STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER ASSISTED LIVING OF MARSHFIELD	305 SOUTH CHESTNUT AVE MARSHFIELD, WI 54449

(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
{U 000}	INITIAL COMMENTS On 11/02/2023, Surveyors conducted an onsite visit at Aster Assisted Living of Marshfield to investigate 4 complaints and complete a Verification Visit. Additional information was received through 11/22/2023. Four (4) of 4 complaints were substantiated and 7 deficiencies were identified. Four (4) of the 6 previous deficiencies were uncorrected Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 52 apartments	{U 000}		
U 117	89.23(2)(a)2.b SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: b. Personal services: daily assistance with all activities of daily living which include dressing, eating, bathing, grooming, toileting, transferring and ambulation or mobility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Tenant 4 received daily	U 117		

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

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assistance with all activities of daily living to include toileting and ambulation.

Findings include:

On 04/13/2023, the department received a complaint that alleged care concerns.

On 11/02/2023 and 11/10/2023, Surveyor reviewed portions of Tenant 4's record. Tenant 4 resided at the facility 12/19/2022 through 09/17/2023, was elderly and had diagnoses to include Parkinson's disease. The record identified Tenant 4's needs for full staff assistance with toileting, transferring and ambulation.

Tenant 4's task and medication administration records for August and September 2023 prompted caregivers to provide the following services at scheduled times:

Physical therapy walks - "must be walked down the hallway and back 3x daily with 1 person following behind with wheelchair." Scheduled 10:00 AM, 2:00 PM and 6:00 PM.
August - 53 of 93 times charting was blank
September - 28 out of 51 times charting was blank

Toileting - "will be assisted with toileting every 2 hours (5 times) during the hours of 10pm and 6am." The care was scheduled during the overnight hours at 10:00 PM, 2:00 AM, 4:00 AM and 6:00 AM (4 times)
August - 96 out of 124 times charting was blank.
September - 63 of 68 times charting was blank

On 11/02/2023 at 9:10 AM, Surveyor interviewed Maintenance/Caregiver J. Maintenance/Caregiver J said his/her primary assignment is

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maintenance, but s/he is cross trained and also works as a caregiver. Maintenance/Caregiver J said Tenant 4 was not getting the care s/he should have, "like staff not answering call lights or taking [him/her] to the restroom or the daily walks. Just not enough staff, not enough time...[s/he wasn't] getting the good treatment [s/he] deserved." Maintenance/Caregiver J explained some caregivers would change Tenant 4, but leave him/her in a urine soaked bed. S/he recalled, "When you pulled the bed covers off...you could see the circles of urine and you could tell by the smell it had been a long time." Maintenance/Caregiver J added, "It makes me sad."

On 11/02/2023 at 12:21 PM, Surveyor interviewed Caregiver/Medication Passer L. Caregiver L said Tenant 5 (Tenant 4's spouse) would complain night shift would not check on Tenant 4. Caregiver L works 1st shift and said sometimes Tenant 4 would need a complete bed change and shower because s/he was so soaked with urine from the overnight. Caregiver L also expressed concerns about insufficient staffing levels as a contributing factor to some care concerns.

On 11/13/2023 at 1:09 PM, Surveyor interviewed Tenant 5 who stated s/he was very dissatisfied with Tenant 4's care. Tenant 5 said caregivers did not consistently offer Tenant 4 the opportunity to walk 3 times daily and often would not provide toileting assistance overnight. Tenant 5 said there were times Tenant 4's bed was so urine soaked the urine would pool on the floor and there were also times night staff would change Tenant 4's brief but leave him/her in the wet bedding. Tenant 5 said s/he complained repeatedly to Director A and Lead Caregiver B but there were "always excuses" and the problems were ignored. Tenant

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U 117	Continued From page 3 5 said the care and interactions really declined once staff knew the tenants were looking for a new facility. Tenant 5 said the care at the new facility has been much better. Cross Reference: U0118 DHS 89.23(2)(a)2c Services U0131 DHS 89.23(4)(b)1 Services U0188 DHS 89.27(4) Service Agreement U0272 DHS 89.35(4) Grievances	U 117		
{U 118}	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Tenant 2, Tenant 4, Tenant 7 and Tenant 8 received services to meet their needs for medication administration and/or medication management.	{U 118}		

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{U 118}	Continued From page 4 Tenant 2: On 4/10/2023, facility staff administered Tenant 3's medications to Tenant 2. Tenant 2 was sent to the ED (Emergency Department) and hospitalized due to low blood pressures and feeling lightheaded and dizzy. Tenant 4: Between 09/01/2023 and 09/16/2023, Tenant 4 did not receive carbidopa/levodopa at the specific intervals ordered by the physician. Tenant 7: Between 11/01/2023 and 11/07/2023, facility staff attempted to administer Tenant 7's oxybutynin 3 times/day scheduled, contrary to the physician's order dated 09/28/2023 to only administer as needed for bladder spasms. Tenant 8: Between August and October 2023, some staff administered Tenant 8's medications whole and were unaware of physician orders allowing for medications to be cut or crushed. Tenant 8's hospice registered nurse and his/her power of attorney for health care both stated Tenant 8 benefited from having medications crushed to make it easier for him/her to consume them. In addition, when the facility's pill crusher broke the provider did not inform the POA or hospice or make other efforts to promptly secure a replacement. This is a repeat deficiency. See SOD N3L511, dated 03/02/2023. Findings include: The department received 3 complaints that alleged concerns with medication administration. TENANT 2	{U 118}		

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{U 118}	Continued From page 5 On 11/06/2023, Surveyor reviewed Tenant 2's closed medical record. The record indicated the tenant was admitted to the facility on 02/18/2019 with diagnoses of atrial fibrillation, asthma and hypothyroidism. Tenant 2's ISP (Individual Service Plan) dated 02/27/2023 required staff to manage and administer all his/her medications. Tenant 2's incident report dated 04/10/2023 at 7:30 AM stated, "...Med Passer rushed passing, popping out pills to assist. Passed out wrong pills to wrong tenant. Staff noticed right away and notified team lead. Team lead notified hospice, family and Executive Director...[Tenant 2] was sent to ED to be monitored." Additionally, the report indicated the "Prevention Plan" was to re-train and remove the med passer from medications until retaining/competency review was complete. Tenant 2's Hospital Discharge Summary report dated 04/11/2023 indicated, Tenant 2 was admitted to the hospital on 04/10/2023 and discharged on 04/11/2023 with diagnoses to include accidental medication error and hypotension. The report stated, "[Tenant 2] presented to the ED yesterday after accidentally being given [Tenant 3's] blood pressure medication at the assisted living facility that [s/he] resides at. [Tenant 2] was feeling lightheaded and dizzy and at the assisted living facility [her/his] systolic blood pressure was in the 80s. [S/he] was given amlodipine 5 mg, hydralazine 25 mg, and lisinopril 40 mg. In the ED [her/his] lowest recorded blood pressure was 79/48 with a heart rate of 52...[Tenant 2] was given about 2 and half liters of normal saline in the ED to bring [her/his] blood pressure up, but [s/he] kept having low blood pressures even after 3 hours in the ED...[Tenant 2's] EKG was overall unchanged.	{U 118}		

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{U 118}	Continued From page 6 Given that [her/his] blood pressure continued to fluctuate [s/he] was admitted for observation for 1 day...[Tenant 2's] blood pressures eventually came back to [her/his] normal baseline which is about 100/60 all of [her/his] symptoms have resolved. [Tenant 2] was discharged back to [her/his] assisted living facility..." Tenant 3's medication list at 8 AM indicated, "Acetaminophen two 500 (milligrams) tablets, amlodipine 5 mg tablet (medication to treat high blood pressure), clopidogrel 75 mg tablet (blood thinner medication), lisinopril 40 mg tablet (medication to treat high blood pressure), hydralazine 25 mg tablet (medication to treat high blood pressure), and phenazopyridine 100 mg tablet (medication to treat urinary pain)." On 11/02/2023 at 1 PM, Executive Director A verified the above medication error occurred on 04/10/2023 and stated, "A former staff member passed [Tenant 3's] medications to [Tenant 2]." Executive Director A indicated the former staff who made the error received a written warning, was taken off the medication cart and re-trained. Executive Director A went on to say s/he provided verbal re-education at a staff meeting to all staff following the above incident sometime in May 2023. TENANT 4 During the previous survey ending 03/02/2023, deficiencies were identified related to medication administration for Tenant 4. On 11/02/2023 and 11/10/2023 Surveyor conducted interviews and reviewed portions of Tenant 4's records to review for correction of the previous deficiency. Tenant 4 was admitted 12/19/2022 and moved	{U 118}		

