STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013172	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE LANE HOUSE	1707 CARRIE LN WEST BEND, WI 53095

(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 07/18/2024 with additional information gathered through 07/30/2024, Surveyors conducted a standard survey and one complaint investigation. As a result three deficiencies were identified and the complaint was substantiated. Census: 8	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. This Rule is not met as evidenced by: Based on record review and interviews, after receiving an allegation of misappropriation of a resident's property, the provider did not have evidence the allegation of misappropriation was thoroughly investigated for 1 of 1 resident	N 158		

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

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reviewed. Additionally, the provider did not ensure the allegation involving misappropriation was reported to the department within seven calendar days for 1 of 1 resident's reviewed.

APOA (activated power of attorney)-D reported to Assistant Administrator B, Resident 2 was missing valuable personal property. The provider did not conduct an investigation into the allegations of potential misappropriation or report to the department.

Findings Include:

On 07/29/2024, Surveyor reviewed Department records and noted the facility had not submitted any Misconduct Incident Reports (MIR) or self-reports documenting investigations into allegations of misappropriation of resident property in 2024.

On 07/18/2024, Surveyor reviewed Resident 2's medical record. The record indicated Resident 2 was admitted to the facility on 05/19/2022 with diagnoses of diabetes mellitus, hypertension, poor vision, and anxiety. Resident 2 had an APOA (activated power of attorney).

On 07/18/2024 at 11:08 AM, Surveyor interviewed Resident 2's APOA-D. APOA-D indicated s/he visits Resident 2 at the facility three to four times per week. APOA-D indicated, Resident 2 had two watches and a pair of ruby center earrings go missing from Resident 2's top dresser drawer in her/his bedroom. APOA-D stated, "I've seen the watches and ruby earrings in [Resident 2's] top dresser drawer in March 2024 and most of April 2024. Sometime around the end of April 2024, I went into [Resident 2's] dresser and noticed the ruby earrings and were missing. The earrings

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were quite expensive. Then sometime in June 2024, I noticed the watches were missing. I talked to [Assistant Administrator B] about the missing earrings in April 2024 and again during several different meetings after April 2024 about the missing earrings and watches, but I never heard anything. Then sometime in June 2024, I discovered [Resident 2's] hearing aids were missing. The hearing aids were $3800. I told [Assistant Administrator B] about the missing hearing aids and [s/he] told me s/he would look into it, but I never heard anything back from [Assistant Administrator B], so I filed a police report on 07/15/2024."

On 07/18/2024 at 2:30 PM, Surveyor interviewed Assistant Administrator B regarding Resident 2's missing property. Assistant Administrator acknowledged s/he was made aware by APOA-D of a pair of earrings, a watch and hearing aids that went missing several weeks ago for Resident 2. Assistant Administrator B stated, "[Resident 2] never had earrings or a watch that I'm aware of. The hearing aids have been missing for a couple of weeks." Surveyor then asked if s/he completed an investigation into the allegation of missing property for Resident 2. Assistant Administrator B indicated s/he looked around for the alleged missing items and made staff aware, but nothing was found. Prior to leaving the facility on 07/18/2024, Surveyor asked Assistant Administrator B to send any evidence s/he had of a written investigation into Resident 2's alleged missing belongings.

On 07/24/2024 at 2:10 PM, Surveyor interviewed Resident Aide C regarding Resident 2's missing belongings. Resident Aide C stated, "I've heard of [Resident 2's] missing a pair of earrings, a watch and hearing aids a month or so ago. I was told by

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[Assistant Administrator B] to look for the items because [APOA-D] mentioned the items were missing. I was never ask to write a statement or anything for [Assistant Administrator-B] ...I don't recall seeing the earrings or watch and nothing has been found that I'm aware of. A police officer did call me last week to ask me some questions about [Resident 2's] missing items."

