STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017058	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING MARKET ST CBRF	1870 MARKET ST CROSS PLAINS, WI 53528

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N 000	Initial Comments On 10/26/2023, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Milestone Senior Living Market Street, a CBRF located in Cross Plains, WI. As a result of the investigation, 2 violations of Chapter DHS 83 were issued. 1 violation is a repeat from statement of deficiency (SOD) #1NLQ11 dated 03/15/2022 Complaint was substantiated Census: 14	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment that was appropriate to meet Resident 1's needs. On 03/15/2023, Resident 1 was admitted to the facility with documentation stating s/he had an upper denture. Resident 1's upper denture was not included in his/her individualized care plan (ISP). On 05/24/2023, Resident 1 was eating steak for lunch without his/her upper denture. Resident 1	N 353		

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

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N 353	Continued From page 1	N 353		

choked on a piece of steak; and 911 was called. Resident 1 was not wearing a DNR bracelet when EMTs (emergency medical technicians) arrived on scene. EMTs performed approximately 10 minutes of CPR on Resident 1.

FINDINGS INCLUDE:

On 09/06/2023, The Department received a complaint related to adequate treatment at the facility.

On 10/26/2023, Surveyor arrived at facility for a compliant investigation.

RECORD REVIEW:

On 10/26/2023, Surveyor reviewed the facility staff roster: Nurse B was hired 08/01/2022, Caregiver D was hired 03/08/2023 and Caregiver E was hired 07/20/2020.

On 10/26/2023, Surveyor reviewed a self-report sent to the Department on 05/24/2023. Nurse B documented the following," At 1205 on 5/24/23 [Resident 1] was eating lunch and began coughing. [S/he] walked from the DR (dining room) into hallway, heavy drooling and wheezing, Writer directed [Caregiver E] to call 911. Writer performed Heimlich when [Resident 1] no longer making noise, gave abdominal thrusts once [s/he] dropped to the floor. No food expelled. EMTs arrived...[Resident 1] was DNR..."

On 10/26/2023, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 03/15/2023. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: neurocognitive disorder.

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N 353	Continued From page 2 On 10/26/2023, Surveyor reviewed Resident 1's discharge paperwork faxed to the facility on 03/14/2023. In the discharge paperwork was an after-visit summary from an admission to an emergency room (ER) on 02/02/2023. In the discharge summary Advanced Practice Nurse Practitioner (APNP) J documented the following, "REVIEW OF SYSTEMS," the following, "Ears/Nose/Throat:...Does have an upper plate (denture). Fair repair of the lower teeth, missing a few lower teeth...PHYSICAL EXAMINATION...Oropharynx: pink and moist mucus membranes, upper plate, missing some lower teeth." On 10/26/2023, Surveyor reviewed Resident 1's facility choking assessment. On 04/14/2023, Nurse K documented Resident 1 had intact teeth and did not require additional interventions to prevent choking. On 10/26/2023, Surveyor reviewed Resident 1's individualized service plan (ISP) which was signed on 03/15/2023. Resident 1's ISP documents Resident 1 is independent when eating meals. Resident 1's ISP does not mention the upper denture. On 10/26/20/23, Surveyor reviewed the facility investigation related to Resident 1's passing on 05/24/2023. In a document titled, "INTERNAL INVESTIGATION," Staff L documented Resident 1 choked during lunch and when emergency medical technicians (EMTs) arrived at facility Resident 1's DNR paperwork was not prepared. Staff L documented, "EMT's arrived on the scene and began CPR, which they performed for approximately 5 minutes. [Resident 1] was DNR but had refused to wear the bracelet. [Nurse B]	N 353		

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produced the paperwork and after EMT verified with (local hospital) that [s/he] was DNR and they stopped CPR at 1225..." Surveyor reviewed an interview with Former Caregiver I. In response to the question, "Is there anything else you would like to tell us that you think we should know about?" Former Caregiver I answered with, "[s/he] didn't have [his/her] dentures in but seemed to be eating fine past few days."

On 10/27/2023, Surveyor reviewed Resident 1's DNR order. The order was signed by Resident 1's activated power of attorney on 03/14/2023.

On 10/27/2023, Surveyor reviewed Resident 1's facility admission assessment. The admission assessment was completed by Nurse B on 03/14/2023. Nurse B documented that Resident 1 had partial dentures, Resident 1 wore his/her denture regularly and the denture was kept clean. Nurse B documented Resident 1 was a CPR Code status.