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{U 118}	Continued From page 7 out 09/16/2023. S/he was elderly and had diagnoses to include Parkinson's disease. Tenant 4 needed staff assistance with medication administration. The record included, "Physician orders for ASTER ASSISTED LIVING MARSHFIELD...Clarification: Carbidopa/levodopa 25/250 (immediate release blue pill) 1 tablet p.o. (by mouth) 3 times daily is specifically ordered for these times: 6 AM-11:30 AM-5 PM (Starting 09/01/2023)...Clarification: Carbidopa/levodopa ER 50/200, 1 tablet p.o. daily at bedtime is specifically timed for 9 PM.(Starting 09/01/2023)..." Signed by the physician on 08/16/2023. September 2023 medication administration record for times when the medication was administered more than 30 minutes earlier or later than the physician ordered time: 6:00 AM, 11:30 AM and 5:00 PM 6:00 AM - 13 of 16 times 11:30 AM - 8 of 16 times 5:00 PM - 4 of 15 times (moved out on the 16th before this dose) 9:00 PM 9:00 PM - 15 of 15 times In addition: 12 times the medication was administered more than an hour after the scheduled time, including one dose administered 2 hours and 39 minutes late At least once every day between 09/01/2023-09/16/2023, the medication was administered more than 30 minutes too early or too late	{U 118}		

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{U 118}	Continued From page 8 On 11/02/2023 at 12:21 PM, Surveyor interviewed Med Passer I who said s/he is cross trained as a medication passer and maintenance staff. Med Passer I said there have been struggles at the facility with medication administration and attributed it to poor oversight and lack of staffing. Med Passer I stated Tenant 5 (Tenant 4's spouse) would often complain to him/her that most other staff did not administer Tenant 4's medications on time. During an interview with Director A on 11/13/2023 at 2:00 PM, Surveyor reviewed the MAR documentation and noted the medications were routinely not administered at the times ordered. Director A did not dispute the findings. Surveyor note: "Patients with Parkinson's disease require strict adherence to an individualized, timed medication regimen of antiparkinsonian agents. Dosing intervals are specific to each individual patient because of the complexity of the disease. It is not unusual for patients being treated with carbidopa/levodopa to require a dose every one to two hours. When medications are not administered on time and according to the patient ' s unique schedule, patients may experience an immediate increase in symptoms.2 Delaying medications by more than one hour, for example, can cause patients with Parkinson ' s disease to experience worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating...." Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5737245/ TENANT 7 On 11/02/2023 at 9:55 AM, Surveyor interviewed	{U 118}		

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{U 118}	Continued From page 9 Tenant 7. S/he described a recent medication concern and said, "We had a little battle last night. And several weeks ago too." Tenant 7 explained in September s/he received a new prescription for a medication to treat bladder spasms and the doctor said the medication was to be taken as needed, not daily. "Well, they thought I should be taking them all the time. I said, 'No, it's as needed.' They called the clinic and clarified it. And it was fine for a while. But last night, here they come with it. When they gave me my night meds I said, 'No, no, no, no this is only as needed. I'm not taking it.'" Tenant 7 said again this morning Medication Passer L tried to administer the medication. On 11/02/2023 at 12:21 PM, Surveyor interviewed Medication Passer L. S/he confirmed Tenant 7's explanation of the morning medication pass. Medication Passer L said in September or October, oxybutynin was originally filled as a scheduled, daily medication. Tenant 7 caught the error, asked facility staff to contact the physician, and it was changed to PRN (as needed) in ECP (electronic resident record keeping system) however, when the pharmacy delivered refills for November, they sent a new medication card for oxybutynin with instructions to administer 3 times daily and ECP now prompts daily for administration. During an interview on 11/02/2023 at 1:47 PM, with Medication Passer N, s/he stated she had a different understanding of the medication orders. Medication Passer N said s/he was confident oxybutynin was scheduled 3 times daily and expressed annoyance because Tenant 7 was "determined" the medication was PRN and refused to take it. Medication Passer N said the day before s/he requested and received an order	{U 118}		

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from the pharmacy (not the physician) confirming the medication was scheduled 3 times per day. Medication Passer N said s/he had not talked to Tenant 7 to discuss the order.

On 11/02/2023 at approximately 2:00 PM, Surveyor reviewed portions of Tenant 7's records. Tenant 7 was admitted 07/01/2023, was his/her own legal decision maker and was described as alert and oriented with no confusion or memory loss. According to the record, Tenant 7 relied on staff's assistance with medication administration/management. Surveyor reviewed September - November 2023 medication administration records (MARs) and noted the following:

September - oxybutynin 5 mg tablet scheduled 3 times daily beginning 09/26/2023. On 09/28/2023 and end date was entered and did not prompt for administration as a scheduled or PRN for the remainder of the month.
October - oxybutynin 5 mg tablet was entered as a PRN medication 3 times daily. It was not administered at all.
November - oxybutynin 5 mg tablet scheduled 3 times daily beginning on 11/01/2023 with the 4:00 PM dose. It was documented as administered at 4:00 PM, refused at 9:00 PM and refused on 11/02/2023 at 9:00 AM. According to the MAR notes, Tenant 7 refused because the medication was ordered PRN only.

On 11/02/2023 at 3:10 PM, Surveyor interviewed Director A about the medication concerns. S/he said, "I addressed it yesterday." S/he explained, "[Medication Passer N] said, '[Tenant 7] is refusing to take [his/her] meds. It's in ECP for 3 times a day blah blah blah' and I said, 'Verify with the doctor what [his/her] script is supposed to be

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so I know if I need to change anything in ECP.'" Director A said on 11/01/2023 an order dated 09/25/2023 for administration 3 times a daily. Director A said since receiving the order, no one had discussed it with Tenant 7 or explained to the physician what Tenant 7 was saying. Director A also said s/he did not review the MAR to determine how or if the medication was administered during October 2023. Surveyor shared the concerns reported by Tenant 7 and Director A confirmed Tenant 7 is alert, oriented and fully aware of his/her medication regime. Director A said s/he would follow up on the situation.

On 11/06/2023, Director A sent Surveyor an email with a document that read, "We received a prescription on 9/25/23 for 1-tab oral TID (3 times daily), x30 day(s). We entered this order into ECP. On 09/28/23 we received a new order for 1-tab TID, PRN..." Director A included the revised physician's order dated 09/28/2023 which read, "Take oxybutynin 5 mg one, three times a day PRN for bladder spasms."

On 11/08/2023 at 4:47 PM, Surveyor interviewed Pharmacist Q. S/he said the only order they had was for oxybutynin TID, dated 09/25/2023. Pharmacist Q said neither the provider or the physician sent them the revised 09/28/2023 PRN order so they refilled the medication for November assuming the tenant needed it.