On 07/24/2024 at 2:40 PM, Surveyor interviewed Resident Aide A regarding Resident 2's missing belongings. Resident Aide A stated, "I'm well aware of [Resident 2's] missing items over the last few months. We've heard about the missing earrings and watch because [APOA-D] brought it up to [Assistant Administrator-B] that the ruby earrings and watch have been missing for over a month. [Assistant Administrator-B] asked me if I've seen the items and to look for them...I just told [Assistant Administrator B] verbally that I didn't see any of the items. I didn't give [Assistant Administrator-B] a written statement. Resident Aide A went on to say, "I did know about [Resident 2's] missing hearing aids. [APOA-D] reported the hearing aids missing a month or so ago...[Resident 2] did have the hearing aids during an appointment a few months, but I haven't seen them since."

On 07/24/2024 and again on 07/29/2024, Surveyor emailed Assistant Administrator B asking him/her for additional information regarding Resident 2's missing property, including a completed investigation. Assistant Administrator B replied on 07/29/2024 and stated the following, "Unfortunately, I did not keep track of any investigating done concerning any allegations of items stolen from [Resident 2]...I took this seriously, questioned the staff and searched the house, inside and out, on more than

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one occasion...I need to work on my documenting. This is very challenging most days due to lack of time on my end, but I will make it a priority..." No documentation of an investigation into Resident 2's missing property was provided.

On 07/30/2024 at 10:15 AM, during an exit interview Assistant Administrator B stated, "I have no documentation of an investigation into [Resident 2's] missing property...My new Administrator just shared with me the online MIR, how to fill out the correct paperwork and investigate allegations of misappropriation."

On 07/30/2024, Surveyor reviewed West Bend Police report dated 07/15/2024 and noted the following:
On 07/15/2024, an Officer was dispatched to Carrie Lane House for a complaint by [APOA-D], who reported [Resident 2] had several items go missing while residing in the home...[APOA-D] stated since April of 2024, [s/he] had noticed some of [Resident 2's] items were missing from [her/his] room. [APOA-D] stated a pair of $175 ruby earrings were inside of a jewelry box next to [Resident 2's] bed in a drawer in the night stand. [APOA-D] stated [s/he] noticed the earrings were gone, the drawer was a mess and the box was still inside of the drawer. [APOA-D] stated approximately one week later, the box went missing as well. [APOA-D] stated on 06/18/2024 [s/he] visited [Resident 2] at the hospital and realized [Resident 2's] hearing aids were gone. [APOA-D] stated [Resident 2] could not recall how they were lost or where they went. [APOA-D] stated [s/he] informed [Assistant Administrator B] of the missing hearing aids... [APOA-D] stated on 06/24/2024, [s/he] notice two of the Walmart Apple style watches [s/he] purchased for $30.00 each were also missing

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N 158	Continued From page 5 from [Resident 2]'s room. [APOA-D] stated [s/he] told [Assistant Administrator B] around this time but has not heard anything significant since. [APOA-D] stated [s/he] told [Assistant Administrator B] [s/he] would be filing a police report as none of the missing items were located..." The provider did not conduct an investigation into Resident 2's missing personal property and did not report misappropriation of Resident 2's property to the department within 7 calendar days.	N 158		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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N 239	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 employees (Resident Aide A, Resident Aide C, and Resident Aide E) obtained all department approved training as required. Resident Aide A and Resident Aide E did not have training in fire safety within 90 days after starting employment. Resident Aide C did not have training in first aid and choking within 90 days after starting employment. Resident Aide C who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties. Resident Aide E who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties. Findings include: On 07/24/2024, Surveyor reviewed Resident Aide A's record and noted Resident Aide A was hired on 02/23/2024. Surveyor noted Resident Aide A's record did not contain evidence of the department-approved Fire Safety course. On 07/24/2024, Surveyor reviewed Resident Aide	N 239		

