sic] given late there is no documentation to explain why, this [sic] goes all against our mission. Termination will be effective as of 2-29-24 for resident neglect." On 03/26/2024, Surveyor requested additional information and records for Resident 1 and Resident 3 via email from ED A. ED A provided	N 170		

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N 170	Continued From page 5 additional information for review via email later in the day. Resident 1 was admitted to the facility on 04/07/2023 and had identified an activated Power of Attorney (POA) for Health Care. Resident 3 was admitted to the facility on 01/01/2021 and identified an activated Power of Attorney for Health Care. When asked if Resident 1's POA was notified of the neglect allegations reported on 02/29/2024, ED A responded, "We got a complaint that the resident was not receiving treatments on time. They were given but given a late number of times ...We ran the report, it [sic] shows that we addressed [Caregiver C], management termed [sic] employee on 2-29-24 ... We did talk to [Resident 1], and we assessed [him/her], [sic] [s/he] showed no signs of distress and was at baseline. If [Resident 1] was showing signs of difficulty breathing and may have had to be sent out an incident report would have been done and a state report would have been filed. At Jan [sic]11th staff meeting we talked about meds. After Jan [sic] 11 when we had the meeting, this should have never kept on continuing so that also helped me decide to terminate this employee." When asked if Resident 3's POA was notified of the neglect allegations made by staff on 02/17/2023, ED A stated Resident 3's POA stopped at the facility daily, and if they had any concerns, they would call or talk to staff, and they would address them immediately..." Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 170		

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N 352	Continued From page 6	N 352		
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 each resident received all prescribed medication in the dosage and at intervals prescribed by a practitioner. Resident 1 received his/her scheduled nebulizer treatment late 29 times between November 2023 and February 2024. Resident 1 had scheduled nebulizer treatments that were not given and unavailable in December 2023 and January 2024. This is a repeat violation. See Statement of Deficiencies (SOD) J55711, dated 12/14/2021 and SOD J55712, dated 06/21/2022. Findings include: The provider is licensed to serve up to 20 residents in the following client groups: advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 03/30/2024, at 9:45 AM, Surveyor interviewed Executive Director (ED) A. When asked about any recent staff concerns, ED A stated Caregiver C was recently terminated. Surveyor requested all investigation reports and staff misconduct reports involving Caregiver C.	N 352		

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N 352	Continued From page 7 At 10:35 AM, Surveyor reviewed Caregiver C's records that included the following: -A handwritten note, dated 02/29/2024, that appeared to be signed by Caregiver D and Caregiver E. The note stated concerns with Caregiver C's conduct that read, in part, "[S/he] tends to not give [Resident 1] [his/her] scheduled 2am neb (nebulizer) most mornings until 4am-5am. [Resident 1] has come out complaining about this multiple times while coughing and wheezing." -A document titled, "Performance Management/Corrective Action Form," included the following summary, "Violated Resident Rights by not giving [Resident 1] [his/her] Ipratropium - Albuterol neb treatment at 2:00 am, Eldermark shows 25 times from 11-6-23 to 2-22-24, 25 times that it was given 2 to 3 hours late in the shift." Under the section titled, "Expectations and Performance Improvement Plan," it stated, "This is very serious and it is our duty to pass meds (medications) as assigned, if given late there is no documentation to explain why, this goes all against our mission. Termination will be effective as of 2-29-24 for resident neglect." At 12:23 PM, Surveyor interviewed Registered Nurse (RN) B. RN B stated they first became aware Caregiver C was administering late medications when they received a handwritten note from staff with the allegations. RN B stated they identified Caregiver C had been giving the medications late and that was the reason for his/her termination. RN B stated they had previously talked with Caregiver C about his/her work performance issues in the weeks leading up to his/her termination. On 03/26/2024, Surveyor requested additional information and records for Resident 1 via email	N 352		