On 11/08/2023, Surveyor reviewed the most current version of Tenant 7's November MAR. Surveyor noted changes were not promptly made to ensure Tenant 7 received the medication as ordered.
After Surveyor's onsite visit 11/02/2023, the MAR continued to prompt administration of oxybutynin

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{U 118}	Continued From page 12 3 times daily. Refusals were documented each time, except for once on 11/06/2023 when it was documented as administered. On 11/07/2023, the MAR was updated after the 4:00 PM dose to reflect administration PRN only. TENANT 8 During the previous survey ending 03/02/2023, deficiencies were identified related to medication administration for Tenant 8. Staff were unaware of orders allowing for crushed medications and were administering large pills making it difficult for Tenant 8 to consume the pills. On 11/02/2023 and 11/08/2023, Surveyor conducted interviews and reviewed Tenant 8's record to review for correction of the previous deficiency. Tenant 8 was admitted to the facility on 02/23/2017, and as of 03/23/2023, Family P was his/her activated power of attorney for health care (legal decision maker due to incapacitation.) Tenant 8's most recent assessment dated 06/14/2023, identified the need for complete staff assistance with medication management and administration. On 11/02/2023 at 12:21 PM, Surveyor interviewed Medication Passer L. S/he stated for the past 2 1/2 months, s/he administered Tenant 8's pills whole in applesauce. Medication Passer L stated, "I guess there was a crush order in [his/her] file, but it wasn't in ECP so we weren't crushing them...Now it is in the system that we can crush them." Medication Passer L said s/he started crushing meds near the "end of October" and Tenant 8 accepted medications better after that, however, recently the pill crusher broke so s/he had been cutting the pills in half and putting them in applesauce. Medication Passer L said s/he	{U 118}		

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{U 118}	Continued From page 13 didn't know whose responsibility it was to replace the pill crusher. On 11/02/2023 at 1:47 PM, Surveyor conducted a joint interview with Medication Passer N and Medication Passer M. They were not in agreement with the method of administration of Tenant 8's medications. Medication Passer N stated s/he cuts the pills in half and lets them sit in applesauce to soften. S/he said Tenant 8 does not have an order allowing medications to be crushed. Medication Passer M disagreed. S/he explained up until 2 weeks ago, s/he also was cutting the medications, but since then s/he learned the medications were supposed to be crushed. Medication Passer M confirmed the pill crusher was broken, so this was not occurring. On 11/02/2023 at 2:00 PM, Surveyor asked Medication Passer M to provide physician orders from Tenant 8's record for the proper method for administration and s/he provided the following: order dated 01/06/2022 read, "Ok to crush large pills" order dated 02/09/2023 read, "Ok to split medications" An ECP prompt dated 02/13/2023 read, "Dr. order to crush pills in half, administer with applesauce." Medication Passer M commented that did not make sense, pills should either be cut in half or crushed, not both. Surveyor noted the orders and prompt in ECP were unchanged from the last survey ending 03/02/2023. On 11/02/2023 at 3:10 PM, Surveyor interviewed Executive Director A. Surveyor shared the inconsistencies reported by the staff about Tenant 8's needs for medication administration. ED A	{U 118}		

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{U 118}	Continued From page 14	{U 118}		

said s/he "didn't know off hand" what the current orders were. Director A acknowledged based on the ECP prompt and 2 orders located in the record on the day of the visit, there had not been changes to or clarifications in orders since the last survey when deficiencies were identified. Director A also said no one had reported to him/her that the pill crusher was not working, but qualified s/he had only been back in work status for 3 days after a medical leave.

On 11/08/2023 at 1:20 PM, Surveyor interviewed Family P. S/he expressed frustration about an incident on 10/19/2023 when s/he observed a medication passer try to administer Tenant 8's medications whole in applesauce. Family P said the staff person commented Tenant 8 had been having difficulty ingesting the pills and was unaware there was an order allowing for them to be crushed. Family P said it was his/her understanding the medications should be crushed, but staff didn't seem to know if the pills should be whole, cut or crushed and added, "They don't communicate well" with each other or with Family P about Tenant 8's needs. Family P was unaware the pill crusher had not been working and no one contacted him/her in an effort to replace it. Family P said s/he would follow up with facility staff on the medication concerns.

On 11/08/2023 at 1:55 PM, Surveyor interviewed Hospice Registered Nurse (RN) O who said Tenant 8 had been receiving hospice services for approximately 1 year. RN O said no one had contacted him/her for clarification on orders in the past 6 days or at any point prior. RN O said s/he was under the impression medications were being administered crushed, which would be best for Tenant 8. S/he stated after speaking with Surveyor, s/he would ensure the provider had an

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{U 118}	Continued From page 15 order to crush all Tenant 8's medications (except 1 that may be contraindicated and one that should be sprinkled from a capsule.) Surveyor asked if anyone contacted him/her to inquire about a replacement pill crusher. S/he initially replied no, but during the interview said s/he received an email at 2:06 PM today from the office that stated the provider just requested a new pill crusher. RN O said s/he would order and deliver one immediately. On 11/08/2023, RN O sent an email to Surveyor, "New orders from today PLEASE CRUSH FOLLOWING MEDICATIONS - ACETAMINOPHEN, AMLODIPINE, ASPIRIN, LORAZEPAM, MIRTAZAPINE, ROPINIROLE, SENNA, TORSEMIDE. DO NOT CRUSH EXTENDED RELEASE MEDICATIONS. DO NOT CRUSH LACTOBACILLUS/PROBIOTIC, POTASSIUM, OR LEVOTHYROXINE. LACTOBACILLUS AND POTASSIUM MAY BE BROKEN APART AND THE SMALL CAPSULES INSIDE MAY BE MIXED WITH APPLE SAUCE... Pill crusher was dropped off today by myself after requested today. I did not know about a broken pill crusher before today." Cross Reference: U0117 DHS 89.23(2)(a)2b Services U0131 DHS 89.23(4)(b)1 Services U0188 DHS 89.27(4) Service Agreement U0272 DHS 89.35(4) Grievances	{U 118}		
{U 131}	89.23(4)(b)1. SERVICES PROVIDER QUALIFICATIONS. Service manager.	{U 131}		

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{U 131}	Continued From page 16 Each residential care apartment complex shall have a designated service manager who shall be responsible for day-to-day operation of, including ensuring that the services provided are sufficient to meet tenant needs and are provided by qualified persons; that staff are appropriately trained and supervised; that facility policies and procedures are followed; and that the health, safety and autonomy of the tenants are protected. The service manager shall be capable of managing a multi-disciplinary staff to provide services specified in the service agreements. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the designated service manager ensured services provided were sufficient to meet tenants' needs, staff were appropriately trained and supervised, facility policy and procedures were followed; and the health and safety of residents were protected. Director A did not ensure a prompt or thorough investigation was completed after Tenant 9 alleged potential misappropriation of $200. Director A did not ensure staff were trained or proficient in catheter care. Tenant 6's catheter bag was not stored in sanitary conditions and would often leak because staff did not close the valve.	{U 131}		

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{U 131}	Continued From page 17 Director A did not ensure staff were properly supervised or Tenant 4's health and safety were protected. Over a period of 4 months, Caregiver R did not provide necessary toileting assistance to Tenants 4 and 10, took away Tenant 4's call pendant, yelled and argued with Tenants 5 and 11 and slept during 3rd shift. This is a repeat deficiency, see Statement of Deficiency (SOD) N3L511, dated 03/02/2023. Findings include: The department received a complaint that alleged care concerns and lack of management response and oversight. EXAMPLE 1 During the entrance conference with Director A on 11/02/2023 at 8:35 AM, Surveyor requested documentation of any misappropriation investigations dating back to July 2023. Director A said s/he had not completed any investigations and there was no documentation to provide. On 11/02/2023 at 8:02 AM, Surveyor interviewed Tenant 9 and asked how s/he liked living at the facility. S/he replied, "Not too hot. I'm looking for another place....A lot of things around here I'm disgusted with." Tenant 9 said Director A did not resolve problems and gave the following example, "...I went to the doctor last Thursday and when I came home there was $200 missing out of my room. That's the 2nd time that's happened...I was going to talk to [Director A] yesterday, but [s/he] was too busy...I told them downstairs they said they'd look into it....It don't do any good to say anything about anything, they	{U 131}		

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just let it go...I talked to [my case manager] I want them to get me someplace else." Tenant 9 said s/he also reported the missing money to Maintenance Staff J, and s/he really liked Maintenance Staff J and trusted s/he would tell someone.