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N 239	Continued From page 7 C's record and noted Resident Aide C was hired on 03/29/2024. Surveyor noted Resident Aide C's record did not contain evidence of the Standard Precaution and First Aid and Choking Courses. On 07/24/2024, Surveyor reviewed Resident Aide E's record and noted Resident Aide E was hired on 09/04/2023. Surveyor noted Resident Aide E's record did not contain evidence of the Medication Administration and Fire Safety courses. On 07/18/2024, Surveyor reviewed Resident 1's and Resident 2's MARs (medication administration records) provided by Assistant Administrator B. The following was noted: *Resident Aide E administered medications to Resident 1 fourteen (14) out of 31 days in May 2024. *Resident Aide E administered medications to Resident 2 nine (9) out of 30 days in April 2024. On 07/24/2024, Surveyor reviewed the Community-Based Care and Treatment training registry and verified Resident Aide A, Resident Aide C, and Resident Aide E were not on the registry for the listed department approved trainings. On 07/30/2024 at approximately 10:35 AM, Surveyor interviewed Assistant Administrator B who acknowledged Resident Aide A, Resident Aide C and Resident Aide E did not have the required trainings and did not meet any exemptions. Assistant Administrator B stated Resident Aide E had completed in-house training and indicated one of the instructors failed to submit the completion to the Community-Based Care and Treatment training registry.	N 239		

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N 352	Continued From page 8	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 interviews, the provider did not ensure residents right to receive all medications as prescribed by their physician. On 04/18/2024, Resident 1 was given Resident 2's eight (8) AM medication, which included baclofen (a muscle relaxant), bumetanide (a diuretic), anastrozole (a drug used to treat breast cancer), Eliquis (an anticoagulant), gabapentin (an anticonvulsant) and sertraline (an antidepressant). Later in the evening on 04/18/2024, Resident 1 felt dizzy and became unresponsive. Resident 1 was was sent to the ED (Emergency Department), hospitalized for four days, and discharged back to the facility with a heart monitor. This is a repeat deficiency. See Statement of Deficiency RKG211, dated 07/18/2019. Findings include: On 07/18/2024, Surveyor reviewed Resident 1's medical record. The record indicated Resident 1 was admitted to the facility on 12/17/2021 with diagnoses of diabetes mellitus, hypertension, schizophrenia, and intellectual disability.	N 352		

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N 352	Continued From page 9 Resident 1 had an APOA (activated power of attorney) and required staff to administer all his/her medications. Review of Resident 1's "Medication Error/Deviation Report" dated 04/18/2024 indicated, "[Resident Aide A] gave another resident's meds to [Resident 1] at 8 AM. The only med [Resident 1] had that was correct was [his/her] 8 AM lorazepam 0.5 mg (milligram) tab...Both the resident's physician and pharmacy were contacted for assistance with the error. Both advised to call poison control and monitor vitals during the day. [Resident 1] was given the following medications on 04/18/2024 at 8 AM that were not [Resident 1's] meds: acetaminophen 500 mg-2 tabs, anastrozole 1 mg, baclofen 10 mg, bumetanide 1 mg, Eliquis 5 mg, gabapentin 300 mg, sertraline 100 mg, B-complex, docusate 100 mg, losartan potassium 25 mg, mag-tab sustained release 84 mg, omeprazole 40 mg, vitamin B-12 500 mcg (mircograms), vitamin C 1000 mg, and vitamin D3 2000 IU (international unit). [Resident 1] was given [his/her] own scheduled 8 AM lorazepam 0.5 mg along with the meds listed above. Approximate rough timeline on 04/18/2024: At 9:15 AM- Staff realized [Resident 1] had been given the wrong medications. They then determined exactly which meds [Resident 1] received and that they were administrated at approximately 7:30-7:40 AM, at 9:17 AM-vitals were done and [Resident 1] was monitored with a caregiver one to one from 9:17 AM to 2:15 PM...[Resident 1] was closely monitored the remainder of the evening by [Assistant Administrator B]. [Assistant Administrator B] left the house at 9:30 PM with [Resident 1] still at baseline and no signs of distress. At approximately 11:23 PM, night staff woke [Resident 1] to toilet. Once in the	N 352		

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bathroom, [Resident 1] stated, [s/he] was dizzy. Staff help [Resident 1] to the ground and [s/he] was unresponsive for approximately 1 to 2 minutes...[Assistant Administrator B] advised staff to immediately call 911. [Assistant Administrator B] met the ambulance at the house where [Resident 1] was coherent. Transported to hospital ED..."

