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N 000	Initial Comments On 10/25/2023, with information obtained through 10/27/2023, the Bureau of Assisted Living, Southern Regional Office, conducted 2 complaint investigations at Victory Vision Community Living East, a community-based residential facility (CBRF) located in Waterloo, WI. As a result of the survey, 6 deficiencies were identified. One complaint was substantiated, one complaint was unsubstantiated. Census: 6	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 and Resident 2 received all prescribed medications in the dosages and at intervals prescribed by a practitioner. On 10/23/2023, Resident 1 did not receive his/her prescribed 4:00 p.m. ferrous sulfate tablet. From August - October 2023, Resident 2 received the incorrect insulin dosage on 22 occasions. On 1 occasion when his/her blood sugar level was	N 352		

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

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within parameters to receive an as needed (PRN) glucose chew, s/he did not receive it.

Findings include:

On 10/25/2023, Surveyor conducted a complaint investigation into concerns that staff were making errors in administering medications to residents.

Example 1 - Resident 1

On 10/25/2023, from approximately 8:53 - 9:50 a.m., Surveyor observed the medication cart with Supervisor A. Surveyor observed a medication card for Resident 1. The pharmacy label on the card indicated that it contained 28 ferrous sulfate 325 mg tablets, had a start date of 10/19/2023, and included instructions to, "Take one tablet by mouth three times daily with meals for supplement." The card had a typed label indicating that it was his/her 4:00 p.m. dose card. Five tablets were observed punched out of the card (spots #19, #20, #21, #22, and #24) with 23 tablets remaining, including for spot #23 (see Photo 1). Supervisor A confirmed that staff would've started on spot #19 due to the cycle start date and would punch out the number tablet corresponding with the date. Surveyor reported to Supervisor A that based on the card, it didn't seem like Resident 1 received 1 dose of his/her ferrous sulfate and that this was possibly on 10/23/2023 if staff were corresponding the days with the medication card numbers (due to spot #23 still being in the card). Supervisor A agreed but reported s/he wasn't sure why Resident 1 wouldn't have gotten his/her medication.

On 10/25/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 12/16/2020 with diagnoses including nutritional

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anemia. Surveyor reviewed Resident 1's October 2023 medication administration record (MAR) and observed that his/her 4:00 p.m. ferrous sulfate tablets were marked as administered daily from 10/19/2023 - 10/24/2023 (6 days of documented administration as opposed to the 5 tablets administered from the medication card observation).

At approximately 3:34 p.m., Surveyor interviewed Supervisor A. Supervisor A acknowledged that it seemed like a medication error and that s/he would follow up with staff.

On 10/27/2023, at approximately 12:05 p.m., Surveyor interviewed Licensee B. Licensee B acknowledged Surveyor's concern about the medication error and reported s/he would follow up with staff.

Example 2 - Resident 2

On 10/26/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 03/22/2021 with diagnoses including type I diabetes mellitus. Surveyor reviewed Resident 2's prescriptions, which included the following:

- (Breakfast and lunch) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject 1 unit for every 9 grams of carbs eaten at breakfast and lunch twice daily plus sliding scale: 0-150 = +0, 151-200 = +1, 201-250 = +2, 251-300 = +3, 301 - 350 = +4, 351 - 400 = +5 (Max = 50 units/day)." This order was active from 04/26/2023 - 10/23/2023, when a new order on 10/23/2023 changed the insulin-to-carb (ICR) ratio to be 1 unit for every 8 grams, plus the same sliding scale.

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- (Dinner) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject 1 unit per every 12 grams at dinner plus sliding scale: 0-150 = +0, 151-200 = +1, 201-250 = +2, 251-300 = +3, 301 - 350 = +4, 351 - 400 = +5 (Max = 50 units/day)." This order was active from 04/25/2023 - 10/11/2023, when a new order on 10/11/2023 changed the ICR ratio to be 1 unit for every 20 grams, plus the same sliding scale.

- (Bedtime) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject per correction scale once daily at bedtime: 0-200 = +0, 201-250 = +1, 251-300 = +2, 301-350 = +3, 351-400 = +4 (Max = 50 units/day)." This order was active since 04/26/2023.

With the doses above, there was an additional clarification to "Decrease by 2 units if activity occurs within 1-2 hours of mealtime in order to avoid hypoglycemia four times daily."

Additionally, Resident 2 had an order for TruePlus glucose chew tablets (start date: 07/07/2023) with instructions to, "Take 4 tablets every 15 minutes as needed for hypoglycemia may repeat in 15-20 minutes if blood sugar still <60 mg/dL."

Surveyor reviewed Resident 2's MARs from 08/01/2023 - 10/24/2023 and observed the following 20 discrepancies between his/her written prescription and what was administered:

- 08/07/2023 (bedtime): Blood sugar documented as 279 (within parameters for 2 units of sliding scale insulin), 1 unit documented as administered

- 08/11/2023 (dinner): Blood sugar documented as 57 (within parameters for his/her PRN glucose), glucose chew not documented as

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N 352	Continued From page 4 administered - 08/12/2023 (lunch): Blood sugar documented as 284 with 59 grams of carbs consumed (within parameters for 7 units of ICR insulin), 8 units of ICR insulin documented as administered - 08/21/2023 (lunch) Blood sugar documented as 151 (within parameters for 1 unit of sliding scale insulin), 1 unit of sliding scale insulin documented as administered - 09/07/2023 (breakfast): Blood sugar documented as 399 (within parameters for 5 sliding scale units of insulin), 4 units of sliding scale insulin documented as administered - 09/17/2023 (lunch): Blood sugar documented as 238, with 65 grams of carbs consumed (within parameters for 7 units of ICR insulin and 2 units of sliding scale insulin), 10 units of ICR insulin and 7 units of sliding scale insulin documented as administered - 09/17/2023 (bedtime): Blood sugar documented as 238 (within parameters for 1 unit of insulin), 2 units documented as administered - 09/26/2023 (breakfast): Blood sugar documented as 345 (within parameters for 4 units of sliding scale insulin), 0 units of sliding scale insulin documented as administered - 09/26/2023 (lunch): Blood sugar documented as 375 (within parameters for 5 units of sliding scale insulin), 0 units of sliding scale insulin documented as administered - 09/28/2023 (breakfast): Blood sugar documented as 355, with 91 grams of carbs	N 352		

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consumed (within parameters for 10 units of ICR insulin), 13 units of ICR insulin documented as administered

- 09/29/2023 (lunch): Blood sugar documented as 374, with 53 grams of carbs consumed (within parameters for 6 units of ICR insulin), 11 units of ICR insulin documented as administered

- 10/01/2023 (lunch): Blood sugar documented as 136 with 28 grams of carbs consumed (within parameters for 3 units of ICR insulin), 4 units of ICR insulin documented as administered

- 10/02/2023 (breakfast) Blood sugar documented as 187, with 78 grams of carbs consumed (within parameters for 9 units of ICR insulin and 1 unit of sliding scale insulin), 6 units of ICR insulin and 0 units of sliding scale insulin documented as administered

- 10/02/2023 (lunch): Blood sugar documented as 346, with 92 grams of carbs consumed (within parameters for 10 units of ICR insulin and 4 units of sliding scale insulin), 6 units of ICR insulin and 2 units of sliding scale insulin documented as administered

- 10/03/2023 (lunch): Blood sugar documented as 356 (within parameters for 5 units of sliding scale insulin), 6 units of sliding scale insulin documented as administered

- 10/04/2023 (lunch): Blood sugar documented as 174 (within parameters for 1 unit of sliding scale insulin), 0 units of sliding scale insulin documented as administered

- 10/05/2023 (breakfast): Blood sugar documented as 284, with 17 grams of carbs

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consumed (within parameters for 2 units of ICR insulin), 6 unit of ICR insulin documented as administered

- 10/09/2023 (bedtime): Blood sugar documented as 285 (within parameters for 2 units of insulin), 6 units documented as administered

- 10/13/2023 (lunch): Blood sugar documented as 54, with 54 grams of carbs consumed (within parameters for 6 units of ICR insulin and 0 units of sliding scale insulin), 5 units of ICR insulin documented as administered and 5 units of sliding scale insulin documented as administered. Resident 2's glucose chew was not documented as administered.