On 11/02/2023 at 9:10 AM, Surveyor interviewed Maintenance Staff J. Maintenance Staff J said s/he used to be a caregiver, but the onsite management was not responsive to concerns and did not ensure appropriate staffing or oversight of the schedule. As a result, s/he transitioned to a maintenance position but still fills in often as a caregiver. Maintenance Staff J confirmed Tenant 9's report of the missing money. S/he said, "On the 26th, Thursday...after coming back from the clinic [s/he] said [s/he] noticed [s/he] was missing $200. That's what [s/he] specifically told me." Maintenance Staff J said Tenant 9 was occasionally confused but overall, "[S/he]'s pretty accurate. [S/he] can voice herself. It's logical to me. If you're gone something could have happened...I told [Director A] Monday this week (10/31/2023.)"

Surveyor conducted a follow up interview with Director A on 11/02/2023 at 3:10 PM. Director A denied receiving any allegations about missing money from Maintenance Staff J. Director A said Tenant 9 reported a housekeeping concern on 11/01/2023, but did not report missing money. Director A confirmed s/he "had no idea" of the allegations and stated s/he "will do an investigation." S/he agreed to send Surveyor the documentation once the investigation was completed.

On 11/06/2023, Director A sent Surveyor an email regarding the misappropriation allegation which

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{U 131}	Continued From page 19 was inconsistent with statements s/he made on 11/02/2023 when s/he denied any knowledge of the allegation of missing money. The documentation consisted of: -A word document that read, "On 11/1/23 [Tenant 9] reported to me that on 10/26/23 [s//he] had $200.00 go missing from [his/her] apartment. An investigation was done with staff to see if anyone had seen any money in [his/her] apartment. Two staff members also looked over [his/her] apartment with [his/her] permission to see if they could find it. At that time, [s/he] stated [s/he] thought maybe [a family member] took the money to hold on to when [s/he] was there. We discussed at that time if [s/he] would like for us to hold onto [his/her] money and disburse it to [him/her] as [s/he] needed it. [S/he] agreed to it and signed a form stating [s/he] will give us [his/her] money to be locked up." A form was included signed by Tenant 9 on 11/03/2023 authorizing the provider to hold his/her money. -Documentation of interviews with 4 staff on 11/03/2023 which consisted of 2 questions; "Have you ever seen [Tenant 9] have money on [him/her] physically?" and "Have you ever seen money in [Tenant 9]'s apartment." Signatures were illegible for 2 of 4 staff and the 2 legible signatures were for dietary staff. Surveyor conducted another interview with Director A on 11/13/2023 at 2:00 PM and asked for confirmation of the date s/he first received the allegation. S/he replied, "That morning of your arrival. Maybe it was the morning before. The 1st is when I found out. [Tenant 9] came in and talked to me, yes." Surveyor asked for the names and positions of the staff s/he interviewed. Director A said 3 were dietary staff and the 4th s/he could	{U 131}		

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not read the signature or remember who it was. Surveyor asked if s/he reviewed the schedule and interviewed the direct care staff that were working on the 26th. S/he said, "Yes....I had no new staff on. Nobody new coming in and out of the building. It was staff that work on a regular basis. People that have been here, longevity...When those people are working, there's no reports (of missing money.)" Director A said s/he documented the staff interviews, but did not include them in the email to Surveyor. S/he also said s/he interviewed tenants, but did not include those interviews either. Director A said s/he would send the documentation by the end of the day.

On 11/13/2023 Director A emailed Surveyor additional documentation. It consisted of a word document titled "11/01/2023 RE: [Tenant 9] missing money" and contained a 3 sentence summary of a "meeting" with the 3 caregivers working on 10/26/2023 who stated they had not seen money in Tenant 9's apartment or seen anyone going in/out of the apartment. The only date on the document was 11/01/2023. The email contained a 2nd document dated 11/01/2023 that documented 3 interviews with tenants. None of the questions asked if they had ever experienced missing money or property.

Surveyor noted: the 6 interviews documented with a date of 11/01/2023, directly contradicted the statements from Director A on 11/02/2023 that s/he had not conducted any misappropriation investigations since July and had not received any allegations of Tenant 9 missing $200.

Surveyor note: According to the Wisconsin Caregiver Program Manual and pursuant to DHS 13.05(2) and (3), "Immediately upon learning of the incident, the entity must take necessary steps

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to protect clients from possible subsequent incidents of misconduct...In addition to DQA reporting requirements, entities are required to notify local law enforcement authorities in any situation where there is a potential criminal offense...All entities regulated by DQA must conduct a thorough internal investigation...to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident...and document the findings for all allegations or incidents..."

EXAMPLE 2

On 11/02/2023 at 09:55 AM, Surveyor interviewed Tenant 7. S/he explained s/he has a suprapubic catheter. Tenant 7 said, "The new people when they come, like last night [Caregiver S], [s/he] had never put me to bed before, so I just train them. I've trained many of them....most people even if they have experience have never had anything to do with suprapubic catheter. That's foreign to them. There's no training for them....[Caregiver S]'s job was to put me to bed and part of that is switching the bag and I told [him/her] how to do that [s/he] did it just fine. [S/he] said the first time [s/he]'s ever had to change a bag...Then last week had a young [caregiver]...[s/he] just comes on the weekends. [S/he]'s observed a couple times. [S/he] came in and put me to bed and I trained [him/her]...You can observe all you want, but when you actually do it that's the absolute training."

On 11/02/2023 at 11:47 AM, Surveyor interviewed Tenant 6's family friend, Person K. Person K said the quality of care has declined and there are not enough staff. Person K said, "Things like, at night they forget to close [Tenant 6]'s catheter bag so it sits on the floor and drains all over the floor. They

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{U 131}	Continued From page 22 forget in the morning and it has drained in [his/her] chair." Person K expressed concerns about the cleaning and sanitary storage of the drainage bags and said Tenant 6 has experienced urinary tract infections. Person K said there has been a significant amount of staff turnover and new staff "don't know what they are doing" with the catheter. On 11/02/2023 at 12:21 PM, Surveyor interviewed Caregiver L. Caregiver L said s/he transitioned from a maintenance/driver position to a caregiver in August or September 2023. Caregiver L said s/he did not receive training in catheter care when s/he changed roles. Caregiver L said, "Two weeks ago...we had retraining, everyone had to watch the video (on catheter care) because night shift had left [Tenant 6]'s leg bag overnight full of urine in the shower and it wasn't properly cleaned." On 11/02/2023 at 3:10 PM, Surveyor interviewed Director A who stated the following: Tenant 6 and Tenant 7 require staff assistance with catheter care. S/he received complaints about staff proficiency with caring for Tenant 6's catheter. This included a recent incident when the bag was left undrained, full of urine and laying on the floor of the shower and instances when staff forgot to close the bag causing it to leak urine. S/he said, "We did a retraining last week on catheter care." The facilty's process for new hires is for Registered Nurse (RN) C to train and "delegate" catheter care. Caregiver S was hired 10/20/2023, has not been trained by RN C and should not have been performing catheter care, which included changing day and night bags. Director A said s/he would address this.	{U 131}		

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{U 131}	Continued From page 23 Records for Caregiver L (hired 08/03/2023) and Caregiver N (hired 07/24/2023) did not contain evidence of catheter care training until the "retraining" on 10/25/2023. On 11/06/2023 Director A sent Surveyor an email which contradicted what s/he stated on 11/02/2023 about the training process. S/he wrote, "Catheter care is part of [Tenant 7]'s daily cares. Per our policy, this care is not delegated by our nurse but is part of the shadowed training. [Caregiver S] did shadowed training and [s/he] is able to perform this daily care." The email did not contain documentation of the "shadowed training", the date it was provided or who provided it. On 11/13/2023 during a follow up interview with Director A, s/he said s/he is the one who personally provided the training to Caregiver S and did not offer a valid explanation for why s/he did not provide that information when asked by Surveyor on 11/02/2023. During the interview Surveyor expressed concerns about staff proficiency with proper cleaning and storage of the urinary bags and asked if Tenant 6 had experienced urinary tract infections in the past 3 months. Director A replied, "No." Director of Operations I was present during the interview. S/he corrected Director A and confirmed Tenant 6 had a urinary tract infection on or about 10/23/2023. EXAMPLE 3 The department received a complaint that alleged a staff member took away a tenant's call pendant. On 11/02/2023 and 11/10/2023, Surveyor reviewed portions of Tenant 4's record. S/he was	{U 131}		

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{U 131}	Continued From page 24	{U 131}		

admitted 12/19/2022, was elderly and had diagnoses to include Parkinson's disease. The record identified Tenant 4's needs for full staff assistance with toileting, transferring and ambulation. Tenant 4 needed staff assistance with toileting needs every 2 hours between 10:00 PM and 2:00 AM.

