STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017261	A. BUILDING: _____ B. WING _____	10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MUSKEGO	S64 W13780 JANESVILLE RD MUSKEGO, WI 53150

(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 10/11/2023, Surveyors conducted a standard survey at Heritage Muskego. Four deficiencies were identified. Census: 68	N 000		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident had the right to privacy when confidential information regarding tenant's medications and diets was not safeguarded. Confidential information regarding resident medications was left on the medication cart during the medication pass and confidential information regarding resident diets was posted	N 346		

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

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N 346	Continued From page 1	N 346		

on a food delivery cart. Both the medication and food carts were left unattended in public areas.

Findings include:

Example 1- Medications

On 10/11/2023 at 8:45 AM Surveyor observed Medication Aide F administer medications to Resident 8 and Resident 9. Medication Aide F was observed in the hallway outside of Resident 8's room with the medication cart. The top of the cart contained multiple empty medication strips lying on top of the medication cart. Printed on each strip was the name of resident, and name and dose of each medication administered from the empty strip.

Medication Aide F prepared Resident 8's medication which included the following: Famotine 20 MG- 1 tablet; Ivite one tablet; and multivitamin one tablet. The medications were observed in a medication strip. Medication Aide F tore the bottom of the strip containing the medications. Placed the pills into a small cup and placed the medication strip onto the top of the cart upside down. Medication Aide F locked the cart, took the medications and walked into Resident 8's room.

At 8:50 AM, after administering Resident 8's medications, Medication Aide F left the medication cart in the hallway outside Resident 8's room, walked down the hall and into another resident room. Shortly after, Medication Aide F returned to the cart.

On 10/11/2023, at 8:57 AM Medication Aide F prepared Resident 9's medication which included the following:

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Acetaminophen 500 MG; Amlodipine 5 MG one tablet; B Complex vitamin; Ferrosol 325 MG; Fluticasone nose spray; Furosemide 40 MG one tablet; Gabapentin 10 MG; Loratadine 10 MG; Metformin 500 MG; and Rosuvastatin10 MG. Medication Aide F tore the bottom of the strip containing the tablets/pills and placed the tablets into a cup. Medication Aide F took the empty strip and placed it on top of the cart upside down. Medication Aide F locked the cart and walked into Resident 9's room. At 9:13 AM, Medication Aide F returned to the cart.
Surveyor interviewed Medication Aide F about the empty strips. Medication Aide F stated following the medication pass the strips will be destroyed.
Example 2- Diets

On 10/11/2023 at 9:24 AM, Surveyor observed Caregiver E park a food delivery cart next to the public elevator near the 2nd floor dining room. Caregiver E returned to the dining room.

A chart listing resident's dietary information was taped to the side of the cart (Photos 1 and 2). The chart identified:
Resident 1- Sauce on side
Resident 2- No gravy
Resident 3- Chop (chopped)
Resident 4- Mechanical soft, very small pieces-extra gravy
Resident 5- Mechanical Soft
Resident 6- Mechanical Soft

On 10/11/2024 at 9:29 AM, Caregiver E returned to the elevator with a 2-shelf utility cart containing dirty dishes.

On 10/11/2024 at 9:29 AM, Surveyor interviewed Caregiver E who stated s/he parked the food delivery cart next to the elevator while s/he went

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N 346	Continued From page 3 to get the dirty dishes and was delivering both carts to the kitchen downstairs. On 10/11/2023 at 4:53 PM, Surveyor discussed concern of resident privacy of diets and medications with Executive Director A, Director of Nursing B, Regional Director of Clinical Operations C, and Assistant Director D. Executive Director A stated they would explore different processes to better ensure privacy.	N 346		
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 the resident right to receive all prescribed medications in the dosage and at intervals as prescribed by the physician for 1 of 4 residents reviewed. From 09/06/2023-09/20/2023, Resident 1's Atenolol was administered 6 times when pulse was below 70 despite physician order to hold it. Findings include: On 10/11/2023, Surveyor reviewed Resident 7's record. S/he was admitted 08/28/2023. Diagnoses included hypertension. Facility progress notes dated 08/28/2023-10/07/2023 (summarized):	N 352		

