STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012042	A. BUILDING: _____ B. WING _____	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE OF PLOVER	2831 MAPLE DRIVE PLOVER, WI 54467

(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 05/06/2024, Surveyor conducted 2 complaint investigations at Maple Ridge at Plover, a CBRF located in Plover, WI. As a result of the survey, 3 violations of Chapter DHS 83 were issued. Both complaints were substantiated.	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 4 of 4 residents reviewed received medications in the dosage and at intervals prescribed by a practitioner. Findings include: On 05/06/2024, Surveyor reviewed Caregiver B's employee file. Surveyor noted Caregiver B had been disciplined for administering medications that were discontinued and no longer on the residents' Medication Administration Record (MAR) from 04/15/2024-04/25/2024, when the error was noticed and corrected. Resident 2, Resident 4 and Resident 5 all received medications from 04/15/2024 through 04/25/2024 that had been discontinued and were no longer on their MARs.	N 352		

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

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N 352	Continued From page 1 According to facility documentation dated 04/25/2024, medications were still in the medication cart, but not on the MAR for the following residents. Resident 2: Physician's orders indicate that the following medications were discontinued as of 04/15/2024: Fludicortisone, Sodium Choride AM and PM. According to facility documentation dated 04/25/2024, Resident 2 received the following medications which were discontinued and not found on the MAR from 04/15/2024 through 04/25/2024. Fluoticortisone 04/15/2024, 04/16/2024, 04/17/2024, 04/18/2024, 04/19/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/23/2024, 04/24/2024 Sodium Choride AM and PM shift: 04/15/2024, 04/16/2024, 04/17/2024, 04/18/2024, 04/19/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/23/2024, 04/24/2024 Resident 4: According to facility documentation dated 04/25/2024, Resident 4 received the following medications which were discontinued and not found on the MAR from 04/15/2024 through 04/25/2024. Aspirin 04/15/2024, 04/16/2024, 04/17/2024, 04/18/2024, 04/19/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/23/2024, 04/24/2024 Resident 5	N 352		

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N 352	Continued From page 2 According to facility documentation dated 04/25/2024, Resident 5 received the following medications which were discontinued and not found on the MAR from 04/15/2024 through 04/25/2024. Amlodipine 04/15/2024, 04/16/2024, 04/17/2024, 04/18/2024, 04/19/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/23/2024. On 05/06/2024 at 11:00 AM, Surveyor interviewed Caregiver B. Caregiver B acknowledged administering discontinued medications to Resident 2, Resident 4 and Resident 5 from 04/15/2024 through 04/25/2024. Caregiver B stated the medication cards were still in the medication cart but were not on the MAR for Resident 2, Resident 4 or Resident 5. Caregiver B stated, "I should have checked the MAR first, but I didn't." On 05/06/2024 at 12:00 PM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged Caregiver B should have checked the MAR for Resident 2, Resident 4 and Resident 5 before administering medications. Administrator A acknowledged the discontinued medications should have been removed from the medication cart to avoid residents receiving discontinued medications.	N 352		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects	N 355		

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N 355	Continued From page 3 of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was able to make decisions relating to daily routine and other aspects of life. Caregiver B took Resident 1's phone and deleted pictures that s/he had taken with it. Findings include: On 02/16/2024, the Department received a complaint alleging staff had confiscated resident personal belongings and looked through them without permission. On 05/06/2024, Surveyor conducted a complaint investigation. On 05/06/2024 at 09:15 AM, Surveyor interviewed Administrator A. Administrator A acknowledged Caregiver B had taken Resident 1's personal cell phone in January 2024 because s/he thought Resident 1 had taken photos of another resident with it. Administrator A stated Caregiver B stated s/he deleted the photos of the other resident because s/he believed it to be a privacy violation. Administrator A provided a disciplinary note from Caregiver B's employee file. The disciplinary note, dated 01/22/2024 indicated Caregiver B had taken Resident 1's personal cell phone because Resident 1 had taken photos of another resident.	N 355		