On 11/02/2023 at 3:10 AM, Surveyor interviewed Director A. S/he denied receiving any allegations that 3rd shift staff took Tenant 4's call pendant away because they thought s/he called too much. Director A replied, "I have it night shift staff was not coming in and that [Tenant 5] (Tenant 4's spouse) and Caregiver R got in an argument. I never received an allegation that someone took [Tenant 4]'s call light." Director A said in response to the care concerns s/he investigated, issued a disciplinary notice and did retraining. Director A said s/he would send all the documentation to Surveyor. In addition Surveyor requested documentation of all grievances since July 2023, all disciplinary actions involving Caregiver R and Tenant 4's call light logs.

Director A provided the requested documentation on 11/02/2023, 11/06/2023 and 11/10/2023. Surveyor noted the following timeline between April - August 2023:

04/12 - Grievance from Tenant 5: alleged on 03/29 and 04/10 during 3rd shift, staff refused to take Tenant 4 to the bathroom because s/he had gone enough. During the 04/10 incident a caregiver physically took Tenant 4's call light away. Requested resolution: fire the staff or not allow them to care for Tenant 4. Director A's written response dated 04/13, "...I have investigated and spoke with the staff working on 03/29 & 4/10...They were told they are not to be

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{U 131}	Continued From page 25 taking pendants away from residents and they will address residents needs on a timely manner no matter what time it is." 04/18 - Verbal counseling form for Caregiver R: on 04/15, hospice staff called repeatedly during 3rd shift and no one answered. Hospice responded onsite, searched for staff and found Caregiver R sleeping. On 04/18 Lead Caregiver A discovered Caregiver R and another staff laying in the day room with no lights on and appeared to be sleeping. "Corrective Plan of Action: first and final written warning if this is observed or seen again, it will result in immediate termination." Signed by Director A and Caregiver R 04/18 06/23 - Grievance from Tenant 5: alleged Caregiver R again refused to provide requested toileting assistance to Tenant 4 during night shift. Director A's written response was dated more than a month later on 07/26 and read, ""I have investigated and spoke with [Caregiver R] on this matter. [Caregiver R] will no longer be providing cares for [Tenant 4] or coming into your apartment except to pass medications or unforeseen circumstances per the agreement that you and I discussed on 6/24/2023." 06/24 - Verbal counseling form for Caregiver R: incident 6/23, "Arguing (with) Resident about spouses cares, shouting at one another...Spoke (with) [Caregiver R] on how to speak to Residents reiterated that @ no time do we ever raise our voices to a resident or argue (with) them." [sic - all]. Employee warning notice for Caregiver R: incident 06/23, "[Caregiver R] will not argue with resident, [s/he] will only assist in passing medications to [Tenant 4] unless [Tenant 4] requests [his/her] assistance & [Tenant 5] agrees...No arguing or yelling at any Resident." Signed by Director A and Caregiver R on 07/13 (20 days after the incident.)	{U 131}		

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{U 131}	Continued From page 26 07/24-08/05 - Call logs for Tenant 4. Tenant 2 typically called twice for toileting assistance during 3rd shift. S/he experienced the following wait times: 42 minutes beginning at 4:01 AM on 07/24, 82 minutes beginning 4:34 AM on 07/28 and 69 minutes beginning at 5:01 AM on 08/05. Director A wrote a note explaining the 82 minute wait, "1 staff...in with another Resident showering. [Caregiver R] not to assist [Tenant 4] per [Tenant 5]'s request." 08/08 - Grievance Complaint Form from Tenant 10's family, "Resident wet in morning, bed soaked, Dentures on Floor.." 08/08 - Caregiver R terminated for "arguing with [Tenant 11]...yelling at [Tenant 11] that [s/he] didn't have time to do things [his/her] way, [s/he] was screaming at [Tenant 11] telling [him/her] this is why no one wants to help get you up in the morning. On 11/13/2023 at 2:00 PM, Surveyor conducted a follow up interview with Administrator A (Director of Operations I was also present.). Director A did not dispute the aforementioned timeline and confirmed the following: Contrary to what s/he stated on 11/02/2023, s/he did receive an allegation Caregiver R took Tenant 4's call pendant on 04/10/2023. As of 07/23/2023 Director A determined there had not been "significant gains" in the way Caregiver R spoke to tenants and told Caregiver R if it did not improve his/her employment would be terminated. Director A said confirmed Tenant 4 sometimes experienced long wait times because Caregiver R was not allowed to provide him/her care and only 2 staff are scheduled during 3rd shift. Director A did not did not describe arrangements to make sure other staff were available to meet Tenant 4's	{U 131}		

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{U 131}	Continued From page 27 needs. On 08/08/2023 Caregiver R was fired due to the care concerns with Tenant 10 documented on the 08/08/2023 grievance form and for yelling at Tenant 11. On 11/13/2023 at 4:45 PM, Surveyor conducted an interview with Director of Operations I. S/he stated their company's policy is for the director to inform the corporate office of grievances within 24 hours. Director of Operations I said Director A did not follow that policy and the corporate office only became aware of the aforementioned concerns during the course of the survey. Director of Operations I stated they would be addressing the concerns with Director A. On 11/21/2023, Licensee G sent an email to Surveyor that read, "[Director A]'s employment was terminated with us yesterday...we have a new Executive Director starting today that will help spearhead the areas of improvement that are necessary." Cross Reference: U0117 DHS 89.23(2)(a)2b Services U0118 DHS 89.23(2)(a)2c Services U0188 DHS 89.27(4) Service Agreement U0272 DHS 89.35(4) Grievances	{U 131}		
{U 188}	89.27(4) SERVICE AGREEMENT REVIEW AND UPDATE. The service agreement shall be reviewed when there is a change in the comprehensive assessment or at the request of the facility or at the request or on behalf of the tenant and shall be updated as mutually agreed to by all	{U 188}		

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{U 188}	Continued From page 28	{U 188}		

parties to the agreement.
This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure the service agreement was reviewed and revised when there was a request on behalf of Tenant 4 to change medication management services.

This is a repeat deficiency. See SOD N3L511, dated 03/02/2023.

Findings include:

The department received 2 complaints about the provider's medication management services.

Surveyor reviewed Tenant 4's service plan signed upon admission on 12/16/2022. Tenant 4 shared an apartment with Tenant 5 (spouse) and the service agreement identified charges of $1000/month for medication management and meals.

On 11/22/2023 at approximately 2:00 PM, Surveyor interviewed Family T. S/he explained beginning in March 2023, s/he requested a change in medication management services to allow for him/her to pick up and deliver Tenant 4's medications from the pharmacy of his/her choice, which cost Tenant 4 less money. Family T said after the change there was no written agreement, change to the service plan or system implemented for checking the medications in when s/he delivered them. Family T just left them with whoever was working. Family T said at the end of May and again at the end of June, s/he was contacted by staff to report the medications were about to run out. On both occasions, Family T said there should have been enough medications to last based on what s/he delivered.