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N 352	Continued From page 8 from ED A. Resident 1 was admitted to the facility on 04/07/2023, with diagnoses of unspecified dementia and chronic obstructive pulmonary disease. On a document titled, "Medication List," Resident 1 had the following routine medication order: "06/08/2023 IPRATROPIUM-ALBUTEROL 0.5-2.5 (3) MG/3ML SOLN (Combivent Respimat) - One vial per nebulizer 4 times daily, encourage resident to cough and use breathing following nebulizer. This can be given with Sodium Chloride and Budesonide nebulizers. - 2AM, 7AM, 1PM, 8PM - Indicated for COPD." Documentation provided by ED A titled, "Medication Delivery," showed Resident 1's scheduled 2 AM dose of Ipratropium Albuterol was administered late at the following times: 11/01/2023 - Administered at 5:19 AM 11/02/2023 - Administered at 6:09 AM 11/06/2023 - Administered at 3:19 AM 11/11/2023 - Administered at 3:16 AM 11/14/2023 - Administered at 4:21 AM 11/15/2023 - Administered at 4:00 AM 11/17/2023 - Administered at 4:07 AM 11/21/2023 - Administered at 4:36 AM 11/22/2023 - Administered at 5:03 AM 11/25/2023 - Administered at 4:47 AM 11/30/2023 - Administered at 3:23 AM 12/01/2023 - Administered at 3:33 AM 12/05/2023 - Administered at 3:53 AM 12/09/2023 - Administered at 4:04 AM 12/10/2023 - Administered at 4:14 AM 12/13/2023 - Administered at 3:31 AM 12/14/2023 - Administered at 3:30 AM 12/19/2023 - Administered at 3:25 AM 12/24/2023 - Administered at 3:38 AM 12/27/2023 - Administered at 4:05 AM 01/04/2024 - Administered at 4:32 AM 01/11/2024 - Administered at 3:30 AM	N 352		

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N 352	Continued From page 9 01/18/2024 - Administered at 4:59 AM 01/30/2024 - Administered at 4:19 AM 02/08/2024 - Administered at 3:01 AM 02/15/2024 - Administered at 5:48 AM 02/18/2024 - Administered at 5:48 AM 02/22/2024 - Administered at 3:44 AM 02/26/2024 - Administered at 3:44 AM Resident 1 had the following medication order: "06/01/2023 Budesonide 0.5 MG/2ML SUSP - One vial per nebulizer twice daily, encourage resident to cough and use breathing device following nebulizer. This can be given with Sodium Chloride and Ipratropium/Albuterol nebulizers. -7AM, 8PM - Indicated for COPD." Documentation provided by ED A titled, "Medication Delivery," showed Resident 1's scheduled dose of Budesonide was "Not Given/Held" with a reason that stated, "Med not available" on the following days: 12/16/2023: 8:00 PM dose 12/17/2023: 7:00 AM dose 12/17/2023: 8:00 PM dose 12/18/2023: 7:00 AM dose 12/18/2023: 8:00 PM dose Resident 1 had the following medication order: "06/01/2023 Sodium Chloride 0.9% NEBU - inhale 3ml by nebulization 2 times a day. This nebulizer may be given with Budesonide and Ipratropium/Albuterol nebulizers. -7AM, 8PM - Indicated for COPD." Documentation provided by ED A titled, "Medication Delivery," showed Resident 1's scheduled dose of Sodium Chloride was "Not Given/Held" with a reason that stated, "Med not available" on the following days: 12/31/2023: 7:00 AM dose	N 352		

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N 352	Continued From page 10 12/31/2023: 8:00 PM dose 01/01/2024: 7:00 AM dose 01/01/2024: 8:00 PM dose 01/02/2024: 7:00 AM dose 01/02/2024: 8:00 PM dose 01/08/2024: 7:00 AM dose 01/08/2024: 8:00 PM dose On 04/04/2024, at 11:00 AM, Surveyor interviewed ED A and RN B via phone. When asked why Resident 1's medications were unavailable, ED A stated they had some issues with the pharmacy and recalled a time when there was a shortage of nebulizer treatments. ED A stated there was a time when the pharmacy sent the wrong doses of Sodium Chloride to the facility. ED A stated they were making changes through their quality assurance program to prevent medication issues moving forward. RN B stated they created a new medication binder and would be pulling reports frequently to monitor for medication issues. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect Cross Reference N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations	N 352		