- 10/24/2023 (lunch): Blood sugar documented as 404, with 32 grams of carbs consumed (within parameters for 4 units of ICR insulin), 13 units of ICR insulin documented as administered

Additionally, Surveyor observed the following 3 occasions where staff documented decreasing Resident 2's administered insulin by 1 unit due to activity (as opposed to the 2 units as written in the order):

- 08/26/2023 (dinner): "decrease by 1"

- 09/05/2023 (breakfast): "decrease by 1"

- 10/12/2023 (lunch): "decreased by 1 due to medical"

On 10/27/2023, at approximately 8:29 a.m., Surveyor interviewed Supervisor A. Surveyor asked how staff know whether to decrease Resident 2's insulin units by 1 or 2 due to activity since his/her order states to decrease by 2 units.

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N 352	Continued From page 7 Surveyor also asked if that clarification was documented anywhere. Supervisor A provided Surveyor with a note from Resident 2's insulin prescriber for the insulin decrease but said nothing further. Surveyor reviewed the note, dated 04/07/2023, which documented, "Lyumjev prescription was updated with parameter to allow a decrease by 2 units for activity occurring within 1-2 hours of a meal." There was nothing documented about having staff decrease Resident 2's insulin units by 1 unit instead of 2. On 10/27/2023, at approximately 12:05 p.m., Surveyor interviewed Licensee B. Surveyor discussed the concerns with medication administration, especially with Resident 2's insulin administration and the errors observed. Licensee B acknowledged Surveyor's concern and said s/he would look further into it. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration N432 DHS 83.38(1)(g) Health Monitoring	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that the individual service plans (ISPs) for 3 of 3 residents were followed as written. Resident 3's room was not maintained in accordance with his/her ISP.	N 388		

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Resident 3 and 4's weights, which were documented as requiring to be taken weekly, contained 15 and 6 missing weeks of weight recording, respectively.

Resident 5's bath/shower documentation, which was required to be tracked per his/her ISP, was missing 13 applicable entries. His/her bowel movement monitoring, which was required to be tracked daily per his/her ISP, was missing 31 days of entries.

Findings include:

Example 1 - Resident 3's room

On 10/25/2023, Surveyor conducted a complaint investigation into concerns that residents' rooms were cluttered.

On 10/25/2023, at approximately 10:15 a.m., Surveyor interviewed Caregiver D. Caregiver D reported that Resident 3's room was known to be not clean.

On 10/25/2023, at approximately 11:23 a.m., Surveyor observed Resident 3's room with Supervisor A. The floor of his/her room was nearly completely covered with personal belongings and miscellaneous objects, including clothes, clothing hangers, baskets, electronic cords, books, and blankets (see Photos 2, 3, 4, and 5). There was only enough floor space for Surveyor to walk from Resident 3's doorway to the side of his/her bed. Surveyor was unable to access Resident 3's window, his/her closet, or the lower drawers on his/her black dresser due to the stacked floor clutter blocking those areas. Surveyor observed that Resident 3's window was

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open and observed dust and several dead insects within with windowsill (see Photo 6). Surveyor also observed that the air vent in Resident 3's bedroom appeared to have its lower half covered in thick dust (see Photo 7). While observing Resident 3's room, Supervisor A reported that s/he thought verbal prompts were provided by staff to encourage Resident 3 to clean his/her room. Surveyor asked if these prompts did or did not work. Supervisor A replied that s/he thought Resident 3 was usually pretty agreeable to cleaning his/her room.

On 10/25/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/04/2022 with diagnoses including autism and major depressive disorder, recurrent, with severe psychotic symptoms. Resident 3's ISP, last signed as reviewed on 01/19/2023, documented the following:

- Under the "Housekeeping" section: "Provide cue and reminders with upkeep of room Staff[sic] to document when needed if refuse[sic] or behavior or if no reminder is needed...Hang up clothes and not save paper." The task was set for a daily frequency.

- Under the "Laundry service" section: "Requires assistance with laundry tasks ...Needs reminders to fold put away clothes when laundry is done ...Staff to document when and if need assistance and if [s/he] needs help putting away clothes."

Surveyor reviewed Resident 3's observation notes from 08/01/2023 - 10/25/2023 but did not observe any documented refusals or behaviors noted by staff with regards to Resident 3's room cleaning.

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At approximately 1:10 p.m., Surveyor interviewed Supervisors A and C. Supervisor A confirmed that if there was any documentation of Resident 3 refusing for his/her room to be cleaned or having other behaviors related to his/her room cleaning, they would have been in the observation notes. Surveyor reported to Supervisor A that there didn't seem to be any such behaviors documented. Supervisor A reported that during the survey s/he began assisting Resident 3 with cleaning his/her room and that they were working on it together.

Example 2 - Vitals monitoring for Residents 3 and 4

On 10/25/2023, Surveyor conducted a complaint investigation into concerns that residents were not receiving the support and care they require and concerns of residents experiencing weight loss.

On 10/25/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/04/2022 with diagnoses including autism and major depressive disorder, recurrent, with severe psychotic symptoms. Resident 3's ISP, last signed as reviewed on 01/19/2023, documented the following:

- Under the "Weekly Vitals" heading: "Take their vitals weekly on specified day." The frequency was set for weekly on Mondays at 9:00 a.m. and a list of the vitals to be taken included weight.

Surveyor reviewed Resident 3's weight monitoring from 04/01/2023 - 10/25/2023, provided by Supervisor A, and observed the following 15 missing weeks of weights:

- 2nd week in April (from 04/10/2023 through

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04/16/2023)
- 3rd week in April (from 04/17/2023 through 04/23/2023)
- 1st week in May (from 05/01/2023 through 05/07/2023)
- 3rd week in May (from 05/22/2023 through 05/28/2023)
- 4th week in May / beginning of June (from 05/29/2023 through 06/04/2023)
- 1st full week in June (from 06/05/2023 through 06/11/2023)
- 3rd week in June (from 06/19/2023 through 06/25/2023)
- 1st week in July (from 07/03/2023 through 07/09/2023)
- 2nd week in July (from 07/10/2023 through 07/16/2023)
- 3rd week in July (from 07/17/2023 through 07/23/2023)
- 4th week in July / beginning of August (from 07/31/2023 through 08/06/2023)
- 2nd full week in August (from 08/14/2023 through 08/20/2023)
- 4th week of August / beginning of September (from 08/28/2023 through 10/03/2023)
- 1st full week in October (from 10/04/2023 through 10/10/2023)
- 2nd week in October (from 10/11/2023 through 10/17/2023)

On 10/25/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 12/16/2020 with diagnoses including nutritional anemia and profound intellectual disability. Resident 4's ISP, last signed as reviewed on 10/04/2023, documented the following:

- Under the "Weekly Vitals" heading: "Take their vitals weekly on specified day. Monday's[sic] before breakfast." The frequency was set for

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weekly on Mondays at 8:00 a.m. and a list of the vitals to be taken included weight.