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N 355	Continued From page 4 On 05/06/2024 at 11:00 AM, Surveyor interviewed Caregiver B. Caregiver B acknowledge s/he took Resident 1's personal cell phone. Caregiver B stated, "I saw [him/her] taking photos of another resident and thought it was a privacy violation so I took [his/her] phone and deleted the photos and told [Resident 1] not to take photos of others anymore." Surveyor asked Caregiver B if Resident 1 knew s/he had taken his/her phone. Caregiver B stated s/he was under the impression Resident 1 knew s/he took his/her phone and it was given back quickly. Surveyor asked Caregiver B if Resident 1 gave him/her permission to look through and delete pictures from his/her phone. Caregiver B acknowledged Resident 1 did not give him/her permission. On 05/06/2024 at 11:30 AM, Surveyor attempted to interview Resident 1. Resident 1 stated s/he likes to use his/her phone by using applications, taking pictures and messaging. Resident 1 did not appear to know his/her phone was taken by staff. Resident 1 stated s/he "thought I had lost it and asked staff to help me look for it. I did get it back." On 05/06/2024 at 12:00 PM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged staff could not take residents' personal possessions. Administrator A stated, "We have no business going through a resident's phone." Administrator A acknowledged Caregiver B should not have taken Resident 1's cell phone and deleted pictures from it without Resident 1's permission.	N 355		
N 417	83.37(3)(a) Medication storage: original containers.	N 417		

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N 417	Continued From page 5 Original containers. The CBRF shall keep medications in the original containers and not transfer medications to another container, unless the CBRF complies with all of the following: 1. Transfer of medications from the original container to another container shall be done by a practitioner, registered nurse, or pharmacist. Transfer of medication to another container may be delegated to other personnel by a practitioner, registered nurse or pharmacist. 2. If a medication is administered by CBRF employees and the medication is transferred from the original container by a registered nurse, or practitioner or other personnel who were delegated the task, the CBRF shall have a legible label on the new container that includes, at a minimum, the resident ' s name, medication name, dose and instructions for use. The CBRF shall maintain the original pharmacy container until the transferred medication is gone. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure medications were stored in the original containers for Resident 1, Resident 2 and Resident 3. Caregiver B dispensed medications for Resident 1, Resident 2 and Resident 3 and placed them in the top drawer of the medication cart. Findings include: On 02/16/2024, the Department received a complaint regarding medication administration and medication storage practices at the facility. On 05/06/2024 at 10:00 AM, Surveyor observed the facility medication cart along with Administrator A. Three cups of medications were observed in the top drawer labeled for Resident	N 417		

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N 417	Continued From page 6 1, Resident 2 and Resident 3. On 05/06/2024 at 10:15 AM, Surveyor interviewed Administrator A. Administrator A acknowledged medications were only supposed to be dispensed immediately before administering the medication. Administrator A acknowledged there were 3 medication cups with medications labeled for Resident 1, Resident 2 and Resident 3. Administrator A stated that Caregiver B was the medication passer that day. Administrator A stated the medication pass should have started around 7:00 AM and should have been finished by 9:00 AM. The medications that were in cups labeled for each resident are as follows: Resident 1: Morning dose Tylenol, Amlodipine, Aspirin, Buspirone, Culturella, Fluoxetine, Fenofibrute, Gabapentin and Metoprolol Resident 2: Morning dose Hydrocortisone, Levothyroxine, Rivastigmine Resident 3: Morning dose Clopididogrel, Fosiniprol, Glipizide, Metoprolol, Myrbetriq, Vitamin D-3. On 05/06/2024 at 11:30 AM, Surveyor interviewed Caregiver B. Caregiver B acknowledged s/he had dispensed medications for Resident 1, Resident 2 and Resident 3. Caregiver B stated s/he got busy and had not gotten the chance to administer Resident 1, Resident 2 or Resident 3's medications yet. Caregiver B acknowledged medications were only to be dispensed immediately before administering medications.	N 417		

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N 417	Continued From page 7 On 05/06/2024 at 12:00 PM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged medications were not to be dispensed if not being administered immediately. Administrator A acknowledged Caregiver B should not have dispensed the medications for Resident 1, Resident 2 or Resident 3 if s/he was not going to immediately administer the medications.	N 417		