| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>On 11/12/2024, with information obtained through 12/09/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at VitaCare Living Mount Horeb, a community-based residential facility (CBRF) located in Mount Horeb, WI.<br><br>As a result of the survey 2 deficiencies were identified.<br><br>The complaint was substantiated.<br><br>Census: 13 | N 000 | | |
| N 353 | 83.32(3)(i) Rights of Residents: Adequate treatment<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Resident 1 received adequate treatment appropriate to his/her resuscitation needs.<br><br>Staff called for emergency medical services (EMS) response on the morning of 10/01/2024 due to Resident 1 having been found not breathing. The EMS report of the incident documented the provider's staff having been initially unavailable to allow them entry into the building and being unavailable within Resident 1's room to provide further information as needed. Staff were later unable to produce Resident 1's | N 353 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 353 | Continued From page 1 | N 353 | | |

"Do Not Resuscitate" (DNR) bracelet or order, which per staff interview was unclear they had access to. As a result, Resident 1 received resuscitation measures against his/her wishes that included application of a mechanical chest compression system, 3 doses of epinephrine administration, and respiratory intubation. Later record review identified that Resident 1's DNR order had been in place since 2018.

Findings include:

According to the Department, Wis. Stat. ch. 154, which covers advanced directives, and covers DNR orders. A DNR order, which is a document signed off on by a health care professional, "tells EMS practitioners and emergency medical responders to not perform CPR (cardiopulmonary resuscitation) if your heart stops or you can't breathe. If you don't have a DNR order, the care team will try CPR...The purpose of the DNR order is to make sure that your wishes are honored..." (Source: Wisconsin Department of Health Services, EMS: Do Not Resuscitate Information, April 03, 2023, https://www.dhs.wisconsin.gov/ems/dnr.htm (retrieval date - November 15, 2024).).

On 11/12/2024, Surveyor conducted an investigation into concerns of resident record access related to DNR wishes.

On 11/12/2024, at approximately 10:00 a.m., Surveyor interviewed Assistant Director B. Assistant Director B reported that resident records consisted of both paper records, which were maintained in the facility's office, and the provider's electronic record platform. When asked specifically about how DNR paperwork was maintained, Assistant Director B replied that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 353 | Continued From page 2 | N 353 | | |

DNR paperwork for applicable residents "should be" both in the residents' paper files as well as the provider's electronic record platform.

On 11/12/2024, Surveyor reviewed a list provided by Administrator A of residents who were discharged from the provider since 09/01/2024 due to voluntary discharge, involuntary discharge, or death. One resident, Resident 1, was identified as having been discharged on 10/04/2024 due to passing away.

On 11/12/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 02/10/2023 (of note, Resident 1 continued to be a resident through a change of ownership that became effective on 04/15/2024 according to Department records). Resident 1's face sheet identified him/her being discharged from the provider on 10/04/2024 and having had a DNR status.

At approximately 10:40 a.m., Surveyor interviewed Administrator A and reviewed all resident DNR information with him/her. Surveyor requested DNR paperwork for Resident 1. Administrator A showed Surveyor a provider face sheet from Resident 1's binder (different from the one observed by Surveyor previously) showing an active date of 12/21/2023. The face sheet contained general overview information of Resident 1, including his/her allergies, diagnoses, and contacts. One line of the face sheet documented, "Code Status: DNR." Administrator A then showed Surveyor an assessment from the provider dated 07/19/2023, which appeared to be a generalized assessment of Resident 1's functioning. One line on the first page documented, "CODE STATUS: DNR." Administrator A then showed Surveyor a "Provider

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 353 | Continued From page 3 | N 353 | | |

Contact/Visit Form", which documented information regarding a visit Resident 1 had with his/her medical provider. The print date on the form was 01/19/2024. The form contained a line which documented "Code Status: DNR." Administrator A confirmed Surveyor's observation that none of these documents contained the DNR order for Resident 1. Administrator A reported that the licensee's previous management group, who was active until approximately June 2024, must have gotten the DNR information from somewhere but confirmed s/he was unable to find a DNR order or bracelet in Resident 1's record.