Surveyor reviewed Resident 4's weight monitoring from 09/01/2023 - 10/25/2023, provided by Supervisor A, and observed the following 6 missing weeks of weights:

- 1st full week of September (from 09/04/2023 through 09/10/2023)
- 2nd week of September (from 09/11/2023 through 09/17/2023)
- 3rd week in September (from 09/18/2023 through 09/24/2023)
- 4th week in September (from 09/25/2023 through 10/01/2023)
- 2nd week in October (from 10/09/2023 through 10/15/2023)
- 3rd week in October (from 10/16/2023 through 10/22/2023)

On 10/25/2023, at approximately 12:55 p.m., Surveyor interviewed Supervisor A. Surveyor asked if Resident 3 or Resident 4 had medical conditions or concerns from their medical teams that warranted weight monitoring on a weekly basis or if the weekly frequency was just arbitrarily chosen by the provider. Supervisor A replied that s/he wasn't sure.

On 10/27/2023, at approximately 12:05 p.m., Surveyor interviewed Licensee B. Surveyor discussed the concern that weekly weight monitoring for Residents 3 and 4, as specified in their ISPs, did not seem to be happening. Licensee B stated, "I totally agree."

Example 3 - Cares documented for Resident 5

On 10/25/2023, Surveyor conducted a complaint

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investigation into concerns that residents were not receiving the support and care they require.

On 10/25/2023, at approximately 10:15 a.m., Surveyor interviewed Caregiver D. Caregiver D reported concerns that incontinence cares for Resident 5 were not being completed consistently. Caregiver D reported that s/he felt some staff were good about performing cares but others were not. Caregiver D reported on one recent occasion, on 10/18/2023 while working a shift at another home operated by the provider, s/he came to the house to pick up an extra gallon of milk and saw both staff, who were currently on shift, sitting in a car in the driveway of the home. Caregiver D reported that s/he walked around the inside of the home and confirmed that no other staff were present. Caregiver D reported that s/he saw Resident 5 sitting in the recliner in the living room, his/her wheelchair nearby with the cushion wet, and a wet spot on the floor near his/her wheelchair. Caregiver D reported that when s/he inspected further, s/he saw that Resident 5 was still wet sitting in his/her recliner. Caregiver D reported that because of these observations, s/he thought that staff had just left Resident 5 wet when they transferred him/her from his/her wheelchair to the recliner. Caregiver D confirmed with Surveyor that Resident 5 requires staff assistance to change his/her brief. Caregiver D reported s/he was in the home for approximately 5 total minutes with no staff on duty present in the home. Caregiver D reported that s/he discussed these concerns with Licensee B and that Licensee B reported s/he would handle it.

On 10/25/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 12/16/2020 with diagnoses including profound intellectual disability, urinary incontinence, and

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scoliosis. Resident 5's ISP, last signed as reviewed on 05/18/2023, documented the following:

- Under the "Bathing" heading: "Provide full assistance bathing/showering ...Staff to document showers, if two staff needed, if resident refuses ..." The frequency of Resident 5's bathing schedule was set for 3 days weekly.

- Under the "Bowel Movement Monitoring" heading: "Monitor and document their bowel movement." The frequency was set to daily.

Surveyor reviewed Resident 5's task administration record (TAR) from 09/01/2023 - 10/25/2023, where staff appeared to document Resident 5's bathing/showering and had his/her shower/bathing schedule set for Mondays, Wednesdays, and Fridays. While reviewing both Resident 5's observation notes for the same date range (where staff also sometimes appeared to document cares) and TAR, Surveyor observed the following, which included 13 missing entries:

- 09/01/2023 (Friday): "Partial" shower documented as provided
- 09/04/2023 (Monday): Shower refusal documented
- 09/06/2023 (Wednesday): Blank in the TAR, no shower entry in the observation notes
- 09/08/2023 (Friday): Bed bath documented as given
(One of 3 bath/shower entries missing for the week of 09/04/2023 - 09/10/2023)
- 09/11/2023 (Monday): Blank in the TAR, no shower entry in the observation notes
(One of 3 bath/shower entries missing for the week of 09/11/2023 - 09/17/2023)
- 09/18/2023 (Monday): Blank in the TAR, no

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shower entry in the observation notes
(One of 3 bath/shower entries missing for this week of 09/18/2023 - 09/24/2023)
- 09/25/2023 (Monday): Blank in the TAR, no shower entry in the observation notes
- 09/27/2023 (Wednesday): Blank in the TAR, no shower entry in the observation notes
- 09/29/2023 (Friday): Blank in the TAR, no shower entry in the observation notes
(Three of 3 bath/shower entries missing for the week of 09/25/2023 - 10/01/2023)
- 10/02/2023 (Monday): Blank in the TAR, no shower entry in the observation notes
- 10/04/2023 (Wednesday): Blank in the TAR, no shower entry in the observation notes
- 10/06/2023 (Friday): Blank in the TAR, no shower entry in the observation notes
(Three of 3 bath/shower entries missing for the week of 10/02/2023 - 10/08/2023)
- 10/09/2023 (Monday): Blank in the TAR, no shower entry in the observation notes
- 10/13/2023 (Friday): Blank in the TAR, no shower entry in the observation notes
(Two of 3 bath/shower entries missing for the week of 10/09/2023 - 10/15/2023)
- 10/18/2023 (Wednesday): Blank in the TAR, no shower entry in the observation notes
- 10/20/2023 (Friday): Blank in the TAR, no shower entry in the observation notes
(Two of 3 bath/shower entries missing for the week of 10/16/2023 - 10/22/2023)

Surveyor then reviewed Resident 5's task administration record (TAR) from 09/01/2023 - 10/25/2023, where staff appeared to document Resident 5's bowel movement monitoring. While reviewing both Resident 5's observation notes for the same date range (where staff also sometimes appeared to document cares) and TAR, Surveyor observed the following 31 missing days of entries:

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N 388	Continued From page 16 - 09/07/2023 - 09/18/2023 - 09/19/2023 - 09/21/2023 - 09/24/2023 - 09/25/2023 - 09/26/2023 - 09/27/2023 - 09/28/2023 - 09/29/2023 - 09/30/2023 - 10/01/2023 - 10/02/2023 - 10/03/2023 - 10/04/2023 - 10/05/2023 - 10/06/2023 - 10/07/2023 - 10/08/2023 - 10/09/2023 - 10/13/2023 - 10/14/2023 - 10/15/2023 - 10/17/2023 - 10/18/2023 - 10/19/2023 - 10/20/2023 - 10/21/2023 - 10/22/2023 - 10/23/2023 - 10/24/2023	N 388		
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	N 389		

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N 389	Continued From page 17 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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that the individual service plans (ISPs) for Residents 2 and 5 were updated to reflect their change in needs. Resident 2's ISP was not updated to include his/her catheter leg bag refusal and did not include strategies to ensure proper positioning of his/her urine bag. Resident 2 was hospitalized from 10/13/2023 - 10/23/2023 in part due to a urinary tract infection, and was observed during the survey on 10/25/2023 for almost 2 hours with his/her bag improperly positioned. Resident 5's ISP was not updated to include his/her hospice services. Findings include: On 10/25/2023, Surveyor conducted a complaint investigation into concerns that residents were not receiving the support and care they require. Example 1 - Resident 2's catheter	N 389		

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According to the Cleveland Clinic, "Always keep your urine bag below your bladder, which is at the level of your waist. This will prevent urine from flowing back into your bladder from the tubing and urine bag, which could cause an infection." Urine bags are also not recommended to be placed on the floor (Source: Cleveland Clinic, Urine drainage bag and leg bag care, December 03, 2020, https://my.clevelandclinic.org/health/articles/14832-urine-drainage-bag-and-leg-bag-care (retrieval date - November 01, 2023).).

