STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015337	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER ASSISTED LIVING OF CLINTONVILLE	38 N MAIN ST CLINTONVILLE, WI 54929

(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
U 000	INITIAL COMMENTS An investigation into a complaint was conducted on 05/07/2025 with information gathered through 05/12/2025 at Aster Assisted Living of Clintonville. As a result of this survey the complaint was substantiated with 2 deficiencies identified. Census: 64 tenants	U 000		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by: Based on record review and staff, family, and tenant interviews the provider did not ensure medications were administered to 1 of 2 tenants	U 267		

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

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U 267	Continued From page 1	U 267		

as prescribed by the tenant's physician in 2 separate instances. Tenant 1 did not receive Donepezil 10 mg (milligrams) as ordered from May through October 2024. Tenant 1 received Tenant 2's medications on 11/01/2024 in error during the morning med pass.

Findings include:

On 05/07/2025 Surveyor investigated concerns of medications not being given as ordered.

1. Tenant 1's record showed admission to the facility on 07/22/2023 with diagnoses of mild cognitive impairment, hypertension, and hypothyroidism. Tenant 1 had a physician's order for Donepezil HCL 10 mg nightly effective 05/03/2024 through 04/29/2025.

Tenant 1's MAR (Medication Administration Record) for May 2024 showed Donepezil HCL 10 mg was refused 05/17, 05/18, 05/19, and 05/20. It was given on 05/21/2024 and marked as refused 05/22/2024 through 05/31/2024. The June MAR for Tenant 1 showed Donepezil was refused on 06/01/2024 through 06/07/2024. Tenant 1's MAR's showed Donepezil HCL 10 mg was held 06/08/2024 through 10/29/2024.

In an interview with Surveyor on 05/07/2025 at 11:45 AM WD (Wellness Director) A confirmed Tenant 1's MAR's show Donepezil was not given to Tenant 1, May 2024 through October 2024 and that the "HLD" on the MAR means "held", not given.

On 05/07/2025 at 2:12 PM in an interview with Tenant 1 and Surveyor, and confirmed by FMBR (Family Member) - D, Tenant 1 recalled not being given his/her pill for memory for months and did

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not refuse this medication. FMBR - D said they noticed Tenant 1 was starting to become more confused. FMBR - D said s/he was notified by ED (Executive Director) - F on 10/30/2024 that they knew why Tenant 1 was becoming more confused. ED - F said they found that Tenant's 1's Donepezil (Aricept) had been filled and billed to Tenant 1 but had not been given for 5 months. ED - F told FMBR - D that Tenant 1 had refused the medication one night and it had not been given since. After this phone call, FMBR - D and Tenant 1 had the medication resumed.

The provider did not give Tenant 1 Donepezil HCL 10 mg as ordered from 06/08/2024 through 10/29/2024. Tenant 1 had increased confusion as a result.

2. In an interview with Surveyor on 05/07/2025 at 2:12 PM, Tenant 1 said s/he didn't get his/her Alprazolam medication at breakfast on 11/01/2025. Tenant 1 said s/he questioned the medications being given in the pill cup that only had 3 pills in it as s/he has more pills than that. Tenant 1 said s/he did not recognize a large blue pill and was told it was a heart pill. Tenant 1 said s/he did not take a heart pill. Tenant 1 said RA (Resident Assistant) - H said Tenant 1 needed to take his/her medications before breakfast so s/he took them. Tenant 1 said s/he "knew right away those weren't my pills and told the girl that but I took them." Tenant 1 said s/he didn't get sick and didn't have to go to the hospital. FMBR - D confirmed this medication error.

On 05/07/2025 at 1:00 PM Surveyor asked WD (Wellness Director) - A about this medication error. WD - A provided a Medication Error form dated 11/01/2024 that verified the error. RA - H wrote on the form, "I accidentally gave (Tenant 1,

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U 267	Continued From page 3 Tenant 2's) meds as s/he responded to me calling (Tenant 2's similar name). On 05/12/2025 WD - A sent an email to Surveyor with the medications Tenant 1 was given in error on 11/01/2024 which WD - A based on Tenant 2's morning medications. These had not been recorded on the Medication Error form. WD - A said the medications presumed given to Tenant 1 in error on 11/01/2024 were Diltiazem ER 180 mg, Eliquis 5 mg, and Solifenacin 5 mg. Notes provided to Surveyor on 05/07/2025 showed Tenant 1's physician was contacted on 11/01/2024 and no transfer to the ER was needed but heart rate and blood pressure were monitored with no adverse effects noted in Tenant 1. In a phone interview with Surveyor on 05/07/2025 at 2:40 PM, CEO (President Chief Executive Officer) - C, DO (Director of Operations) - B, and WD - A confirmed these medication errors occurred.	U 267		
U 272	89.35(3) GRIEVANCES Written Summary. (3) The residential care apartment complex shall provide a written summary of the grievance, findings, conclusions and any action taken as a result of the grievance to the tenant, the tenant's designated representative, if any, and, for tenants whose services are funded under s. 46.277, Stats., the county department or aging unit designated to administer the medical assistance	U 272		

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waiver.
This Rule is not met as evidenced by:
Based on record review and staff interviews the provider did not provide a written summary of the grievance, findings, conclusions and actions taken to the Tenant 1 or Tenant 1's legal representative, as the result of a grievance for 1 of 1 grievances reviewed.

Findings include:

On 05/07/2025 Surveyor reviewed the providers grievance files for missing money in response to concerns brought to the State Agency. Surveyor spoke with FMBR (Family Member - Tenant. 1) - D at 8:15 AM regarding concerns of missing money for Tenant 1 in amounts of possibly up to $8,000 from July 2024 through 11/02/2024. FMBR - D indicated on 10/17/2024 s/he and Tenant 1 brought the concerns of missing money to SMD (Sales Marketing Director) - E who passed this information onto ED (Executive Director) - F. At this time Tenant 1 and family declined contacting police as they wanted to be sure Tenant 1 hadn't misplaced the money. Per FMBR - D, money continued to go missing for Tenant 1 even though ED - F had provided Tenant 1 with a lock box. On 11/03/2024 family of Tenant 1 brought their concerns to the Clintonville Police. PO (Police Officer) - G investigated this incident.

On 05/07/2025 at 11:45 AM Surveyor requested a copy of the provider's investigation into this incident with the outcome from WD (Wellness Director) - A who indicated the only copy regarding this investigation was the one done on 11/08/2024 by ED - F who no longer worked at this facility. Surveyor reviewed the report completed by ED - F that indicated on 10/22/2024

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U 272	Continued From page 5 Tenant 1 had complained of missing about $800.00 from his/her room. ED - F notified family of Tenant 1's concerns and offered a lock box. That was the extent of the report. The provider had no further proof of looking into this allegation of missing money. There was no evidence of talking to other residents if they were missing money or questioning staff about missing money. There was no follow-up mentioning the police department investigation and no conclusion regarding this incident. There was no evidence of providing the final report and findings to Tenant 1 or Tenant 1's Legal Representative, Activated Durable Power of Attorney (FMBR - D). During an exit meeting with Surveyor on 05/07/2025 at approximately 3:00 PM, CEO- C said there was no further written investigation into this incident and no summary of the outcome of this grievance. On 05/09/2024 Surveyor received a copy of the Clintonville Police Department Investigation dated 11/03/2024 through 11/11/2024. The report indicated this investigation was closed and stated, "At this time there are no leads that can be tracked down on who would have been entering the apartment and taking money from the victim (Tenant 1).	U 272		