STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017549	A. BUILDING: _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS ASSISTED LIVING ANGELICA 2	9311 ANGELICA DR MOUNT PLEASANT, WI 53177

(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
M 000	INITIAL COMMENTS On 07/25/2023, Surveyor completed 2 complaint investigations at Open Arms Assisted Living Angelica 2. As a result, 2 deficient practices were identified and the complaints were substantiated. Census: 4	M 000		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident's Individual Service Plans (ISPs) were updated at least every 6 months and with changes. Resident 4's ISP was not updated at least every 6 months and with a change in needs regarding wounds. Resident 3's ISP was not updated at least every 6 months in 2022 and 2023.	M 424		

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

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M 424	Continued From page 1 Findings include: On 07/21/2023, at 11:30 AM, Surveyor reviewed resident records and identified the following: Example 1: Resident 4 was admitted to the facility on 09/30/2021. Resident 1's record contained evidence her/his ISP was developed on 10/30/2021. Resident 4's ISPs were due for review in 04/2022, 10/2022, and 04/2023. On 05/31/2023, Resident 4 was admitted to home health services for wound treatment. Resident 4's ISP was not updated with her/his change in condition and services provided. There was no evidence Resident 4's ISPs were reviewed in 04/2022, 10/2022, 04/2023, and 05/2023 with changes. Example 2: Resident 3 was admitted to the facility on 05/04/2022. Resident 3's record contained evidence her/his ISP was reviewed on 06/04/2022. Resident 4's ISPs were due for review in 12/2022 and 06/2023. There was no evidence Resident 4's ISPs were reviewed in 12/2022 and 06/2023. On 07/21/2023, at approximately 9:45 AM, Surveyor interviewed Administrator B regarding residents' ISPs. Administrator B reported s/he was responsible for updating resident ISPs. Administrator B confirmed s/he was aware of the requirement to review resident ISPs every 6 months and with changes. Administrator B reported resident cares "haven't changed." Administrator B reported the house manager was responsible for updating her/him with ISPs coming up for review.	M 424		

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M 424	Continued From page 2 On 07/27/2023, at 9:00 AM, Surveyor interviewed Licensee A regarding residents' ISPs. Licensee A reported s/he was not aware Resident 3's and Resident 4's ISPs were not updated as required. Licensee A stated, "They should have been done." Licensee A reported the house manager, assistant administrator and Administrator B were responsible for the reviews and updates. Licensee A reported s/he would ensure all ISPs were updated.	M 424		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not provide or arrange for the provision of individual services specified in each resident's individual service plan (ISP), that are the licensee's responsibility for 4 of 4 residents. On 06/20/2023, Resident 3 and Resident 4 did not receive repositioning every 2 hours and as needed. On 06/20/2023, Resident 1, Resident 2, Resident 3, and Resident 4 did not receive morning medications and breakfast. Findings include: On 06/23/2023, the Department received 2	M 436		

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complaints alleging the residents did not receive medications and meals on 06/20/2023 between 7:00 AM and 12:45 PM.

RECORD REVIEW

On 07/21/2023, at approximately 9:15 AM, Surveyor reviewed records and identified the following:

Example 1:
Resident 3 was admitted to the facility on 05/04/2022. Resident 3's ISP, dated 05/04/2022, identified Resident 3 was blind, required a Hoyer lift for transfers, was incontinent and required incontinence cares every 2 hours or as needed, complete staff assistance with medication administration, meal preparation, and total assistance with feeding.
Resident 3's June 2023 medication administration record (MAR) indicated Resident 3's morning medications included furosemide, levothyroxine, losartan, divalproex, memantine, buspirone, and Miralax.

Example 2:
Resident 4 was admitted to the facility on 09/30/2021. Resident 4's ISP, dated 03/30/2021, identified Resident 4 required a Hoyer lift for transfers, incontinence cares every 2 hours or as needed and complete staff assistance with medication administration and meal preparation.
Resident 4's June 2023 MAR indicated Resident 4's morning medications included alendronate, escitalopram, phenobarbital, fluticasone, pantoprazole, multivitamin, and Miralax.