On 10/25/2023, at approximately 8:23 a.m., Surveyor arrived onsite and observed Resident 2 eating breakfast at the kitchen counter while seated in his/her wheelchair. Resident 2 appeared to have a catheter, with the urine bag sitting in his/her lap (level with his/her waist). Surveyor continued observing Resident 2 and noted the following:

- At 8:43 a.m., Surveyor observed both Supervisor A and Caregiver D walk by Resident 2, who had his/her urine bag still sitting in his/her lap. Neither said anything indicating awareness of his/her catheter bag positioning. Caregiver D was observed standing in the kitchen area for a couple of minutes, within view of Resident 2, before attending to a task elsewhere.

- At 8:53 a.m., Surveyor observed Resident 2, still in the kitchen area with his/her urine bag sitting in his/her lap. Supervisor C was observed sitting approximately 5 feet away at the kitchen table, within view of Resident 2.

- At 9:14 a.m., Surveyor observed Resident 2, still in the kitchen area with his/her urine bag sitting in his/her lap. Supervisor A handed Resident 2 a

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cup of water but otherwise did not say anything indicating awareness of his/her catheter bag positioning.

- At 9:52 a.m., Surveyor observed Resident 2, still in the kitchen area with his/her urine bag sitting in his/her lap. Supervisor A, Supervisor C, and Caregiver D were all present in the kitchen area, none of whom said anything indicating awareness of his/her catheter bag positioning.

- At 10:00 a.m., Surveyor observed Resident 2's bag hanging from his/her wheelchair in a position lower than his/her waist to allow for adequate drainage. However, at 10:02 a.m., Surveyor observed the urine bag fall onto the floor, where it remained for approximately 2 minutes (see Photo 8). At this time 2 other residents, Resident 1, who was wandering around the kitchen, and Resident 5, who was propelling him/herself in his/her manual wheelchair, were also observed ambulating within the kitchen.

- At approximately 10:04 a.m., Surveyor observed Resident 2, still in the kitchen, with his/her urine bag back sitting in his/her lap. Caregiver D handed Resident 2 a cup of coffee but did not say anything indicating awareness of his/her catheter bag positioning.

On 10/25/2023, Surveyor observed Resident 2's record. Resident 2 was admitted to the provider on 03/21/2021 with diagnoses including type I diabetes mellitus, hemiplegia and hemiparesis status post cerebral infarction affecting his/her right dominate side, and history of urinary tract infection. Resident 2's ISP, last signed as reviewed on 01/31/2023, documented the following:

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- Under the "Catheter check" heading: " ...Change to leg bag in morning and night bag at night ..."

Surveyor observed an after-hospital care plan from Resident 2's recent hospitalization from 10/13/2023 - 10/23/2023. The report documented that Resident 2 was hospitalized due to diabetic ketoacidosis and a urinary tract infection.

On 10/25/2023, at approximately 3:12 p.m., Surveyor interviewed Supervisor A and Caregiver D. When asked why Resident 2 did not have his/her leg bag on that day, Supervisor A replied that Resident 2 didn't like to wear the leg bag due to a feeling of pulling that caused it to not be comfortable. Surveyor discussed the concern that for almost 2 hours that morning Resident 2's urine bag was improperly positioned in his/her lap, which would not allow for adequate urine drainage. Caregiver D reported that Resident 2 gives attitude when staff attempt to correct it. Upon Surveyor reporting that staff were not observed that morning attempting to correct Resident 2's catheter bag positioning, Caregiver D reported that s/he understood. Supervisor A acknowledged Surveyor's concern that Resident 2's ISP was not updated to include Resident 2's preference for his/her night urine bag (instead of his/her leg bag) or strategies to ensure appropriate positioning of the bag. Supervisor A reported s/he would look further into it.

Example 2 - Resident 5's hospice cares

On 10/25/2023, at approximately 9:10 a.m., Surveyor observed an outside person enter the home, wearing scrubs, and assist Resident 5 to the bathroom where s/he proceeded to shower him/her. Supervisor A reported to Surveyor that that was a hospice aide from Resident 5's

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N 389	Continued From page 21 hospice agency. On 10/25/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 12/16/2020 with diagnoses including profound intellectual disability, urinary incontinence, and scoliosis. Resident 5's ISP, last signed as reviewed on 05/18/2023, documented the following: - Under the "Bathing" heading: "Provide full assistance bathing/showering ...Staff to document showers, if two staff needed, if resident refuses ..." The frequency of Resident 5's bathing schedule was set for 3 days weekly. Surveyor did not observe any information about his/her hospice agency or hospice-related cares. At approximately 2:20 p.m., Surveyor interviewed Supervisor A. Supervisor A reported that Resident 5 had received hospice services for at least a couple of months. Supervisor A reported that an aide typically came once per week to shower Resident 5 and a nurse came in a different day to assess his/her health. Surveyor asked if the hospice showering was counted as part of Resident 5's 3 weekly showers, to which Supervisor A replied that they did. Supervisor A acknowledged Surveyor's report that Resident 5's hospice information was not part of his/her ISP.	N 389		
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	N 415		

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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 that at the time of medication administration, the person administering the medication documented the dosage of medication taken.

Resident 2's medication administration record (MAR), from 08/01/2023 - 10/24/2023, contained 30 missing entries with regards to his/her insulin administration.

Findings include:

On 10/26/2023, Surveyor observed Resident 2's record. Resident 2 was admitted to the provider on 03/21/2021 with diagnoses including type I diabetes mellitus. Surveyor reviewed Resident 2's prescriptions, which included the following:

- (Breakfast and lunch) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject 1 unit for every 9 grams of carbs eaten at breakfast and lunch twice daily plus sliding scale: 0-150 = +0, 151-200 = +1, 201-250 = +2, 251-300 = +3, 301 - 350 = +4, 351 - 400 = +5 (Max = 50 units/day)." This order was active from 04/26/2023 - 10/23/2023, when a new order on 10/23/2023 changed the insulin-to-carb (ICR)

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ratio to be 1 unit for every 8 grams, plus the same sliding scale.

- (Dinner) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject 1 unit per every 12 grams at dinner plus sliding scale: 0-150 = +0, 151-200 = +1, 201-250 = +2, 251-300 = +3, 301 - 350 = +4, 351 - 400 = +5 (Max = 50 units/day)." This order was active from 04/25/2023 - 10/11/2023, when a new order on 10/11/2023 changed the ICR ratio to be 1 unit for every 20 grams, plus the same sliding scale.