Review of Resident 1's hospital Discharge Summary dated 04/22/2024 indicated, "Date of admit: 04/19/2024. Date of Discharge: 04/22/2024...Reason for hospitalization: Syncope (pass out or faint for a short time)...Hospital course: [Resident 1] was admitted on 04/19/2024 for syncope while on the toilet. Accidental Medication Administration- In the morning of admission, [Resident 1] was given the incorrect medications including baclofen, bumetanide, anastrozole, Eliquis, gabapentin and sertraline. [Resident 1] does not normally take any of these medications listed. [Resident 1] had syncope episode while on the toilet that evening. Poison control was contacted who recommended observation. EKG demonstrated type 1 second degree AV block on admission. Now normal sinus rhythm. ED spoke with cardiology who recommended admission for evaluation of the need of a pacemaker...Syncope likely due to receiving incorrect medications versus vagal response...[Resident 1] admitted for passing out and low heart rate due to wrong meds being administrated...Cardiology referral placed...Event monitor placed at discharged. Will need to wear for a month..."

On 07/18/2024 at 11:08 AM, Surveyor interviewed Resident 1's APOA-D. APOA-D indicated s/he visits Resident 1 at the facility three to four times per week. APOA-D stated, "[Resident 1] was

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N 352	Continued From page 11 hospitalized on 04/18/2024 for at least 4 days because of a med mix-up. [Resident 1] was given [Resident 2's] meds the morning of 4/18/2024. Then later in the evening on 04/18/2024, [Resident 1] passed out and went unresponsive. [Resident 1] was sent out to the ED. The ED doctors said [Resident 1] had heart issues and would possibly needed a pacemaker. [Resident 1] did not need the pacemaker but was sent home with a heart monitor to wear for a month...This was a serious med error..." On 07/18/2024 at 2:30 PM, Surveyor questioned Assistant Administrator B regarding the medication error with Resident 1 on 04/18/2024. Assistant Administrator B verified the medication error occurred and stated, "[Resident Aide A] gave [Resident 1's] all [Resident 2's] 8 AM medications by mistake on 4/18/2024. I did send a facility self-report to the state via fax within the required timeframe." (Note- Surveyor reviewed department records and no evidence was found the provider submitted any self-reports for 2024.) On 07/24/2024 at 2:40 PM, Surveyor interviewed Resident Aide A regarding above medication error with Resident 1. Resident Aide A stated, "During the morning of 04/18/2024 there was a lot going on in the home and I gave all [Resident 2's] eight (8) AM medications to [Resident 1]. I feel bad about it, it was an accident." Surveyor then asked Resident Aide A if s/he received any re-training on proper medication administration procedures. Resident Aide A stated, "After the med error I was taken off the medication cart for a few days and [Assistant Administrator B] went over all the medications with me again." On 07/24/2024 and again on 07/29/2024, Surveyor sent Assistant Administrator B an email	N 352		

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N 352	Continued From page 12 asking for evidence training or re-education occurred following the above med error incident. No evidence was provided to verify Resident Aide A and/or staff who passed medications were re-educated on the facility's medication policy/procedure following the above the medication error. On 07/29/2024 at 4:57 PM, Assistant Administrator B sent the following email, "At this time, I did not retrain [Resident Aide A], or any of my other staff on medications. This was an isolated incident and we've barely had any med errors at all over the last 3 to 4 years. I did attempt to have [Resident Aide A] shadow me on meds to give [her/him] the chance to ask questions and help give [her/him] more confidence. Unfortunately, [Resident Aide A] just wasn't picking it up and I no longer felt comfortable with [her/him] passing meds on [her/his] own..."	N 352		