On 11/07/2023, Surveyor reviewed an email sent from Chief N to Surveyor on 11/05/2023 at 8:43 PM. Chief N stated s/he was one of the responding EMTs on 05/24/2023. Chief N stated EMTs performed CPR on Resident 1 for approximately 10-12 minutes. Chief N stated the following, "[Chief N] had made attempts to contact the director to meet and discuss our protocols compared to their procedures, all attempts were unanswered...Here is my narrative from the call: R32 paged to local skilled nursing facility for pt. choking, unknown responsiveness. Escorted to pt. by staff. Found pt. lying supine...and facility RN performing CPR which RN stopped when [s/he] saw crew. Writer knelt on pt. right side, unable to feel a pulse and no respirations noted, while feeling for a pulse, writer

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questioned pt. DNR status w/staff. Staff stated pt. was not a DNR, staff member sent to office to confirm. Writer began CPR per protocol, No DNR bracelet noted on pt. body...Nursing facility staff member returned with copy of DNR order." Chief N documented Doctor O was called and gave the order to end CPR on Resident 1 at 12:48 PM.

INTERVIEWS:

On 10/26/2023 at 9:15 AM, Surveyor interviewed Caregiver D. Caregiver D stated s/he remembers Resident 1. Caregiver D stated s/he was working the memory care unit when Resident 1 passed away. Caregiver D stated s/he did not remember Resident 1 having artificial upper denture. Caregiver D stated s/he was never instructed to check to see if Resident 1 was wearing his/her upper dentures while eating. Caregiver D stated s/he did not know if Resident 1 had his/her artificial upper teeth on the day s/he passed away. Caregiver D stated Resident 1 was eating strips of steak when s/he had started choking.

On 10/26/2023 at 9:25 AM, Surveyor interviewed Caregiver E. Caregiver E stated s/he remembers Resident 1. Caregiver E stated s/he was working the memory care unit when Resident 1 passed away. Caregiver E stated s/he was never made aware Resident 1 had artificial upper denture. Caregiver E stated s/he was never instructed to check to see if Resident 1 was wearing his/her upper dentures while eating. Caregiver E stated s/he did not know if Resident 1 had his/her artificial upper teeth on the day s/he passed away.

On 10/26/2023 at 10:00 AM, Surveyor spoke with Family Member G on the phone. Family Member G stated s/he visited Resident 1 weekly while

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s/he lived at the facility. Family Member G stated Resident 1's was missing his/her 4 front teeth and Resident 1's upper denture had four artificial front teeth. Family Member G stated Resident 1 had his/her upper denture at the time of his/her admission to the facility. Family Member G stated the upper denture had gone missing multiple times and s/he had reported the issue to multiple staff. Family Member G stated Resident 1's upper denture was missing the week prior to his/her passing. Family Member G stated Resident 1 was not wearing his/her upper denture when s/he choked on a piece of steak, and Resident 1 shouldn't been eating steak without his/her upper denture.

On 10/26/2023 at 10:20 AM, Surveyor interviewed Nurse B. Nurse B stated s/he was the facility nurse while Resident 1 lived there. Nurse B stated s/he did not remember Resident 1 having an upper denture. Nurse B stated s/he did not remember if Resident 1 had his/her upper denture on the day s/he choked on a piece of steak. Nurse B stated Resident 1 had a DNR (do not resuscitate) order. Nurse B stated when EMTs arrived they initiated CPR because the DNR bracelet/paperwork was not on scene. Nurse B stated staff brought out the DNR paperwork after CPR had been initiated. Nurse B stated Resident 1 did not live at the facility for very long. Nurse B stated Resident 1 had come to the facility from a hospital.

On 10/26/2023 at 10:48 AM, Surveyor interviewed Advanced Practice Nurse Practitioner (APNP) J. APNP J stated s/he was Resident 1's healthcare provider while Resident 1 lived at the facility. APNP J stated Resident 1 did have an upper denture that replaced his/her missing upper teeth. APNP J stated s/he was not notified that

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Resident 1 was missing his/her upper denture. APNP J stated Resident 1's upper denture was an assistive tool for eating. APNP J stated Resident 1 was at an increased risk of choking by eating without his/her upper denture.

On 10/26/2023 at 11:30 AM, Surveyor discussed the above concerns with Administrator A and Nurse B. Administrator A and Nurse B acknowledged Resident 1's transfer packet faxed to the facility on 03/14/2023 stated Resident 1 had an upper plate (denture) and missing teeth. Administrator A and Nurse B acknowledged that Resident 1's upper denture was not included in Resident 1's ISP. Administrator A and Nurse B acknowledged Resident 1 was at an increased risk of choking on steak without his/her upper denture. Nurse B acknowledged Resident 1 was a DNR code status but had CPR performed on him/her on 05/24/2023.