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N 352	Continued From page 4 09/01/2023- Sent via 911 to hospital due to stroke like symptoms. Pulse 60, BP 108/92. 09/05/2023- Admitted to hospital with diagnoses of syncope and transient hypotension. 09/05/2023-Returned from hospital 09/05/20/2023. Pulse 66, BP 154/73. No additional vitals were documented in facility progress notes. Per Medication Administration Record (MAR), physician orders included: Atenolol 50 MG 1 tablet daily, hold for pulse below 70 (start date 09/06/2023, stop date 09/20/2023). From 09/06/2023-09/20/2023, staff documented administering Atenolol when pulse was below 70: 09/09/2023 pulse 69 09/11/2023 pulse 66 09/14/2023 pulse 66 09/15/2023 pulse 61 09/19/2023 pulse 61 09/20/2023 pulse 61 On 10/11/2023 at 4:19 PM, Surveyor interviewed Director of Nursing B who stated on 10/11/2023 s/he saw that Resident 1's Atenolol was administered when pulse was below 70. Director of Nursing B stated orders printed on MAR match physician orders. On 10/11/2023 at 4:53 PM, Surveyor discussed concern administering Resident 1's Atenolol when pulse was below 70 with Executive Director A, Director of Nursing B, Regional Director of Clinical Operations C, and Assistant Director D. Director of Nursing B stated it was staff over-sight and Executive Director A stated it was another opportunity to train staff. Cross Reference:	N 352		

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N 352	Continued From page 5 N0431 DHS 83.38(1)(g) Health Monitoring	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, staff interview and record review, the provider did not update the individual service plan when there was a change in the resident's physical needs for 1 out of 5 resident reviewed. Resident 10 was at risk for falls, hospice initiated the use of a floor mat and broda chair. The individual service plan did not address the use of the devices. Findings include: On 10/11/2023, at 2:30 PM, Surveyor observed Resident 10 seated in a broda chair in the living room. Resident 10 stated to Surveyor that s/he that the person sitting by Resident 10 was loud	N 389		

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N 389	Continued From page 6	N 389		

and Resident 10 was not able to leave the area. Staff entered the area and began interacting with Resident 10.

Surveyor observed Resident 10's room. The area by the bed contained a thin mat. The bed was in the lowest position.

Surveyor asked Executive Director A to provide the most recent individual service plan for Resident 10. The plan was dated 11/30/2022. A review of the plan noted Resident 10 used a wheelchair for mobility, did have a history of falls and was able to transfer self with stand by staff assist.

According to progress notes dated 09/05/2023, hospice services were initiated. The note stated Resident 10 would be returning from hospital admission.

Documented on 09/10/2023- the progress note indicated Resident 10 was found on the floor next to the bed with broda chair behind Resident 10.

09/11/2023- Hospice to get scoop mattress.
09/14/2023- Resident 10 found lying on floor next to bed. Bed was in low position. Will request mat for floor from hospice.

The individual service plan (ISP) did not address the implementation of hospice services on 09/05/2023 following hospitalization. The ISP did not address the use of the broda chair and floor mat.

On 10/11/2023, at approximately 3:00 PM, Surveyor interviewed Director of Nursing B. Director of Nursing B reviewed the ISP and stated the hospice information was not on the ISP but

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N 389	Continued From page 7 would be added. Director of Nursing B stated the use of the broda chair and fall mat would be added to the ISP as it should have been included. Surveyor asked about the scoop mattress. Director of Nurses B stated after following up with hospice, they did not feel the scoop mattress was needed at this time.	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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N 431	Continued From page 8	N 431		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the CBRF provided services adequate to meet the needs of residents in the area of health monitoring.