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{U 188}	Continued From page 29 Family T explained there were then 2 incidents that brought the situation to head. First, at the end of June, Tenant 4 ran out of medications and missed doses. Family T had to file a police report in order for the pharmacy to refill the medications early. Second, on 07/11/2023, Tenant 4 was discharged back to the facility after a hospital stay at approximately 4:00 PM. Director A informed Family T effective immediately, the provider would no longer administer medications that were delivered from Family T because there was no way to track the chain of custody. Family T said it was impossible for him/her to administer all of Tenant 4's medications because s/he lives more than 45 minutes away. The evening of 07/11/2023, Family T had to leave multiple 8:00 PM medications with Tenant 5 to administer. Family B also said Tenant 4 was prescribed an antibiotic when discharged from the hospital, but Director A would not agree to administer that either because it was in a bottle and not blister packaged in a medication card. Family B said at that point s/he just agreed to switch to the provider's preferred pharmacy. On 11/22/2023, Surveyor reviewed Tenant 4's observation notes and medication administration records specific to the June and July 2023 incidents described by Family T. 06/28 - 8:00 PM dose of Vitamin C not administered with note from Mediation Passer M, "I just took the last vitamin c pill. other medications is done tomorrow 6/28." [sic - all] 06/29 - the following medications were not administered or administered late: 4:00 PM dose of carbidopa/levodopa - "not in	{U 188}		

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cart waiting for refill"
5:00 PM dose of donepezil - "not in cart waiting for refill"
8:00 PM doses of Eliquis, montelukast, methenamine, vitamin c, carbidopa/levodopa, ezetimibe, atrovastin, tamsulosin and memantine - "not in cart waiting for refill"
8:00 PM dose of clonazepam - administered 10:00 PM after Family T brought in an "emergency refill"

07/11 -
8:00 PM doses of Eliquis, montelukast, Methenamine, vitamin c, carbidopa/levodopa, ezetimibe, atrovastin, tamsulosin, clonazepam and memantine - not administered
8:00 PM dose of a newly prescribed antibiotic, levetiracetam (500mg 1 tablet 2x daily for 7 days) - not administered.
Corresponding observation note: 4:15 PM by Director A, "Resident returned to the facility from hospital...with a new medication that was entered into ECP when delivered. Spoke with [Family T] about changing to (provider's preferred pharmacy)...so we are not breaking the chain of custody...[Family T] took evening meds to give to [Tenant 4]. Attempted to reach [Registered Nurse C] on administering meds for the rest of the month but unable to reach [him/her]..."

On 11/02/2023 at 3:10 PM, Surveyor interviewed Director A. S/he confirmed the provider entered into a verbal agreement to adjust medication management services to allow Tenant 4 to use his/her preferred pharmacy. Director A said Family T brought medication refills in late which caused problems. Director A said s/he did not implement a process for staff to document when Family T delivered medications in order to account for the supply. S/he also confirmed on

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{U 188}	Continued From page 31 07/11/2023 s/he informed Family T that starting immediately they would no longer administer any medications that had been or would be brought in by family and also would not administer the newly antibiotic prescribed at hospital discharge. Director A said s/he was instructed to do this by RN C "We asked the family to give (the) meds while we got it straightened out." Director A said the next day s/he learned there was "confusion between what nurse thought was going on and what was actually going on." RN C thought all medications were being delivered in bottles and didn't know all medications but the new antibiotic were unit dosed. S/he stated on 07/12/2023, the provider resumed medication administration services. Cross Reference: U0117 DHS 89.23(2)(a)2b Services U0118 DHS 89.23(2)(a)2c Services U0131 DHS 89.23(4)(b)1 Services U0272 DHS 89.35(4) Grievances	{U 188}		
U 200	89.28(2)(a)1. RISK AGREEMENT (2) CONTENT. A risk agreement shall identify and state all of the following: (a) Risk to tenants. 1. Any situation or condition which is or should be known to the facility which involves a course of action taken or desired to be taken by the tenant contrary to the practice or advise of the facility and which could put the tenant at risk of harm or injury.	U 200		

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This Rule is not met as evidenced by:
Based on record review and staff interview, the provider did not develop a risk agreement that identifies a condition which is known to the facility that puts the tenants at risk. Tenant 1 had a history of falls that were not addressed in order to prevent harm or injury to the Tenant.

Findings include:

On 11/02/2023 at 10:15 AM, Surveyor reviewed Tenant 1's closed medical record.

Tenant 1 was admitted to the facility on 12/07/2022 with diagnoses to include diabetes. Tenant 1's undated ISP (Individual Service Plan) documented the tenant was independent with ADLs, assessed to be at high risk for falls and had more than 1 fall in the last 3 months. Tenant 1 had sixteen unwitnessed falls in her/his bedroom on the following dates and times:

*04/13/2023 at 4:26 PM
*05/03/2023 at 5:14 PM, which resulted in a bruise on her/his lower back. Tenant 1 also complained about pain in her/his ribs from a previous fall.
*05/04/2023 at 2:45 PM
*05/04/2023 at 9:15 PM
*05/12/2023 at 1:33 PM, which resulted in pain "From [her/his] broken ribs from a prior fall."
*06/06/2023 at 8:48 PM
*06/07/2023 at 4:10 PM
*06/07/2023 at 9:37 PM
*06/09/2023 at 7:49 PM
*06/10/2023 at 5:45 PM
*06/11/2023 at 10:02 PM
*06/14/2023 at 8:53 PM

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U 200	Continued From page 33 *06/15/2023 at 11:30 PM *06/23/2023 at 12:30 AM *06/27/2023 at 12:02 AM *06/28/2023 at 9:45 PM Surveyor found no record of Tenant 1 entering into a risk agreement with the provider for addressing the falls. Tenant 1's record did not contain a risk agreement to identify a course of action for the facility to take for both Tenant 1's protection and the facility's. There was no information provided by Executive Director A to show a risk agreement had been identified addressing the risk of falls had by Tenant 1. On 11/02/2023 at 1:40 PM, Executive Director A confirmed Tenant 1 did not have a risk agreement for falls.	U 200		
U 237	89.29(3)(b) ADMISSION & RETENTION OF TENANTS (3) TERMINATION OF CONTRACT. (b) Supplemental services as an alternative to termination. A residential care apartment complex shall not terminate its contract with a tenant for a reson under par. (a) 1. to 3. if the tenant arranges for the needed services from another provider consistent with s.HFS 89.24(2)(b) and any unmet needs or disputes regarding potentially unsafe situations are documented in a risk agreement. This Rule is not met as evidenced by:	U 237		

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U 237	Continued From page 34 Based on record review and interview, the provider did not ensure a Tenant's contract was not terminated if the tenant arranged for the needed services from another provider. Tenant 2 was issued a 30-day notice to terminate his/her placement from the Residential Care Apartment Complex (RCAC) due to a PICC (Peripherally inserted Central Catheter) line requiring care, when Tenant 2 arranged for the needed nursing services for the PICC line from another provider. The provider did not allow Tenant 2 to contract for the additional nursing services, as an alternative to termination. Additionally, the provider did not complete a risk agreement to reflect safety concerns, disputes or any unmet needs related to the PICC line. Findings include: Per Mayo Clinic website https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748 dated 06/06/2023 indicated, "A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart...It's generally used to give medications or liquid nutrition...A PICC line is commonly recommended for: ...Liquid nutrition (total parenteral nutrition). If your body can't process nutrients from food because of digestive system problems, you may need a PICC line for receiving liquid nutrition...PICC line care. A nurse or other provider will show you how to care for your PICC line. This might involve checking the area daily for signs of infection and flushing the line with solution weekly to keep it clear from clogs. It's easier if you have someone to help you with PICC line care. If you need help, you might consider	U 237		

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hiring a home health care provider..."

On 11/06/2023, Surveyor reviewed Tenant 2's closed medical record. The record indicated the tenant was admitted to the facility on 02/18/2019 with diagnoses of atrial fibrillation, asthma and hypothyroidism. Tenant 2's ISP (Individual Service Plan) dated 02/27/2023, documented s/he required assistance with showers and utilized a four wheeled walker for ambulation. Additionally, the ISP indicated Tenant 2 was independent with toileting needs, transfers, positioning, dressing, grooming, oral cares and evacuation.