Example 3:
Resident 1 was admitted to the facility on 06/28/2019. Resident 1's ISP, dated 11/12/2021,

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identified Resident 1 required a Hoyer lift for transfers, required 2-hour repositioning, and emptying of her/his urinary catheter bag and complete staff assistance with medications administration and meal preparation.
Resident 1's June 2023 MAR indicated Resident 1's morning medications included cetirizine, furosemide, levothyroxine, metoprolol succinate, omeprazole, oxybutynin, Advair inhaler, docusate sodium, and baclofen.

Example 4:
Resident 2 was admitted to the facility on 06/28/2019. Resident 2's ISP, dated 11/12/2021, identified Resident 2 required complete staff assistance with medication administration and meal preparation.
Resident 2's June 2023 MAR indicated Resident 2's morning medications included amlodipine besylate, arnuity ellipta inhaler, aspirin, clopidogrel, sertraline, metoprolol tartrate, pantoprazole, hydralazine, and sevelamer carbonate.

Sturtevant Police Records
Sturtevant Police Department Report # 23-005138, dated 06/20/2023, indicated at 12:49 PM, Lieutenant (Lt.) F was dispatched to the facility regarding a welfare check complaint alleging no staff were on site. Lt. F reported s/he entered the facility and spoke with Resident 1, who stated, "[S/He] had not received [her/his] medications and no one had been fed, including [her/his] [spouse]." Lt. K reported Caregiver H was present in the home; however, Lt. K could not communicate with Caregiver H due to a language barrier.

INTERVIEWS:

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M 436	Continued From page 5 Between 07/21/2023 and 07/27/2023, Surveyor conducted interviews with staff, residents, and collateral persons and identified the following: On 07/21/2023, at 8:30 AM, Surveyor interviewed Caregiver C. Caregiver C reported s/he was informed Caregiver H's main duties in the facility were household tasks, such as cleaning. Caregiver C reported Caregiver H did not administer medications. Caregiver C reported Caregiver H did not speak or read English. Caregiver C reported Caregiver H was not to work alone in the facility. On 07/21/2023, at 8:55 AM, Surveyor interviewed Caregiver D regarding the incident on 06/20/2023. Caregiver D reported s/he worked 3rd shift and left at 7:00 AM, on 06/20/2023. Caregiver D reported s/he left before the 1st shift caregiver arrived due to an emergency. Caregiver D reported Caregiver H was in the facility. Caregiver D reported s/he did not pass resident's morning medications or prepare meals prior to leaving the facility. On 07/21/2023, at 10:40 AM, Surveyor interviewed Resident 2 via telephone. Resident 2 reported on 06/20/2023, s/he and her/his spouse, [Resident 1] did not receive their morning medications or meals. On 07/21/2023, at 3:50 PM, Surveyor interviewed Home Health Nurse (HHN) E. HHN E confirmed on 06/20/2023, between 11:15 AM and 11:45 AM, s/he arrived at the facility to complete Resident 4's treatment. HHN E reported upon arrival, Resident 2 approached her/him and indicated s/he did not receive morning medications or any meals. HHN E reported Resident 4 confirmed s/he had not received any meals. HHN E reported	M 436		

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M 436	Continued From page 6 Resident 4 was in bed upon arrival. HHN E reported Resident 4's incontinence garment was "soaked." On 07/25/2023, at 4:25 PM, Surveyor interviewed Lt. F regarding the incident on 06/20/2023. Lt. F reported upon arrival to the facility, at approximately 1:00 PM, s/he was met by Resident 2. Resident 2 reported s/he had not seen any staff, did not receive breakfast or lunch and morning medications. Lt. F reported s/he reviewed resident's June 2023 MARs. Lt. K reported the boxes for 06/20/2023 were blank. On 07/27/2023, at 9:00 AM, Surveyor interviewed Licensee A and Chief Operations (CO) G. Licensee A reported prior to the incident, staff utilized a punch-in system on their phones. Since the 06/20/2023 incident a new punch-in system was installed. CO G reported the new system required staff to enter the facility to punch-in. The iPad was mounted on a wall and the system utilized facial recognition. CO G reported the new system would alert management if staff had not punched-in for their shift.	M 436		