On 10/26/2023 at 2:18 PM, Surveyor interviewed Family Member F. Family Member F stated Resident 1 had an upper denture to replace his/her missing front teeth. Family Member F stated Resident 1 did not have his/her upper denture the week prior to 05/24/2023. Family Member F stated his/her family had reported the missing denture to multiple staff members. Family Member F stated during his/her last visit with Resident 1 s/he was sucking on almonds because s/he did not have his/her upper denture. Family Member F stated the family still has not gotten the upper denture back from the facility. Family Member F stated Resident 1 was a DNR code status.

On 10/26/2023 at 2:56 PM, Surveyor interviewed Family Member H. Family Member H stated Resident 1 was missing his/her 4 upper front

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N 353	Continued From page 7 teeth and Resident 1 had an upper denture that artificially replaced his/her four front teeth. Family Member H stated Resident 1 should not have been eating steak without his/her upper denture. Family Member H stated Resident 1 had the upper denture upon admission to the facility. On 10/27/2023 at 10:25 AM, Surveyor interviewed Doctor M. Doctor M stated s/he had been a healthcare provider for Resident 1. Doctor M stated that according to Resident 1's electronic health record Resident 1 had an upper denture. Cross Reference N0415 DHS Chapter 83.37 (2) (d) Documentation of Medication Administration	N 353		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the staff administering the medication documented in the resident record the name, dosage, date and time of the medication	N 415		

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N 415	Continued From page 8 taken and initialed the medication administration record (MAR). From 05/01/2023 to 05/23/2023, there are 18 medications not documented as administered or refused on Resident 1's May 2023 MAR. This is a repeat violation of statement of deficiency (SOD) #1NLQ11 dated 03/15/2022. FINDINGS INCLUDE: On 09/06/2023, The Department received a complaint related to adequate treatment at the facility. On 10/26/2023, Surveyor arrived at facility for a compliant investigation. On 10/26/2023, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 03/15/2023. On 10/26/2023, Surveyor reviewed Resident 1's individualized service plan (ISP) which was signed on 03/15/2023. Resident 1's ISP documents staff are to administer Resident 1's medications. On 10/26/2023, Surveyor reviewed Resident 1's May 2023 MAR. Surveyor reviewed documentation of medication administration from 05/01/2023 to 05/23/2023. The following medication were not documented as administered or refused: 05/10/2023 at 10:00 AM - CertaVite Senior Oral Tablet 05/13/2023 at 8:00 PM - Divalproex Sodium ER Tablet 500 mg	N 415		

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N 415	Continued From page 9 05/18/2023 at 8:00 PM - Divalproex Sodium ER Tablet 500 mg 05/10/2023 at 10:00 AM - Pantoprazole Sodium Tablet 40 mg 05/10/2023 at 8:00 AM - Acetaminophen 500 mg 05/13/2023 at 8:00 PM - Acetaminophen 500 mg 05/18/2023 at 8:00 PM - Acetaminophen 500 mg 05/10/2023 at 10:00 AM - Divalproex Sodium DR Tablet 250 mg 05/13/2023 at 8:00 PM - Divalproex Sodium DR Tablet 250 mg 05/18/2023 at 8:00 PM - Divalproex Sodium DR Tablet 250 mg 05/10/2023 at 8:00 AM - Risperidone Tablet 1 mg 05/13/2023 at 8:00 PM - Risperidone Tablet 1 mg 05/18/2023 at 8:00 PM - Risperidone Tablet 1 mg 05/18/2023 at 2:00 PM - Trazadone HCL Tablet 50 mg 05/10/2023 at 8:00 AM - Voltaren External Gel 1% 05/10/2023 at 12:00 PM - Voltaren External Gel 1% 05/13/2023 at 8:00 PM - Voltaren External Gel 1% 05/18/2023 at 8:00 PM - Voltaren External Gel 1% On 10/26/2023 at 11:30 AM, Surveyor discussed the above concern with Administrator A and Nurse B. Administrator A and Nurse B acknowledged that 18 medications on Resident 1's May 2023 MAR were not documented as administered or refused. Nurse B stated documentation of medication administration is a consistent issue at facility. CROSS REFERENCE N0353 DHS Chapter 83.32 (3)(i) Rights of Residents: Adequate Treatment	N 415		