Review of Tenant 2's Hospital Discharge Summary report, located within the medical record and dated 04/25/2023 indicated, Tenant 2 was admitted to the hospital on 04/13/2023 and discharged on 04/25/2023 with diagnoses to include Cronkhite-Canada Syndrome (a rare syndrome characterized by multiple polyps of the digestive tract), malnutrition, and hypotension. The report stated, "...[Tenant 2] with medical history significant for Cronkhite-Canada syndrome...was admitted to the hospital for initiation of TPN (total parenteral nutrition). [Tenant 2] Is followed by GI as outpatient for [his/her] feeds and was started on prednisone, isotonic oral formula post [his/her] diagnosis with Cronkhite-Canada syndrome. Unfortunately, [Tenant 2] has failed outpatient treatment given significant weight loss and hypotension. [Tenant 2] is directly admitted from GI clinic for initiation of TPN. PICC line placed on 4/13 for TPN...Discharge Disposition: Home with private RN.

Review of Tenant 2's Hospital "Transition Planning" note dated 04/25/2023 and written by

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Hospital Case Manager E indicated, "Return home with home health RN and TPN teaching and infusion for TPN. Family arranged private caregivers for doing tenant's TPN daily...[Tenant 2] was discharged around 2 PM today. Many clarifications, prescription issues with Aster related to new meds, and meds that the discharge summary said were changes. Worked with [Lead RA (Resident Assistant)-B] to provide what the Aster required after the fact. Spoke with [Lead RA-B] and faxed information to [Lead RA-B] late this afternoon. Encouraged [Lead RA-B] to call me if they need anything further."

On 11/02/2023 Surveyor reviewed Tenant 2's observation notes which revealed the following:

*04/25/2023- "Nurse Called with update on resident. [S/he] will be returning today 4/25/2023..."

*04/27/2023- "[Lead RA-B] and [Facility RN (Registered Nurse)-C] went to see resident and [his/her] family in apartment. Family present said that [Tenant 2's family] coordinated with [Hospital Case Manager-E] the discharge planner at Marshfield Medical Center and spoke to "Aster" who told [Tenant 2's family] that coming back with a feeding tube was ok as long as we didn't hang the feedings. [Facility RN-C] informed them that having spoken to [Licensee F] and [President G] to confirm, that it is not within the scope of our state license as an RCAC to allow a PICC line in the facility. Options discussed but they stated that they were "blind-sided." [Tenant 2] said [s/he] will not go to rehab for a brief period as family said, "We don't even know if this will work yet" and [Tenant 2] said if the tube comes out, [s/he] would have to go on hospice as [s/he] will never be able to eat again ..." ***The above entry

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ASTER ASSISTED LIVING OF MARSHFIELD	305 SOUTH CHESTNUT AVE MARSHFIELD, WI 54449

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U 237	Continued From page 37 was written by [Facility RN-C] *04/29/2023- "Staff delivered the Emergency Eviction notice at 10:05 AM. [Facility RN-C] was on speaker phone during conversation..." On 04/29/2023, Tenant 2 received a discharge notice from the provider which indicated the following: "RE: Emergency Eviction Notice...Upon your return to the facility on 04/25/2023 it was discovered that you had a medical procedure an implanted PICC line requiring ongoing treatment that we're unable to provide care for and furthermore, rendering the staff unable to provide assisted living to you...Since the provider is no longer an appropriate facility to keep you safe and cared for, this is an immediate threat to your health and safety. With that in mind, we are forced to present you with this emergency eviction requiring you to vacate the community immediately..." On 05/02/2023, Tenant 2 received a letter from the provider indicating, "This letter serves as a notice that Aster Assisted Living in Marshfield is rescinding the Emergency Eviction notice issued on 04/29/2023." On 05/02/2023, the provider issued Tenant 2 a 30-day discharge notice which indicated, "RE: Eviction Notice ...At this time, Aster Assisted Living of Marshfield can no longer provide the level of care that you require. Please know that we enjoyed having you as a resident of Assisted Living of Marshfield. It is with sadness that I present to you a 30-day notice to find placement at a facility that can provide the care that you need. We ask that you and your family find a new placement for you by June 1, 2023..." Surveyor noted Tenant 2 was discharged from the facility on 5/30/2023.	U 237		

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U 237	Continued From page 38 On 11/06/2023 at 9:50 AM, Surveyor interviewed Hospital Case Manager E regarding Tenant 2. Hospital Case Manager E stated, "I talked and discussed [Tenant 2's] case with [Lead RA-B] when [Tenant 2] was hospitalized from 4/13/23-4/25/23. [Lead RA-B] indicated [Tenant 2] was allowed back at the facility with a PICC line and TPN if outside services were set up." Hospital Case Manager E went on to say, "We had to wait to discharge [Tenant 2] from the hospital, even though [s/he] was medically ready, until we could get a private nurse set up. [Tenant 2's] family had home health all set up along with a private hired nurse prior to hospital discharge to care for [Tenant 2's] PICC line and TPN. Hospital Case Manager E then stated, "[Tenant 2] was doing well at discharge. [S/he] was independent with ambulation and all ADL's...No one from the facility ever came to the hospital to assess [him/her]." On 11/02/2023 at 9 AM, Surveyor interviewed Tenant 2's Family Member. Family Member D indicated Tenant 2 was hospitalized from 04/13/2023 through 04/25/2023 due to Cronkhite-Canada Syndrome. Family Member D indicated during the hospital stay a PICC line was placed to allow for TPN because Tenant 2 was unable to tolerate food by mouth. Family Member D stated, "[Hospital Case Manager E] talked to [Lead RA-B] to explain [Tenant 2's] situation. [Lead RA-B] said [Tenant 2] could come back to the facility if we had arranged for additional contracted services for the PICC line and TPN. We were happy to make the arrangements with outside professional nursing care service providers to provide services, which began upon [Tenant 2's] release from the hospital on 04/25/23. [Lead RA-B] was aware we had the	U 237		

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additional services all set up with a home health agency to begin immediately. The outside provider we hired was coming twice a day to take care of the PICC line, set up and start the TPN and disconnect the TPN. [Tenant 2] was back at the facility receiving these services from the outside provider for a few days, when [Facility RN-C] showed up in [Tenant 2's] apartment and announced that [Tenant 2] had to leave the facility. [Facility RN-C] said [s/he] would be the only person in the company who could approve [Tenant 2] staying after the PICC line procedure and [s/he] did not give approval. [Facility RN-C] said that the facility would lose their license if [Tenant 2] lived there. [Facility RN-C] said [Tenant 2] needed to find a new place to live immediately." Family Member D went on to say, "Home health had been coming to the apartment for multiple days when [Tenant 2] received the emergency eviction notice on 4/29/23. Then on 5/2/2023, the emergency eviction was withdrawn, and a 30-day discharge notice was issued. I asked [Facility RN-C] if [Tenant 2] could do a risk agreement for the PICC line and TPN, but [Facility RN-C] told us "NO" because this was not the kind of situation for a risk agreement." Family Member D indicated Tenant 2 was "very upset" [s/he] had to find a new place to live and leave [his/her] significant other who was living in the same apartment with [him/her]. Family Member D stated, "We were going crazy trying to find a new place for [Tenant 2] to live...[Tenant 2] did move out and later passed away...We believe this discharge was all so upsetting to [Tenant 2] and contributed to [his/her] downfall."

On 11/02/2023 at 12:30 PM, Executive Director A indicated Tenant 2 had been issued a 30-day discharge notice "Sometime in May 2023." Surveyor asked about the provider's reasoning for

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the discharge notice. Executive Director A stated, "We could not meet [Tenant 2's] care needs for the PICC line and TPN." Executive Director A went on to say, "[Facility RN-C] did not want to be responsible for the PICC line and cares because [s/he] was not here to do it." Executive Director A verified Tenant 2 was receiving services in the facility from a home health agency related to the PICC line and TPN. Surveyor then asked Executive Director A if Tenant 2 was provided a risk agreement for potential unsafe conditions or unmet needs related to the PICC line or TPN. Executive Director A confirmed no risk agreements were completed or found for Tenant 2. No information was provided by Executive Director A to show a risk agreement had been identified addressing the risks, disputes or potential unsafe conditions related to Tenant 2's PICC line.