- (Bedtime) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject per correction scale once daily at bedtime: 0-200 = +0, 201-250 = +1, 251-300 = +2, 301-350 = +3, 351-400 = +4 (Max = 50 units/day)." This order was active since 04/26/2023.

With the doses above, there was an additional clarification to "Decrease by 2 units if activity occurs within 1-2 hours of mealtime in order to avoid hypoglycemia four times daily."

Surveyor reviewed Resident 2's MARs from 08/01/2023 - 10/24/2023 and observed the following 30 missing entries:

- 08/03/2023: Bedtime insulin
- 08/04/2023: Bedtime insulin
- 08/08/2023: Bedtime insulin
- 08/09/2023: Bedtime insulin
- 08/10/2023: Bedtime insulin
- 08/12/2023: Breakfast insulin, dinner insulin, and bedtime insulin
- 08/13/2023: Bedtime insulin
- 08/14/2023: Bedtime insulin
- 08/15/2023: Bedtime insulin
- 08/16/2023: Bedtime insulin

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N 415	Continued From page 24 - 08/17/2023: Bedtime insulin - 08/18/2023: Bedtime insulin - 08/20/2023: Bedtime insulin - 08/21/2023: Bedtime insulin - 08/22/2023: Bedtime insulin - 08/25/2023: Bedtime insulin - 08/26/2023: Bedtime insulin - 08/27/2023: Bedtime insulin - 09/02/2023: Bedtime insulin - 09/03/2023: Bedtime insulin - 09/05/2023: Bedtime insulin - 09/06/2023: Bedtime insulin - 09/18/2023: Breakfast insulin - 10/08/2023: Breakfast and dinner insulin - 10/10/2023: Dinner insulin - 10/11/2023: Bedtime insulin - 10/12/2023: Dinner insulin On 10/27/2023, at approximately 12:05 p.m., Surveyor interviewed Licensee B. Licensee B acknowledged Surveyor's concern that there were missing entries for Resident 2's insulin administration and reported s/he would look further into it. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N432 DHS 83.38(1)(g) Health Monitoring	N 415		
N 431	83.38(1)(g) Health monitoring. 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 arrange services adequate to meet the needs of the residents in all of the following areas: Health	N 431		

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monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the health of Residents 1, 2, and 3, was monitored.

There was no evidence in Resident 1's record of any follow up monitoring completed by staff when s/he was found to experience ankle swelling on 09/14/2023.

Between 08/01/2023 - 10/24/2023, staff did not document Resident 2's dinner carb consumption

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on 64 occasions, which his/her insulin-to-carb ratio utilized for determining the number of insulin units to be administered to him/her in accordance with his/her prescription. On 14 occasions, Resident 2's blood sugar exceeded the maximum value provided on the sliding scales for his/her insulin administration. Per provider staff and medical provider staff report, staff were expected to contact Resident 2's endocrinology clinic when his/her blood sugars were above 400 in order to receive further medical guidance, however, staff did not contact the clinic on 11 of the 14 occasions. Of these 11 occasions, staff appeared to administer the insulin dosage in accordance with the 351-400 blood sugar range but documented no other follow up blood sugar or symptom monitoring. Resident 2's blood sugar on these 11 occasions ranged from 410 - 547. On 09/19/2023, when Resident 2 had a documented blood sugar of 533 at 9:33 a.m. and 568 at 12:21 p.m., there was no evidence that staff contacted the clinic for further medical guidance until around 1:00 p.m. On 1 occasion where staff seemed to contact Resident 2's clinic on 10/09/2023 for further guidance (based on clinic staff report), the communication, which included a recommendation for Resident 2 to return to the emergency department, was not documented in Resident 2's record. Resident 2 required emergency medical treatment on 4 occasions from 09/19/2023 - 10/13/2023, 1 of which warranted intensive care unit treatment due to diabetic ketoacidosis and 1 of which required hospitalization.

There was no evidence in Resident 3's record of any follow up monitoring completed by staff when s/he reported a thigh/groin area rash on 08/22/2023 or when s/he complained of chest pain on 09/05/2023. Per staff interview, Resident

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N 431	Continued From page 27 3 had a known history of cardiac-related concerns. Findings include: Example 1 - Resident 1 On 10/25/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 12/16/2020 with diagnoses including profound intellectual disability. Resident 1's individual service plan (ISP), last signed as reviewed on 10/04/2023, documented the following: - Under the "Verbal Skills" section: "Has little verbal skills ...[S/he] will sometimes point at things [s/he] likes but cant[sic] always express pain or discomfort, [s/he] will try by pointing at head for headache ..." - Under the "Chronic Illnesses" section: "Staff to document any change in condition immediately, notify leadership so proper steps can be taken to ensure [s/he] is getting proper care, even if minor change ..." Surveyor reviewed Resident 1's observation notes from 08/01/2023 - 10/24/2023 and observed the following entry: - 09/14/2023 (7:15 p.m.): "When toileting resident and getting ready for bed [his/her] socks came off with jeans and staff seen[sic] that [his/her] ankles were starting to swell, retaining water type of swollen. Please monitor this closely and report any changes in size and document." Nothing further was documented in the observation notes about Resident 1's ankle swelling, including any description about the	N 431		

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swelling or follow up monitoring completed.

At approximately 3:15 p.m., Surveyor interviewed Supervisor A. Supervisor A confirmed s/he was not able to find any additional information about Resident 1's ankle swelling but reported that staff maybe knew more about it. Surveyor gave a deadline of 2:00 p.m. on 10/26/2023 to receive any additional information.

On 10/26/2023, at approximately 2:07 p.m., Supervisor A e-mailed Surveyor. The e-mail documented, "September 24th for [Resident 1] Staff[sic] was instructed to push fluids and elevate [Resident 1]'s legs, which was done and resolved the swelling, as when assessing on the next shift there was no swelling to report."

On 10/27/2023, at approximately 12:05 p.m., Surveyor interviewed Licensee B. Surveyor asked Licensee B how staff from the next shift would know to what degree Resident 1's ankles were swollen or if the swelling changed without any objective information or description of the swelling when it was first observed. Licensee B acknowledged Surveyor's question and reported that s/he understood the concern.

Example 2 - Resident 2

On 10/26/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 03/22/2021 with diagnoses including type I diabetes mellitus. Surveyor reviewed Resident 2's prescriptions, which included the following:

- (Breakfast and lunch) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject 1 unit for every 9 grams of carbs eaten at breakfast and lunch twice daily plus sliding scale: 0-150 =

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+0, 151-200 = +1, 201-250 = +2, 251-300 = +3, 301 - 350 = +4, 351 - 400 = +5 (Max = 50 units/day)." This order was active from 04/26/2023 - 10/23/2023, when a new order on 10/23/2023 changed the insulin-to-carb (ICR) ratio to be 1 unit for every 8 grams, plus the same sliding scale.

- (Dinner) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject 1 unit per every 12 grams at dinner plus sliding scale: 0-150 = +0, 151-200 = +1, 201-250 = +2, 251-300 = +3, 301 - 350 = +4, 351 - 400 = +5 (Max = 50 units/day)." This order was active from 04/25/2023 - 10/11/2023, when a new order on 10/11/2023 changed the ICR ratio to be 1 unit for every 20 grams, plus the same sliding scale.

