STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019130	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPON COPPERLEAF AL OPERATIONS LLC	1002 EUREKA ST RIPON, WI 54971

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N 000	Initial Comments On 08/09/2024-08/14/2024, Surveyor completed a complaint investigation and standard survey at Ripon Copperleaf AL Operations LLC. Four deficiencies were identified. The complaint was substantiated. Census: 32	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. 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 law enforcement personnel was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of resident or employees. On 04/07/2024, police responded to the provider due to a verbal argument between Resident 1 and his/her legal representative. Findings include: On 08/09/2024, Surveyor reviewed Resident 1's	N 164		

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

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N 164	Continued From page 1 record and identified the following: Resident 1 admitted on 12/13/2022. At time of the incident in April 2024, Resident 1 had an activated healthcare power of attorney. At time of this survey, Resident 1 was his/her own decision maker. Resident 1's physician visit form dated 04/10/24 documented: " ....nursing home resident seen and examined for follow up [s/he] has a POA who apparently was yelling at [him/her] and grabbed [him/her] by the collar as [s/he] was not eating [his/her] blueberries and this is unacceptable and we have addressed that the now we're in the process of getting a new POA for [him/her] and this was causing [him/her] a lot of anxiety and since this process is occurring [s/he] is feeling better." A review of police record #RD2400685 dated 04/07/2024 at 8:14 AM documented: " Incident Nature: Disorderly Conduct On 04/07/2024, officers were dispatched to the provider's address for a disorderly conduct complaint reported by staff. The report was that two individuals who were both power of attorneys for a resident were arguing. The [fe/male] party was screaming at the [fe/male] party. On today's date, [Power of Attorney (POA) D] had met [Resident 1] and [POA E] out for brunch. [POA D] had made a comment to [Resident 1] about eating [his/her] fruit. [S/he] said this upset [POA E] and [s/he] got upset and yelled at [him/her] making [him/her] cry. [POA D] stated [s/he] had walked out of the restaurant [s/he] was so upset. [POA D] then followed them back to the facility, at which time [Resident 1] told [him/her] that [s/he] wanted [POA E] to be [his/her] primary POA and to care for [him/her] going forward. [POA D] did	N 164		

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N 164	Continued From page 2 raise [his/her] voice and wanted to know why. [S/he] wanted to know what [s/he] has done that was so bad ...Staff wanted [POA D] issued a no trespass warning because of the disturbance caused today ....[POA D] was advised any change in the POA would have to come from the courts and not law enforcement." On 08/09/2024, Surveyor reviewed Department records. There were no self-reports in the Department files regarding the above incident. On 08/14/2024 at 2:00 PM, Surveyor interviewed Campus Director A and Administrator B. Campus Director A stated s/he is responsible for submitting self-reports to the Department. Campus Director A stated s/he forgot to send Resident 1's incident on 04/07/2024 to the Department. Campus Director A stated after the incident, Resident 1 was assessed by his/her physician declaring Resident 1 could resume decision making on his/her own. Campus Director B noted Resident 1 does have POA E as a stand by POA.	N 164		
N 218	83.16(2) Resident care staff at least 18 years old Resident care staff shall be at least 18 years old. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident care staff was at least 18 years old. Findings include: On 08/09/2024, Surveyor conducted a standard survey and identified the following:	N 218		

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N 218	Continued From page 3 On 08/09/2024 at 1:31 PM, Surveyor interviewed Caregiver C. Surveyor asked Caregiver C if s/he was a med passer. Caregiver C stated s/he was not a med passer and could not until s/he turned 18 years old. Caregiver C stated s/he does not turn 18 until April 2025. On 08/09/2024, Surveyor reviewed Caregiver C's record. Caregiver C was hired 04/10/2023. Caregiver C's date of birth is 04/11/2007, which made him/her a minor. On 08/09/2024, Surveyor reviewed the provider's electronic file and did not observe a waiver on file to employee a minor. On 08/14/2024 at 2:00 PM, Surveyor interviewed Campus Director A and Administrator B. Campus Director A stated the previous director was adamant s/he sent a waiver to the Department, but after digging into the matter more, it appears a miscommunication occurred with their former director and a youth apprenticeship program. Campus Director A acknowledged a waiver was never sent for Caregiver C and now know waiver requests had to be completed by the hiring facility. Campus Director A stated s/he would be submitting a waiver for Caregiver C shortly.	N 218		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following:	N 277		

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N 277	Continued From page 4 (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee (who required continuing education) completed at least 15 hours of continuing education in 2023. Findings include: On 08/09/2024, Surveyor reviewed employee files and identified the following: Caregiver F was hired 07/01/2022. Caregiver F's record did not include any hours of continuing education training for 2023. On 08/14/2024 at 2:00 PM, Surveyor interviewed Campus Director A and Administrator B. Campus Director A stated after looking through Caregiver F's record continuing education training for 2023 could not be located. Administrator B stated the provider would be developing a new system to track staff's continuing education hours.	N 277		
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	N 352		

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N 352	Continued From page 5	N 352		

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 3 of 3 residents received prescribed medications in the dosage and at intervals prescribed by a practitioner.

Resident 1's medication were not administered at prescribed times due to unavailability and Resident 1's Metoprolol was not held when parameters indicated to hold this medication.

Resident 2 did not receive his/her AM dose of Amlodipine on 08/09/2024.

On 08/02/2024, staff administered Resident 4's noon medications to Resident 3 instead of his/her own.