On 11/07/2023 at 4:10 PM, Surveyor interviewed Lead RA-B regarding Tenant 2's discharge notice issued on 5/2/23. Lead RA-B stated, "The 30-day discharge notice was given because [Tenant 2] was hospitalized and returned with a PICC line, and our staff were not capable or trained to care for the PICC line." Lead RA-B recalls Tenant 2 had an outside home health agency coming into the facility to provide the needed cares for the PICC line and TPN. Lead RA-B then stated, "Facility staff were instructed not to do anything with [Tenant 2's] PICC line or TPN, due to the potential risks and not having a RN onsite." Surveyor then asked Lead RA-B if Tenant 2 was provided a risk agreement for potential unsafe conditions or unmet needs related to the PICC line or TPN. Lead RA-B stated no risk agreement was discussed. Lead RA-B confirmed facility staff did not care for Tenant 2's PICC line or TPN from 4/25/23 until discharge on 5/30/23.

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U 237	Continued From page 41 On 11/07/2023 at 4:25 PM, Surveyor interviewed Facility RN-C regarding Tenant 2's discharge notice issued on 5/2/23. Facility RN-C stated, "[Tenant 2] was given the 30-day discharge notice because [s/he] had a PICC line and we cannot have a PICC line in the facility. Staff can't care for it and the PICC line was a safety concern...The PICC line was an indwelling, implanted device and I couldn't guarantee [Tenant 2's] safety." Surveyor questioned Facility RN-C if [Tenant 2] was provided/offered a risk agreement. Facility RN-C stated, "NO." Surveyor then asked what options were given to Tenant 2 as an alternative to discharge. Facility RN-C stated, "[Tenant 2's] options were to either remove the PICC line because it was against company policy to have one or relocate to another facility." Surveyor then asked for the company policy Facility RN-C was referring to. Facility RN-C stated, "We don't have an actual policy on what we don't allow. I was just using my clinical RN knowledge that [Tenant 2] should be in a facility with skilled care...I went by protecting the license of the facility when making the decision to issue [Tenant 2] the discharge notice." Facility RN-C confirmed Tenant 2 had home health coming in to provide the needed nursing services for the tenant's PICC line and TPN needs. Facility RN-C stated, "Staff never touched the PICC line or did anything with the TPN." On 11/22/2023, Surveyors sent President G and Director of Operations I an email requesting any additional information regarding Tenant 2's 30-day notice to terminate his/her placement from the RCAC by the end of the day. No additional information was received. No documentation or evidence was found in	U 237		

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U 237	Continued From page 42 Tenant 2's record to indicate supplemental services were allowed or discussed with the tenant as an alternative to termination. Additionally, Surveyor found no record of Tenant 2 entering into a risk agreement with the provider for addressing the PICC line and TPN to identify a course of action for the facility to take for both Tenant 2's protection and the provider's. In conclusion, Tenant 2's contract was terminated without being allowed the opportunity to provide supplemental services as an alternative to termination and/or being provided a risk agreement for any unmet needs or disputes regarding potentially unsafe situations.	U 237		
{U 272}	89.35(3) GRIEVANCES Written Summary. (3) The residential care apartment complex shall provide a written summary of the grievance, findings, conclusions and any action taken as a result of the grievance to the tenant, the tenant's designated representative, if any, and, for tenants whose services are funded under s. 46.277, Stats., the county department or aging unit designated to administer the medical assistance waiver. This Rule is not met as evidenced by: Based on record review and interview the provider did not provide a written summary of a grievance, findings, conclusions and any action taken as the result of a grievance filed by Home Health Worker H on behalf of Tenant 4.	{U 272}		

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{U 272}	Continued From page 43 This is a repeat deficiency. See Statement of Deficiency (SOD) N3L511, dated 03/02/2023. Findings include: On 11/09/2023 at 11:12 AM, Surveyor interviewed Home Health Worker (HHW) H. S/he said Tenant 6 has a catheter and described ongoing concerns about the unsanitary care of the urine drainage bags. HHW H said staff frequently do not close the valve causing urine to leak on the carpet or in the recliner. S/he explained it is unsanitary for urine to be on the carpet, but also for the open valve of the bag to touch the floor where germs could enter the bag and then enter the tubing. HHW H said s/he routinely communicated the concerns to the family who then tried to resolve with the provider. One of the provider's interventions was to place a bucket next to the bed for the night bag to be put in. The bucket also has a bright pink note instructing staff to put the bag in it at night. HHW H also described an incident of concern Sunday morning 10/22/2023, when s/he arrived to find Tenant 6's day bag laying in the shower, full of urine and immediately next to feces on the shower floor. HHW H said s/he was very concerned about the unsanitary conditions and risk of infection. HHW H said Tenant 6 already had an active urinary tract infection at the time of this incident. HHW H stated s/he took a photo of the urine drainage, sent it to Tenant 6's family and also complained to Lead Caregiver B on 10/23/2023. HHW H showed Lead Caregiver B the photo and expressed concerns about the risk of infection. HHW H texted Surveyor the photo of the bag in the shower and Surveyor noted it was consistent with his/her description.	{U 272}		

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{U 272}	Continued From page 44 HHW H said s/he did not receive any sort of response to the complaint and the concerns continued. On 11/02/2023 s/he discovered Tenant 6 in bed and the night urine drainage bag was laying flat on the floor, directly next to the bucket it was supposed to be in. HHW H said s/he texted Director A to inform him/her of the concern. The first text read, "[Tenant 6]'s over night was put in the container." Director A replied, "Great to hear." HHW H realized s/he made a mistake in the text and immediately sent a correction, "was not sorry." Director A did not respond. On 11/03/2023 HHW H again arrived in the morning and found Tenant 6 in bed and the night bag laying on the carpet directly next to the bucket. At 7:41 AM s/he texted Director A about the concern and wrote, "Again not in the bucket" and included a photo. As of the date of the interview (6 days later), Director A had not responded to the texts and HHW W said s/he was frustrated. HHW H texted Surveyor screen shots of the aforementioned text messages and photo and they were consistent with his/her description. On 11/13/2023 at 8:54 AM, HHW H informed Surveyor via text that s/he had not received a response from Director A from the concerns shared via text on 11/02 or 11/03. S/he also said that same morning 11/13, s/he arrived and again found the night urine drainage bag on the floor. Surveyor reviewed all written response to grievances for Tenant 6 (received 11/06/2023 from Director A.) There was one documented grievance filed 10/30/2023 by Family U. The grievance form was authored by Director A and read, "Cath bag left in shower urine in it...date of occurrence...10/21/23." The corresponding response dated 10/30/2023 read, "Thank you for bringing your concern to my attention. I have	{U 272}		

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{U 272}	Continued From page 45 investigated and spoken with staff on this matter. Staff has been retrained and will be doing proper cath cares...Sincerely, [Director A]" On 11/13/2023 at 2:00 PM, Surveyor interviewed Director A. S/he verified the grievance documentation s/he provided was filed by Family U regarding an incident on 10/21/2023. Surveyor asked if HHW H filed any grievances, including a grievance about an incident on 10/22/2023. Director A stated, "[HHW H] texts me every day letting me know whether the bag is in the bucket or not... [S/he] is letting me know if there's a problem with it. So we can continue to address it." Director A did not state written responses were given to HHW H in response to concerns reported on 10/23, 11/02 or 11/03/2023. Surveyor reviewed the provider's "GRIEVANCE/COMPLAINT POLICY" provided by Director A during the onsite visit on 11/02/2023. The policy read in part, "Residents and/or their families are encouraged to exercise their rights to voice or present a complaint, resolution, concern or suggestions addressing all areas of living... (they) shall be acknowledged and addressed in a timely and expeditious manner. DEFINITION: A grievance is a resident's family member's or team member's concern or request not met by the facility that may cause distress to the resident...The (facility) shall provide a written summary of the grievances, findings, conclusions and any action taken as a result of the grievance to the resident, and/or the resident's designated representative." Cross Reference: U0131 DHS 89.23(4)(b)1 Services	{U 272}		