STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018918	A. BUILDING: _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE ACRES	**3737 BLUEBERRY RD WARRENS, WI 54666**

(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 05/17/2024, Surveyor conducted a complaint investigation at Agape Acres. Information for this survey was received and reviewed through 05/29/2024. The complaint was substantiated. Two deficiencies identified. Census: 13	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after Resident 3 fell, resulting in emergency room (ER) treatment for a head laceration. Findings include: On 04/23/2024, the department received a complaint alleging a resident had a fall and received treatment at the emergency room (ER) or hospital. The provider is licensed to serve up to 15 residents in the following client groups: advanced	N 165		

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

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N 165	Continued From page 1 aged, terminally ill, physically disabled, developmentally disabled, emotionally. disturbed/mental illness, traumatic brain injury and irreversible dementia/Alzheimer's disease. On 05/29/2024, Surveyor reviewed Resident 3's incident report. The report indicated that on 04/16/2024, Resident 3 fell while getting out of bed. Resident 3 could not get back up on his/her own and an ambulance was called to transport Resident 3 to the ER. According to ER reports, Resident 3 hit his/her head causing a head/scalp laceration. There was a slow, oozing hemorrhage. This was repaired emergently with 12 5-0 sutures. On 05/29/2024, Surveyor asked Administrator A if s/he submitted a report to the department for the ER visit which resulted in treatment for Resident 3. Licensee C emailed Surveyor on 05/29/2024, stating Resident 3 did have a witnessed fall on 04/16/2024, and was sent to the ER for stitches. Licensee C added, "If the agency did not notify you as expected then we bear some blame for not following up on that." Summary: The provider did not ensure to send a written report to the department within 3 working days after Resident 3 fell, resulting in ER treatment for a head laceration.	N 165		
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:	N 352		

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N 352	Continued From page 2 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 observation and interview, the provider did not ensure Resident 1's right to receive all medications as prescribed when Resident 1 was given Resident 2's AM medications. Findings include: On 04/23/2024, the department received a complaint regarding medication errors which resulted in a resident being hospitalized. The facility provides care for up to 15 residents within the following client groups: irreversible dementia/Alzheimer's, developmentally disabled. physically disabled, emotionally disturbed/mental illness, terminally ill and traumatic brain injury. On 05/17/2024 at approximately 9:00 AM, Surveyor conducted a complaint investigation at the facility. Surveyor was not able to gain much information regarding the complaint as the acting administrator was not in the facility and the medication passer reported only being employed with the provider for approximately two weeks. On 05/28/2024 at 8:30 AM, Surveyor interviewed Administrator A. Surveyor discussed the complaint with Administrator A and asked if s/he was aware of any medication errors regarding Resident 1 and Resident 2. Administrator A stated Resident 1 was given Resident 2's medication by Medication Passer B. Administrator A also stated Medication Passer B was an employee the	N 352		

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N 352	Continued From page 3	N 352		

provider hired from a staffing agency. Administrator A provided Surveyor with the following information:

On 04/16/2024, Resident 1 was administered the following medications of Resident 2:
Acetaminophen 1000 mg/ferosul 325
325 mg/fluphenazine
5 mg/Ibuprofen
400 mg Levothyroxine
50 mg Sertraline
50 mg/trihexyphen
Senna 8.6-50 mg
B 12
stool softener

Administrator A stated some of the medications were "heavy psychotropics" which caused Resident 1 to be sedated and hospitalized.

According to information from the hospital, dated 04/18/2024, Resident 1 arrived at the hospital after being unresponsive in the ambulance. Patient was noted to be obtunded (reduced consciousness) and not able to stay awake for more than a few seconds.

Administrator A stated Resident 2's doctor was contacted and the provider was told not to provide any AM medications for Resident 2 and to start regular scheduled medications in the afternoon. Surveyor asked if Resident 2 received any of his/her morning medications. Administrator A said no.

On 05/28/2024, Surveyor reviewed the incident report and individual service plans (ISP) for Resident 1 and Resident 2.

The incident report was dated 04/16/2024 and

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N 352	Continued From page 4 had Resident 1's name in the "Resident Name" box. The report included all the above medications administered to Resident 1 in error. The incident report also included the name of Medication Passer B. It also reported Medication Passer B was taken off medication administration duties after this incident. Resident 1 was admitted to the facility on 07/24/2023. Resident 1 is diagnosed with alcohol dependence and hypertension. Resident 2 was admitted to the facility on 12/11/2023. Resident 2 is diagnosed with schizophrenia and dystonia. Both resident's ISPs stated the provider was to administer all medications with supervision. Summary: The provider did not ensure all medications prescribed were given as prescribed for Resident 1 and Resident 2.	N 352		