Findings include:

On 04/16/2024, the Department received a complaint alleging concerns with resident medication.

On 08/09/2024, Surveyor reviewed resident record and identified the following:

Example 1: Resident 1

Resident 1 admitted on 12/13/2022 with diagnosis including hyperlipidemia and low back pain. Resident 1's individual service plan (ISP) dated 01/15/2024 documented "Medications will be administered by licensed or certified team members."

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N 352	Continued From page 6	N 352		

Resident 1's physician orders documented: "Atorvastatin 40 mg with directions to take 1 tablet once daily for hyperlipidemia with a start date of 03/01/2024.

Hydroco/APAP tab 5-325 mg with directions to take 1 tablet every 12 hours for pain with a start date of 04/10/2024 and a D/C date of 05/15/2024.

Metoprolol 25 mg with directions to take 1 tablet once daily for hypertension with a start date of 01/09/2024. The following parameters noted Hold if sbp<100 or pulse <60 update MD."

Surveyor reviewed Resident 1's medication administration record (MAR) for the months of March through August 2024 which documented:

"The provider's charting codes noted the following: 9=Other/see progress notes, 18=Med not available from pharmacy

March 2024:
Atorvastatin 40 mg was marked either 9 or 18 on the following dates: 03/02/2024-03/06/2024, 03/09/2024, 03/11/2024-03/13/2024.

April 2024:
Hydroco/APAP 5-325 mg was marked "18" on the following dates: 04/17/2024,
04/26/2024-04/30/2024 (HS dose), and
04/29/2024-04/30/2024 (AM dose).

June 2024:

Resident 1's Metoprolol was not held on the following dates when parameters indicated to hold this medication: 06/26/2024 (pulse 59)

July 2024:

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N 352	Continued From page 7 Resident 1's Metoprolol was not held on the following dates when parameters indicated to hold this medication: 07/01/2024 (pulse 59), 07/07/2024 (pulse 57). The record did not include any evidence to show the provider followed up with the pharmacy to see the status of Resident 1's above medications. Example 2: Resident 2 On 08/09/2024 at 9:01 AM, Surveyor observed Caregiver F administer morning medications. Upon reviewing Resident 2's medications in the med cart, Caregiver F stated Resident 2 was missing his/her Amlodipine bubble pack. Caregiver F stated s/he administered medication a few days ago and the bubble pack was in the med cart. Caregiver F stated Resident 2 was a newer resident so s/he would need to follow up with Administrator B. On 08/09/2024 at 1:00 PM, Surveyor interviewed Administrator B. Administrator B stated s/he followed up with the pharmacy and they only sent enough medications to last until 8/8 since s/he was new. Administrator B noted Resident 2 did not receive his/her morning dose of Amlodipine today. Administrator B stated the provider's cycle fill is occurring soon and the pharmacy is sending out additional doses today. Surveyor asked why staff did not inform him/her Resident 2's bubble pack of Amlodipine was running out. Administrator B did not provide an answer. Resident 2 was admitted on 07/31/2024 with diagnosis including hypertension and arthritis. Resident 2's pre-admission assessment dated 07/30/2024 indicated "Medications will be	N 352		

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N 352	Continued From page 8	N 352		

administered by licensed or certified team members."

Resident 2's physician orders documented: "Amlodipine 2.5 mg with directions to take 1 tablet by mouth daily AM for arthritis with a start date of 07/30/2024."

Resident 2's August 2024 MAR included a blank entry for Amlodipine 08/09/2024-0800 dose.

Example 3: Medication Error with Resident 3 and Resident 4

On 08/09/2024 at 1:48 PM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 3 recently was given Resident 4's medications on 8/2 when Caregiver G committed a medication error. Caregiver F stated s/he was concerned about Caregiver G administering medications because residents have come to him/her reporting when Caregiver G administers medications residents often will not receive their treatments, s/he will only do pills.

Resident 3 admitted to the facility on 06/07/2024. Resident 3's ISP dated 06/07/2024 indicated ""Medications will be administered by licensed or certified team members."

Resident 4 admitted to the facility on 04/26/2024. Resident 4's ISP dated 04/15/2024 indicated "Medications will be administered by licensed or certified team members."

Resident 3's incident report dated 08/02/2024 documented:

"Resident was given [Resident 4's] noon meds instead of [his/her] own. Acetaminophen 1000mg

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N 352	Continued From page 9 and Furosemide 20 mg was given to resident instead of 500 mg Acetaminophen and 10 mg Midodrine. Resident was unable to let us know that]s/he] took the wrong medication. Vitals on resident were taken. BP 93/53 P 79. Staff will continue to monitor resident and push fluids to prevent dehydration. MD was notified. Care team was notified. Family was notified. No injuries observed at time of incident. Med tech stated [s/he] was doing meds in dining room for [Resident 3], when [s/he] discovered that [s/he] gave [him/her] [Resident 4's] noon meds instead of [his/her] own. Med tech reported to RCC right away. Disciplinary form was submitted and will be given. Will also be watching staff on medication." On 08/14/2024 at 2:00 PM, Surveyor conducted an exit conference and shared findings with Campus Director A and Administrator B. Administrator B confirmed the above incident occurred. Administrator B stated Caregiver G had been retrained and there was no adverse effects to Resident 3. Administrator B acknowledged Resident 1 missed the above medication due to issues with the pharmacy and after reviewing his/her record staff did administer Metoprolol when it was supposed to be held.	N 352		