- (Bedtime) Lyumjev KwikPen 100 units/mL injection with instructions to, "Inject per correction scale once daily at bedtime: 0-200 = +0, 201-250 = +1, 251-300 = +2, 301-350 = +3, 351-400 = +4 (Max = 50 units/day)." This order was active since 04/26/2023.

With the doses above, there was an additional clarification to "Decrease by 2 units if activity occurs within 1-2 hours of mealtime in order to avoid hypoglycemia four times daily."

Surveyor reviewed Resident 2's MARs from 08/01/2023 - 10/24/2023 and observed the following 64 occasions in which staff did not document Resident 2's dinner carb consumption, which his/her insulin-to-carb ratio utilized for determining the number of insulin units to be administered to him/her in accordance with his/her order above: 08/01/2023 through 08/11/2023, 08/14/2023, 08/15/2023, 08/17/2023, 08/19/2023 through 08/26/2023, 08/28/2023,

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N 431	Continued From page 30 08/30/2023, 08/31/2023, 09/01/2023 through 09/20/2023, 09/22/2023 through 09/29/2023, 10/01/2023 through 10/07/2023, 10/09/2023, 10/11/2023, 10/23/2023, and 10/24/2023. Surveyor observed that without the documentation of dinner carbs consumed by Resident 2, there was no way to verify whether Resident 2 received the correct amount of insulin in accordance with his/her order. In reviewing Resident 2's MARs, Surveyor also observed the following 14 occasions in which Resident 2's blood sugar exceeded the maximum value provided on the sliding scales for insulin administration: - 08/08/2023 (breakfast): Blood sugar of 476 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) - 08/13/2023 (breakfast): Blood sugar of 484 documented, 3 sliding scale units administered (5 units correlating to the blood sugar range of 351-400, minus 2 units due to documented activity) - 08/27/2023 (breakfast): Blood sugar of 547 documented, 7 sliding scale units administered (not within any prescribed scale) - 08/27/2023 (lunch): Blood sugar of 422 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400; continued high blood sugar from the previous meal) - 08/29/2023 (breakfast): Blood sugar of 410 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400)	N 431		

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N 431	Continued From page 31 - 09/11/2023 (breakfast): Blood sugar of 505 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) - 09/14/2023 (breakfast): Blood sugar of 522 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) - 09/14/2023 (lunch): Blood sugar of 466 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400; continued high blood sugar from the previous meal) - 09/19/2023 (breakfast): Blood sugar of 533 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) - 09/19/2023 (lunch): Blood sugar of 568 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) - 09/29/2023 (breakfast): Blood sugar of 522 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) - 10/04/2023 (breakfast): Blood sugar of 427 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) - 10/07/2023 (bedtime): Blood sugar of 488 documented, 5 sliding scale units administered (not within any prescribed scale) - 10/09/2023 (breakfast): Blood sugar of 491 documented, 5 sliding scale units administered (correlating to the blood sugar range of 351-400) Surveyor did not observe any additional notes in	N 431		

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Resident 2's record regarding the above occasions.

On 10/27/2023, at approximately 9:00 a.m., Surveyor interviewed Nurse H, who was from Resident 2's endocrinology clinic, which provided overall diabetes oversight/management for him/her. Nurse H reported s/he was familiar with Resident 2. Nurse H confirmed Surveyor's observation that Resident 2's insulin sliding scales maxed out at a blood sugar level of 400. Surveyor asked what the provider's staff should do when Resident 2's blood sugar exceeded 400. Nurse H reported that they should call the clinic for further guidance and also reported that staff had been told back on 07/31/2023 to do so. Nurse H reported that it was important staff call for further guidance because at elevated blood sugar levels Resident 2 could be at risk for diabetic ketoacidosis. Nurse H reported that medical provider staff may guide the provider's staff to administer more insulin or may provide a specific monitoring schedule to help provide guidance for any additional administration of unscheduled insulin units.

As part of the same interview, Surveyor asked if there were any communication notes showing the provider's staff reaching out to discuss specific instances or general concerns of Resident 2 having blood sugars above 400 since August 2023. Nurse H replied that there was one call from 09/19/2023 and one on 10/09/2023 but that s/he couldn't find evidence of any other contact from the provider. Surveyor observed that from the MAR Resident 2 was documented on 09/19/2023 as having blood sugars of 533 (breakfast, 9:04 a.m.) and 568 (lunch, 12:21 p.m.). Nurse H reported that staff did not reach out until approximately 1:00 p.m. 09/19/2023 and

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that s/he was the one who talked with them. Nurse H reported that over the course of that phone call, Resident 2's blood sugar appeared to be dropping and so s/he instructed staff to give him/her his/her standard correction insulin dose and call back. Nurse H reported that s/he never received any call back and so s/he called the provider at approximately 3:00 p.m. for an update on Resident 2. Nurse H replied that during that phone call, staff were instructed to send a blood sugar log of Resident 2's recent blood sugar levels, which could have been used to inform changes of his/her prescription or care recommendations. Nurse H reported that the blood sugar logs were not received. Nurse H reported that the clinic staff called the provider on 09/19/2023, 09/25/2023, and 09/28/2023 to continue to request Resident 2's recent blood sugar logs. Nurse H reported that the provider's staff finally sent the logs on 09/28/2023.

As part of the same interview, Nurse H reported that the contact from the provider on 10/09/2023 involved staff calling the clinic to let clinic staff know that Resident 2 was vomiting. Nurse H reported that staff said Resident 2 was just at the emergency department the previous day for blood sugar concerns. Nurse H reported that due to Resident 2 vomiting, staff were instructed to take Resident 2 back to the emergency department.

Surveyor again reviewed Resident 2's record and did not observe any information about this contact or any documentation indicating whether Resident 2 was taken to the emergency department on 10/09/2023. In reviewing Resident 2's record, Surveyor observed the following 4 occasions, per medical provider notes, in which Resident 2 required emergency department or hospital admission due to diabetes-related

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concerns:

- 09/19/2023 (evening): Resident 2 presented to the emergency department "with high glucose over 400" and had an admission diagnosis of hyperglycemia. While in the emergency department, Resident's blood glucose was 420 but s/he showed no other indicators of diabetic ketoacidosis. Resident 2 received intravenous saline and 8 units of insulin intravenously.

- 09/21/2023 (morning, approximately 2 days after last admission): Resident 2 presented to the emergency department from an emergency medical services transport "with complaint of hyperglycemia and vomiting." Resident 2 reported that s/he had been vomiting since approximately 4:00 a.m. Resident 2's blood glucose, taken in the emergency department at 8:01 a.m., was 702. Resident 2 was admitted to the intensive care unit in guarded condition with a diagnosis of diabetic ketoacidosis where s/he received continuous insulin infusion. The discharge summary documented, "Exact etiology of [diabetic ketoacidosis] is unknown but could be secondary to under dosing of insulin or possible dietary noncompliance."

- 10/08/2023 (morning): Resident 2 presented to the emergency department for hyperglycemia and vomiting. Resident 2 was diagnosed with hyperglycemia and was provided insulin.

- 10/13/2023 - 10/23/2023: Hospitalized with one of his/her admission diagnoses as diabetic ketoacidosis.