Resident 7's pulse and blood pressure was not monitored as ordered by physician.

Findings include:

On 10/11/2023, Surveyor reviewed Resident 7's record. S/he was admitted 08/28/2023. Diagnoses included hypertension.

Physician orders included:
Physician Rounding Form dated 09/19/2023 - " ...Decrease atenolol [sic] to 25 MG daily, continue same hold parameters ..."

MD orders listed on September 2023 and October 2023 Medication administration record (MAR):
Take blood pressure on Mondays and Thursday in the morning related to essential primary hypertension (start date 09/07/2023).
Atenolol 50 MG 1 tablet daily, hold for SBP (Systolic blood pressure) <100, DBP (diastolic blood pressure) <50 and heart rate <60 (start date 08/29/2023, stop date 09/05/2023).
Atenolol 50 MG 1 tablet daily, hold for pulse below 70 (start date 09/06/2023, stop date 09/20/2023).
Atenolol 25 MG 1 tablet daily hold for SBP<100,

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N 431	Continued From page 9 DBP <50, Heart rate <70 (start date 09/21/2023). Medication Administration Record (MAR) dated 09/01/2023-10/11/2023: From 09/21/2023-10/11/2023, staff did not document pulse readings on MAR. Staff documented Monday and Thursday 8:00 AM blood pressures readings on the MAR: 09/07/2023, 09/11/2023, 09/14/2023 09/18/2023, 09/21/2023, 09/25/2023, 09/28/2023, 10/02/2023, 10/05/2023, and 10/09/2023. From 09/21/2023-09/30/2023, staff did not document blood pressure readings on MAR on 09/22/2023, 09/23/2023, 09/24/2023, 09/26/2023, 09/27/2023, 09/29/2023, 09/30/2023, 10/01/2023, 10/02/2023, 10/04/2023, 10/06/2023, 10/07/2023, 10/08/2023 and 10/11/2023. On 09/24/2023 and 10/03/2023, staff documented Atenolol was held due to vitals outside of parameters for administration. Facility progress notes dated 07/11/2023-10/07/2023 (summarized): 09/01/2023- Sent via 911 to hospital due to stroke like symptoms. Pulse 60, BP 108/92. Admitted to hospital with diagnoses of syncope and transient hypotension. 09/05/2023-Returned from hospital 09/05/20/2023. Pulse 66, BP 154/73. No additional vitals were documented in facility progress notes. On 10/11/2023 at 4:03 PM, Surveyor interviewed Director of Nursing B who stated s/he would look for supplemental documentation of Resident 7's vitals.	N 431		

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N 431	Continued From page 10 On 10/11/2023 at 4:19 PM, Director of Nursing B stated to Surveyor when Resident 7 returned from hospital on 09/05/2023 there was confusion if vitals were to be taken daily for Atenolol administration or just on Mondays and Thursdays. Director of Nursing B stated when the Atenolol order was changed on 09/19/2023, the supplemental documentation tab was not clicked so the system did not prompt staff to document the pulse and blood pressure readings. Director of Nursing B stated nursing monitors supplemental documentation and they added supplemental documentation for Resident 7's Atenolol on 10/11/2023. Director of Nursing B stated physician orders printed on MAR match original MD orders. Director of Nursing B stated they had no additional documentation of Resident 7's pulse and blood pressure readings. On 10/11/2023 at 4:53 PM, Surveyor discussed concern of not monitoring Resident 7's blood pressure and pulse as ordered by physician with Executive Director A, Director of Nursing B, Regional Director of Clinical Operations C, and Assistant Director D. Regional Director of Clinical Operations C stated if readings are not documented they would not know what the reading was, they did not know if staff were taking Resident 1's blood pressure and pulse, and the supplemental tab should have been clicked to prompt staff when the order changed. Cross Reference: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication	N 431		