STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014663	A. BUILDING: _____ B. WING _____	C 06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ANTIGO II	1415 10TH AVENUE ANTIGO, WI 54409

(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 06/25/2024, Surveyor conducted a complaint and self-report (x2) invevstigation at Care Partners Assisted Living Antigo II. Data collection continued through 06/26/2024. The complaint was substantiated. Two deficiencies were identified. Census: 12	N 000		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare a written temporary service plan (TSP) to meet Resident 1's needs. Resident 1 was an elopement risk. A TSP was not prepared and implemented. The TSP did not provide staff with interventions on how staff should supervise Resident 1 to prevent elopements. Findings include: On 05/06/2024, the Department received two self-reports indicating a resident eloped on 05/01/2024, 05/03/2024 and 05/05/2024. The resident was returned each time by the police. The facility is licensed to serve up to 16 residents	N 385		

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N 385	Continued From page 1 in the client groups advanced aged, irreversible dementia/Alzheimer's and terminally ill. On 06/25/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/01/2024. Resident 1 was discharged on 05/05/2024. According to a "Step Assessment Tool," dated 04/09/2024, Resident 1 was assessed as a wanderer, fall risk and elopement risk. According to nursing notes, dated 05/01/2024 through 05/05/2024, Resident 1 eloped from the facility on 05/01/2024, 05/03/2024 and 05/05/2024, and attempted to exit the facility on numerous occasions between 05/01/2024 and 05/05/2024. Nurse's notes, dated 05/01/2024, stated Resident 1 "was trying to exit seek beginning of the shift and was redirected multiply [sic] X (times)." According to nurse's notes, dated 05/02/2024, Resident 1 "tried to elope 14 times from 2 PM - 6 PM." According to nurse's notes dated 05/05/2024, Resident 1 "was bored and kept exiting [sic] seeking x 5 (5 times)." Resident 1's record did not contain a TSP or individual service plan (ISP). According to a "Behavior Monitoring Log (BML)," dated May 2024, the following information was noted regarding Resident 1: "Targeted Behavior #1: Exit seeking, elopements, agitation, anxious, confused, repeating, verbally aggressive, hitting/grabbing staff." On 06/25/2024 at approximately 2:00 PM, Surveyor interviewed Director A. Surveyor asked Director A if Resident 1 had a TSP or ISP available. Director A reported that a TSP or ISP was not completed for Resident 1. Director A verified Resident 1 eloped on 05/01/2024, 05/03/2024 and 05/05/2024. Director A reported that each time Resident 1 left the facility, staff were present and staff accompanied Resident 1 until the police assisted with returning Resident 1	N 385		

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N 385	Continued From page 2 back to the facility. Director A confirmed Resident 1 was discharged on 05/05/2024. On 06/26/2024, at approximately 11:40 PM, Surveyor interviewed Director A via e-mail. Surveyor asked Director A the following question: "As discussed yesterday, in regards to [Resident 1's] elopements, a temporary service was not completed upon admission; What is the process for completing temporary service plans?" On 06/26/2024, Director A responded via e-mail, "The Kardex that I believe I copied for you for [Resident 1] is in place as the temporary ISP." On 06/26/2024, Surveyor asked Director A via e-mail, "Does the Kardex address interventions for [Resident 1's] elopement behavior?" On 06/26/2024, Director A responded via e-mail, "No it does not go into detail but does state that [s/he] is an elopement risk." On 06/26/2024, at approximately 3:00 PM, Surveyor interviewed Director A via telephone. Director A stated that after Resident 1 was admitted, Resident 1 eloped (walked out of the facility) and tried exit seeking multiple times until s/he was discharged on 05/05/2024. Director A confirmed that a TSP or ISP was not completed for Resident 1.	N 385		
N 432	83.38(1)(h) Medication administration. 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	N 432		

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N 432	Continued From page 3 arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration 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 2 was provided with medication administration appropriate to his/her needs on 05/03/2024. Findings include: On 05/13/2024, the Department received a complaint alleging a resident was given another resident's medication on 05/03/2024. The facility is licensed to serve up to 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's and terminally ill. On 06/25/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 10/17/2013. According to nurse's notes, dated 05/03/2024, Caregiver B noted, "Staff had made the mistake of giving [Resident 2] [Resident 3's] medications. [S/He] took 2 pills that were Midodrine HCL 5 mg. and Rivastigmine 3 mg. cap [sic]. Staff immediately noticed the error and called director. Took vitals. Staff called guardian and informed [him/her] of what happened." According to a "Medication Error Report", Director A noted, "Resident was given another resident's medications on 5-3-24 at 5 PM. [S/He] was given Midodrine HCL 5 mg. and Rivastigmine 3 mg. Staff will continue to monitor [him/her] and take	N 432		

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N 432	Continued From page 4 vitals. No concerns at this time. Primary doctor, POA (power of attorney), and Lakeland Care updated on incident. No changes from primary at this time." According to a "Medication Error Report," dated 05/14/2024, in response to "What rule was broken allowing this medication error to happen?;" Caregiver C wrote, "Staff did not do [sic] triple check." On 06/25/2024 at approximately 2:00 PM, Surveyor interviewed Director A. Director A confirmed Resident 2 was given two of Resident 3's medications (Midodrine HCL 5 mg and Rivastigmine 3 mg.) on 05/03/2024. Director A indicated that despite the medication error, Resident 3 received all of his/her prescribed medications on 05/03/2024 and Resident 2 received all of his/her prescribed medications on 05/03/2024. Director A stated that for the medication error on 05/03/2024, Caregiver B filled out a "Resident/Visitor Incident Report" and completed a "Medication Error Report." Director A reported that there had not been any further concerns with medication errors for Caregiver B.	N 432		