STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009274	A. BUILDING: _____ B. WING _____	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL GROVE ASSISTED LIVING	1308 S 22ND ST MANITOWOC, WI 54220

(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 06/20/2023, with information gathered through 06/22/2023, Surveyor conducted a standard survey and 3 complaint investigations at Laurel Grove Assisted Living in Manitowoc. Two (2) of 3 complaints were substantiated. As a result of the survey, 2 deficiencies will be issued. Census: 77	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide assistance in relocating the resident to ensure that a living arrangement suitable to meet the needs of the resident was available before discharging the resident when a 30 day involuntary discharge notice was given for 1 of 1 (Resident 1) residents reviewed.	N 326		

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

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N 326	Continued From page 1 Resident 1 received a 30 day notice on 05/20/2022. Resident 1 was hospitalized on 07/07/2022. On 07/09/2022 the hospital said Resident 1 was ready to return to the facility. The provider refused to take Resident 1 back into the facility and discharged Resident 1 on 07/09/2022. The provider did not ensure a suitable placement was found for Resident 1 before discharging Resident 1. Findings include: On 07/20/2022, the department received a complaint regarding involuntary discharges and suitable placement. On 06/20/2023, Surveyor reviewed Resident 1's resident record. Resident 1 was admitted to the facility on 04/22/2022 with diagnoses to include Alzheimer's disease, dementia with behaviors, anxiety, depression, restlessness and agitation. On 05/20/2022, Resident 1 was issued a 30 day notice due to an increase in level of care which included 1:1 supervision because of unsafe sexual behaviors with other residents and staff. On 07/07/2022, Resident 1 experienced a change in condition and was sent to the emergency room. Resident 1 was diagnosed with a UTI (urinary tract infection). Resident 1 was medically cleared and ready to be discharged from the hospital on 07/09/2022. Hospital staff called the provider and informed the provider Resident 1 was ready for discharge. The provider refused to take Resident 1 back. Resident 1 ended up staying in the hospital until 07/19/2022 (and additional 10 days) when s/he was discharged to another assisted living facility.	N 326		

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N 326	Continued From page 2	N 326		

Resident 1's record did not indicate any discussions with hospital staff regarding Resident 1 returning to the facility.

On 06/20/2023 at approximately 12:30 P.M., Surveyor interviewed Director of Nursing A. Director of Nursing A stated Resident 1 came from the skilled nursing facility (SNF) located on the same campus of the community based residential facility (CBRF). Resident 1 received therapy services at the SNF and was able to move to the CBRF after completing therapy services. Director of Nursing A verified Resident 1 was ambulatory with a walker and able to transfer self with some assistance but occasionally would attempt to self transfer. Director of Nursing A acknowledged s/he spoke with the hospital discharge planner regarding Resident 1 returning to the CBRF. Director of Nursing A verified they did not take Resident 1 back after the hospitalization. Director of Nursing A stated if Resident 1 would have come back, s/he would have needed to come back to the SNF side and we didn't think we could meet Resident 1's needs on that side. Director of Nursing A stated part of the reason for not being able to meet his/her needs was the 1:1 supervision Resident 1 required and SNF does not have a memory care unit to provide that service.

On 06/21/2023 at 11:15 A.M., Surveyor interviewed Hospital Case Manager B. Hospital Case Manager B stated Resident 1 arrived at the emergency room on 07/07/2022 for increased confusion. Resident 1 was admitted to the hospital on 07/07/2022 and was ready to be discharged back to the CBRF on 07/09/2022. Hospital Case Manager B stated that on 07/08/2022, s/he called Director of Nursing A and informed him/her that Resident 1 would be ready

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N 326	Continued From page 3 to return to CBRF on 07/09/2022. Hospital Case Manager B stated Director of Nursing A informed him/her that they would not be accepting Resident 1 back. Hospital Case Manager B stated Resident 1 was back to baseline on 07/09/2022, was independent with 2 wheeled walker and contact guard assist of 1 with transfer and ambulation. Hospital Case Manager B stated Resident 1 did not require 1:1 supervision while at the hospital. Hospital Case Manager B stated Resident 1 remained in the hospital until 07/19/2022 when Resident 1 was discharged to another assisted living facility. Although the facility issued a 30 day notice on 05/20/2022, the provider did not allow Resident 1 to return after a brief hospitalization and assist Resident 1 find suitable placement to meet the needs of Resident 1.	N 326		
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.	N 389		

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N 389	Continued From page 4 This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the resident or the resident's legal representative signed the individual service plan (ISP), acknowledging their involvement in, understanding of and agreement with the ISP for 1 of 4 (Resident 2) residents reviewed. Resident 2's most recent ISP dated 12/30/2022 did not contain Resident 2's or his/her legal representative's signature acknowledging their involvement or understanding and agreement of the ISP. Findings Include: On 06/06/2023, the department received a complaint regarding medications being administered without permission from the POA (Power of Attorney). On 06/20/2023, Surveyor reviewed Resident 2's closed record. Resident 2 was admitted to the facility on 11/29/2019 with diagnoses to include mild cognitive impairment, type 2 diabetes mellitus, and depression. Resident 2 had an activated POA dated November 2019. Resident 2 discharged from the facility on 03/09/2023. Resident 2's most recent ISP was dated 12/30/2022. The ISP indicated Resident 2 has a mood problem related to dementia, depression, cognitive impairment, short term memory loss, hallucinations and insomnia. Resident 2 has an order for Seroquel (antipsychotic) to help with the mood problem. On 06/20/2023 at 2:15 P.M., Surveyor interviewed Family Member C. Family Member C	N 389		

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N 389	Continued From page 5 verified s/he was the POA for Resident 2. Family Member C stated s/he was unaware Resident 2 was ordered Seroquel and never recalled speaking with them about the medication. On 06/20/2023, Surveyor requested the ISP signature page from Director of Nursing A. On 06/20/2023 at 3:00 P.M., Surveyor interviewed Director of Nursing A. Director of Nursing A indicated they could not locate the signature page for Resident 2's most recent ISP.	N 389		