At approximately 9:45 a.m., Surveyor interviewed Supervisor A. Surveyor asked if the provider had any sort of protocols or procedures for when

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Resident 2's blood sugar level exceeded the maximum level (400) on his/her sliding scale. Supervisor A replied that when Resident 2's blood sugar exceeds 400 staff contact the endocrinology clinic. Surveyor asked if there was evidence Supervisor A could send of the clinic being notified for any of the above dates/times when Resident 2's blood sugar levels exceeded 400. Supervisor A replied that after investigating s/he learned that caregivers were not documenting the follow-ups they had with the clinic. Supervisor A reported after s/he spoke with the director they would be discussing blood sugar protocols and training staff in them.

As part of reviewing Resident 2's record, Surveyor observed e-mail communication between Licensee B, Resident 2's managed care organization (MCO) case managers, and Manager G. On 09/26/2023, at 9:22 a.m., Manager G e-mailed the group and reported, "I do feel my staff does a great job at managing [Resident 2]'s diabetes and blood sugars in general and we really have not had many issues with [him/her] going to the hospital due to blood sugars ..." Manager G also reported, "[Resident 2] has been getting the appropriate [insulin] dosing since [s/he] went to the emergency room ..." Surveyor noted that this e-mail communication was sent approximately 1 week after Resident 2 was admitted to the emergency department for hyperglycemia on 09/19/2023 and admitted to the intensive care unit for diabetic ketoacidosis on 09/21/2023. Surveyor also noted that despite Manager G reporting Resident 2 had been getting the appropriate insulin doses since his/her emergency room admission, staff did not document Resident 2's dinner carb consumption on 09/20/2023, 09/22/2023, 09/23/2023, 09/24/2023, or 09/25/2023, of which his/her

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insulin orders had parameters for insulin-to-carb ratio (ICR) administration. Surveyor observed that without this tracking, there was no way to verify whether Resident 2 had been consistently receiving the correct amount of insulin as Manager G reported.

At approximately 12:05 p.m., Surveyor interviewed Licensee B. Surveyor discussed the concern that not only did staff not seem to document their communication with Resident 2's endocrinology clinic when blood sugar concerns were discussed but also that based on Nurse H's report staff did not seem to be reaching out to the clinic on the majority of occasions in August, September, and October when Resident 2's blood sugars exceeded 400. Licensee B agreed with Surveyor's concern. Surveyor also discussed the concern that it was unclear whether Manager G had awareness of the extent of Resident 2's insulin management given the discrepancy between his/her report to Resident 2's MCO team and the insulin administration errors and lack of ICR monitoring observed by Surveyor within Resident 2's record. Licensee B reported s/he understood Surveyor's concern.

According to Mayo Clinic, diabetic ketoacidosis "is a serious complication of diabetes" which occurs "when the body can't produce enough insulin" and ketones build up in the bloodstream, caused by the body breaking down fat. "More-certain" signs of diabetic ketoacidosis can be high blood sugar or high urinary ketone levels (which can be assessed via a home testing kit), but other symptoms may include increased thirst and urination, weakness, fatigue, stomach pains, vomiting or feeling a need to vomit, shortness of breath, confusion, and fruity-scented breath. It is recommended for people to seek emergency

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care when they experience multiple of the above symptoms, have ketones in their urine but are unable to get guidance from their health care provider, or have blood sugars above 300 mg/dL for more than one test (Mayo Clinic, Diabetic ketoacidosis, October 06, 2022, https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551 (retrieval date - August 15, 2023).).

Example 3 - Resident 3

On 10/25/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/04/2022 with diagnoses including autism. Resident 3's ISP, last signed as reviewed on 01/19/2023, documented the following:

- Under the "Short term illness - assist" section: "Provide assistance as directed to care for/manage short term illness. Monitor and contact appropriate provider with changes, questions or concerns."

Surveyor reviewed Resident 3's observation notes, dated 08/01/2023 - 10/24/2023, and observed the following:

- 08/22/2023 (5:45 p.m.): "Just got out of the shower and noticed [s/he] has a red rash in [his/her] inner thigh near [his/her] private region and [s/he]'s been seeing this for the last 3 weeks or so, it has as of today gotten worse and is very itchy to [him/her], [s/he] waited to tell staff because it wasn't bad when [s/he] first noticed it. [S/he] thinks it could be from using the house laundry detergent due to [him/her] being out of [his/her] own laundry detergent."

- 09/05/2023 (6:45 p.m.): "School, home for

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N 431	Continued From page 38 lunch, went on a few walks, complaints of chest pain - vitals were taken. listened[sic] to music, played video games." Surveyor did not observe any entries that followed up on the above 2 changes in Resident 3's health. Surveyor observed a prescription in Resident 3's medical provider orders for Carbatrol extended release 200 mg capsules (1 capsule twice daily) with a start date of 07/27/2023. Surveyor observed that the prescription directions documented, "*stop if Any Rash[sic]*." At approximately 12:55 p.m., Surveyor interviewed Supervisors A and C. When asked if there was any follow up monitoring done by staff on Resident 3's rash, Supervisor C reported that s/he posted from his/her cellphone about it in the provider's "leadership group" chat, which consisted of the provider's managers, supervisors, and Licensee B. Supervisor C reported that they had no documentation in Resident 3's record about any follow up monitoring with the rash but that maybe there was information in Resident 3's medical records about it. Surveyor asked Supervisors A and C if they had those medical records as part of Resident 3's record. Supervisor A replied that Resident 3 would share his/her electronic medical record access with staff in order to see medical provider notes. Supervisor A showed Surveyor the "leadership group" chat from his/her cellphone showing that Supervisor C had brought up Resident 3's rash. Surveyor observed that no follow up monitoring or comments were made about his/her rash and whether it had resolved or whether it was deemed to be related to the laundry detergent. Supervisor A confirmed s/he had no evidence of any follow up monitoring completed by staff.	N 431		

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N 431	Continued From page 39 As part of the same interview, Surveyor asked about the 09/05/2023 entry regarding Resident 3's chest pain. Surveyor observed that the note indicated that vitals were taken and asked Supervisors A and C if the vitals values were documented anywhere. Supervisor A reported s/he was unable to find any documentation of Resident 3's vitals that day. Surveyor asked if chest pain was a new symptom for Resident 3 or if s/he had any sort of history of cardiac concerns. Supervisor A replied that Resident 3 had cardiac concerns that s/he has had past ultrasound imaging for. Supervisor A reported that Resident 3 was anticipated to have an upcoming surgery related to these cardiac concerns. Surveyor asked if there was any medical provider documentation within the provider's record for Resident 3 showing these imaging concerns and surgery consultation. Supervisor A showed Surveyor a screenshot from his/her cellphone that showed an ultrasound result sent by Resident 3 to Manager G in a group chat (not maintained as part of Resident 3's record). Surveyor asked if there was any other documentation showing that Resident 3 was assessed for any other cardiac-related symptoms sort or that follow up monitoring was completed. Supervisor A reported s/he was unable to find any in Resident 3's record. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 431		
N 432	83.38(1)(h) Medication administration.	N 432		

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N 432	Continued From page 40 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 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 observation, record review, and interview, the provider did not provide medication administration services appropriate to the resident's needs for 2 of 2 residents reviewed. Resident 6's 2 prescription medications were observed in the medication cart both in prescription bottles from his/her previous living situation (dispensed from a previous pharmacy) as well as in medication cards, dispensed from his/her current pharmacy on 10/18/2023 (the day prior to his/her admission). All tablets were observed present in his/her cards and his/her MAR was blank for any medication administration since his/her admission. Staff reported inconsistently administering Resident 6 his/her medications from his/her medication bottles. From 08/01/2023 - 10/24/2023, Resident 3 did not receive his/her 2 morning medications (Carbatrol and Fluticasone) on 27 occasions due to his/her class schedule. There was no evidence that the provider attempted to work with Resident 3's medical provider prior to 10/25/2023 (the day of the survey) to resolve his/her morning	N 432		

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medication administration process when it conflicted with his/her class schedule.

Findings include:

On 10/25/2023, Surveyor conducted a complaint investigation into concerns that staff were making errors in administering medications to residents.

Example 1 - Resident 6

On 10/25/2023, at approximately 8:23 a.m., Surveyor arrived onsite and observed Caregiver D finishing medication pass. Supervisor A then finished by administering Resident 2 his/her morning insulin. No nurse was observed in the building.

On 10/25/2023, from approximately 8:53 - 9:50 a.m., Surveyor observed the medication cart with Supervisor A. Surveyor observed the following 2 medication cards for Resident 6 (see Photos 9 and 10):

- 1 card containing Escitalopram 20 mg tablets. The pharmacy label indicated a dispense of 27 tablets on 10/18/2023 and instructions to, "Take one tablet by mouth in the morning." All 27 tablets were observed still in the card.

- 1 card containing 27 Atorvastatin 10 mg tablets. The pharmacy label indicated a dispense of 27 tablets on 10/18/2023 and instructions to, "Take 1 tablet by mouth once daily." All 27 tablets were observed still in the card.

Surveyor also observed 2 bottles of prescription medications for Resident 6 in the medication cart (see Photo 11). One bottle contained a pharmacy label (from a different pharmacy than the

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medication card) indicating that the bottle contained Escitalopram 20 mg tablets. The other bottle contained a pharmacy label (from a different pharmacy than the medication card) indicating that the bottle contained Atorvastatin 10 mg tablets. Each bottle appeared to contain several tablets.

While observing the above, Surveyor asked Supervisor A what was going on with Resident 6's medications. Supervisor A reported that Resident 6 was a new admission and so s/he thought the 2 bottles were his/her medications from home. Surveyor asked if staff were administering Resident 6 his/her tablets from the bottles since his/her admission since no tablets were popped out of either of his/her medication cards. Supervisor A reported s/he wasn't sure and s/he would have to check with staff.

On 10/25/2023, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 10/19/2023. No diagnoses were indicated in his/her record. Surveyor observed Resident 6's MAR since his/her admission date and observed that all entries were blank.

At approximately 10:45 a.m., Supervisor A reported that s/he was able to get ahold of Caregiver E and Caregiver F to ask them about Resident 6's medication administration. Supervisor A reported that Caregiver D told him/her that s/he had been passing Resident 6's medications from his/her bottle and that Caregiver F told him/her that s/he had not been administering Resident 6 his/her medication. Surveyor asked Supervisor A why staff were not administering Resident 6 his/her medications from his/her cards. Supervisor A replied that s/he wasn't sure.

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N 432	Continued From page 43 On 10/27/2023, at approximately 12:05 p.m., Surveyor interviewed Licensee B. Licensee B reported s/he wasn't sure why staff weren't administering Resident 6 the medications from his/her card. Licensee B also reported s/he wasn't sure why staff did not try to troubleshoot Resident 6's medication administration process earlier in order to ensure that Resident 6 was consistently receiving his/her prescribed medications. Licensee B confirmed that the medication administration process was completed by caregivers who were trained in medication administration and that a registered nurse, practitioner, or pharmacist did not supervise medication administration. Example 2 - Resident 3 On 10/25/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/04/2022 with diagnoses including autism and major depressive disorder, recurrent, with severe psychotic symptoms. Surveyor reviewed Resident 3's prescriptions, which included the following: - Carbatrol extended release 200 mg capsule: "Take one capsule by mouth twice daily" (Times of administration on the MAR were documented at 8:00 a.m. and 8:00 p.m.) - Fluticasone 50 mcg nasal spray: "Instill 2 sprays in each nostril once a day." (Time of administration on the MAR was documented at 8:00 a.m.) Surveyor reviewed Resident 3's MARs from 08/01/2023 - 10/24/2023 and observed the following 27 entries in which the code "DP" was marked for both his/her Fluticasone and 8:00	N 432		

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N 432	Continued From page 44 a.m. dose of Carbatrol: - 08/29/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 08/30/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 08/31/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/01/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/05/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/06/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/08/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/12/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/13/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/14/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/15/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/18/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/22/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/25/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/26/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/27/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 09/29/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/02/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/09/2023: Carbatrol (8:00 a.m. dose), Fluticasone	N 432		

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N 432	Continued From page 45 - 10/11/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/12/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/16/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/17/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/18/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/19/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/23/2023: Carbatrol (8:00 a.m. dose), Fluticasone - 10/24/2023: Carbatrol (8:00 a.m. dose), Fluticasone Surveyor did not observe "DP" in the MAR key code. At approximately 12:34 p.m., Surveyor interviewed Supervisor A. Supervisor A reported that "DP" stood for "day programming" which for Resident 3, was the code used when s/he was in his/her college classes. Supervisor A confirmed that on the entries that "DP" was marked that Resident 3 was not administered those medications because s/he had already left for classes for the day. Supervisor A reported that based on the MAR time, staff could only give those medications within an hour window and Resident 3 had left prior to the time window, which is why his/her medications were not administered. Surveyor discussed the concern that it seemed like Resident 3 had missed several doses of his/her 8:00 a.m. medications and asked if staff were working with his/her medical provider to let him/her know that s/he was missing several doses of his/her medications and to try to come up with a solution that ensured Resident 3 could	N 432		

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be administered his/her medications, such as arranging a different administration time. Supervisor A reported that s/he thought staff had sent an order to Resident 3's medical provider to allow him to self-administer his/her 2 morning medications when s/he was at school but that they were waiting on a signature.

At approximately 2:35 p.m., Surveyor interviewed Supervisor A again. Supervisor A reported that s/he had just spoke with Resident 3 and s/he confirmed that Resident 3 was not receiving his/her 8:00 a.m. medications when s/he had classes. Supervisor A reported that Manager A reported to him/her that s/he called Resident 3's medical clinic that day and confirmed they were just waiting on a medical provider's signature. Supervisor A reported s/he had just heard this from Manager A and couldn't confirm whether Manager A had just initiated contact with Resident 3's clinic that day or whether they had been working with the medical provider previously to solve the issue. Surveyor requested that evidence be sent by 10/26/2023 at 2:00 p.m. of any communication between medical staff and provider staff attempting to solve this, including the order that was reportedly sent/requested.

On 10/26/2023, at approximately 2:07 p.m., Supervisor A e-mailed Surveyor and reported that there was no historical documentation regarding Resident 3's missed morning medications.

On 10/27/2023, at approximately 12:05 p.m., Surveyor interviewed Licensee B. In discussing the concern that staff didn't seem to promptly follow up with Resident 3's medical provider upon discovering that there would be a prolonged concern of his/her morning medication administration due to his/her class schedule,

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N 432	Continued From page 47 Licensee B reported that s/he agreed with Surveyor's concern. Licensee B reported that s/he thought staff were waiting on an update from the pharmacy but also that they should have been following up to ensure a resolution.	N 432		