At approximately 12:18 p.m., Surveyor interviewed Administrator A again. When asked about information specific to Resident 1's passing, Administrator A reported s/he had an e-mail from when s/he notified Resident 1's family member, Family Member D, and his/her managed care organization (MCO) case manager about Resident 1's passing. Administrator A forwarded the e-mail to Surveyor, which Surveyor then reviewed. The e-mail was sent on 10/01/2024 at 8:59 a.m. and documented, "Hi Team, I am reaching out to you guys this morning to let you know I just received a phone call from my staff that [Resident 1] has passed away this morning. They Found [sic] [him/her] during morning medication pass." When asked for more information regarding Resident 1's passing, Administrator A reported s/he was not on site that day. Administrator A reported that Former Caregiver E went into Resident 1's room to administer his/her morning medications and found Resident 1 not breathing. Administrator A reported that Former Caregiver E then called him/her, and s/he instructed Former Caregiver E to contact EMS services. Administrator A reported that it was his/her understanding that sometime

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 353 | Continued From page 4 | N 353 | | |

after the EMS response is when Resident 1 was pronounced dead. Administrator A reported s/he was unsure if EMS performed resuscitation actions on Resident 1 but reported s/he had informed staff during the phone call that Resident 1 had a DNR status.

During the interview, Administrator A reported s/he was able to find Resident 1's DNR order. Administrator A reported s/he found it in the provider's electronic record system shared drive. Administrator A reported s/he wasn't sure if staff had access to these shared drive files or if they would know where to find them, since some files in residents' electronic records had limited viewing permission. Surveyor then reviewed the record provided by Administrator A, which showed the DNR order for Resident 1. The DNR order was signed by Resident 1 on 06/20/2018 and by a physician on 08/27/2018.

As part of the interview, Administrator A reported s/he was aware of a request made by Resident 1's family for Resident 1's DNR bracelet. Administrator A reported that staff were unable to find his/her bracelet and s/he could not recall Resident 1 ever having worn the bracelet prior to his/her passing.

On 11/13/2024, Surveyor reviewed outside records obtained from the local EMS department. The record included a "Prehospital Care Report" which documented the following:

"Arrive on location to make access to find no staffing present, directing or answering EMS for assistance. EMS makes way into building to find someone in kitchen who directs us around corner. EMS finds no further direction, makes patient room access no staffing is present.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 353 | Continued From page 5<br><br>"[Patient] is observed on bed...[Patient] is unresponsive, of poor color, not breathing, no resuscitative efforts made by staffing...Staffing arrives reporting [patient] is a DNR...and will fetch paperwork...[due to] lack of paperwork and concern, patient is immediately moved to floor to prepare for resuscitative efforts. Staffing provides paperwork however it's immediately identified that this paperwork is not DNR paperwork, resuscitative efforts had already been started at this point by EMS with immediately placement of Lucas Device [mechanical chest compression device]...<br><br>"A tube is readied with Airtraq [guided video intubation system]...tube subsequently placed...Placement is confirmed by visualizing the tube pass through the cords...The tube did sink to a 25 depth during securement process...<br><br>"...Initial dosing of 1 mg Epi[nephrine, a drug often used for resuscitation efforts to treat cardiac arrest] delivered via [introsseous access]... [Medical doctor] indicates 3x epi to be delivered...A directive of...20 minutes of CPR and 3x EPI and EMS could [discontinue]...<br><br>"@ 20 minutes a follow-up call is given to [medical doctor] with resuscitative efforts stopping @ 9:20:27..."<br><br>On 11/13/2024, at approximately 7:07 a.m., Surveyor interviewed Paramedic C, from the provider's local fire and EMS department. Paramedic C clarified that the DNR "paperwork" staff had provided to the EMS responders was a facility face sheet, but not the actual DNR order. Paramedic C reported that upon EMS trying to clarify the DNR order versus a face sheet with | N 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 353 | Continued From page 6<br>staff that staff reported not being aware of what a DNR order was.<br><br>On 11/14/2024, at approximately 4:02 p.m., Surveyor interviewed Family Member D, who was Resident 1's family member. Family Member D reported that staff had called him/her on the morning of 10/01/2024 to report that Resident 1 was currently being resuscitated. Family Member D reported that s/he asked staff why Resident 1 was being resuscitated since Resident 1 had a DNR order. Family Member D reported that staff reported to him/her that they did not have a DNR order for Resident 1. Family Member D reported that Resident 1's DNR status was confirmed most recently during his/her last meeting with his/her MCO case managers and provider staff. Family Member D reported that this was sometime in July 2024 and that the provider's staff confirmed having had Resident 1's necessary DNR paperwork. Family Member D reported that MCO meetings occurred approximately twice a year and that at every meeting it was standard to confirm Resident 1's DNR status. Family Member D confirmed that staff had been unable to find or produce Resident 1's DNR bracelet upon his/her request. | N 353 | | |
| N 454 | 83.42(1) Resident record maintained.<br><br>The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following:<br>(a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal | N 454 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 7 | N 454 | | |

physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 8<br>(t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure that the records for 3 residents, Residents 1, 2, and 3, were maintained with all the required information.<br><br>The provider's record for Resident 2 indicated that s/he had a "Do Not Resuscitate" (DNR) order, but the order was not maintained as part of his/her record. Outside information obtained indicated that Resident in fact did not have a DNR order.<br><br>The provider's record for Resident 3 indicated that s/he had a DNR order, but the order was not maintained as part of his/her record.<br><br>The date, time, and circumstances of Resident 1's death, including the name of the person to whom his/her body was released, was not maintained as part of Resident 1's record.<br><br>Findings include: | N 454 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 9<br>Examples 1 and 2 - DNR order for Residents 2 and 3<br><br>On 11/12/2024, Surveyor conducted an investigation into concerns of resident record access related to DNR wishes.<br><br>According to the Department, Wis. Stat. ch. 154, which covers advanced directives, covers DNR orders. A DNR order, which is a document signed off on by a health care professional, "tells EMS practitioners and emergency medical responders to not perform CPR (cardiopulmonary resuscitation) if your heart stops or you can't breathe. If you don't have a DNR order, the care team will try CPR...The purpose of the DNR order is to make sure that your wishes are honored..." (Source: Wisconsin Department of Health Services, EMS: Do Not Resuscitate Information, April 03, 2023, https://www.dhs.wisconsin.gov/ems/dnr.htm (retrieval date - November 15, 2024).).<br><br>On 11/12/2024, at approximately 10:00 a.m., Surveyor interviewed Assistant Director B. Assistant Director B reported that resident records consisted of both paper records, which were maintained in the facility's office, and the provider's electronic record platform. When asked specifically about how "Do Not Resuscitate" (DNR) paperwork was maintained, Assistant Director B replied that DNR paperwork for applicable residents "should be" both in the residents' paper files as well as the provider's electronic record platform.<br><br>At approximately 10:13 a.m., Surveyor interviewed Assistant Director B at the provider's medication cart, where a laptop was located. Assistant Director B identified from the provider's | N 454 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 10 | N 454 | | |

electronic record platform that Resident 3 was someone who was shown as having a DNR status. Surveyor requested Assistant Director B to show him/her the DNR order from Resident 3's record. Assistant Director B walked with Surveyor to the provider's office and grabbed a binder containing paper records for Resident 3. Assistant Director B was observed searching through a few pages, and reported to Surveyor that Resident 3 had started hospice services sometime in October 2024. Assistant Director B reported s/he was unsure if Resident 3 had DNR paperwork and did not provide any DNR order to Surveyor.

At approximately 10:40 a.m., Surveyor interviewed Administrator A and reviewed all resident DNR information. Of 13 residents who resided with the provider, Administrator A identified 6 residents who showed in the provider's electronic record platform as having a DNR status, which included Residents 2 and 3. Administrator A reported that the "DNR" option was checked in the "Advanced Directives" section of the applicable residents' profile, and the residents who had a DNR status showed as having a red box around their names/photos on the platform's main screen. Administrator A confirmed s/he was unable to find DNR order paperwork for 2 residents - Residents 2 and 3 - after looking in both the provider's electronic record platform for both residents as well as the residents' binders, which contained paper records. Regarding Resident 3, Administrator A reported s/he was informed verbally through Resident 3's hospice team as well as Resident 3's family that s/he had a DNR order, but was still awaiting paperwork.

Administrator A then showed Surveyor a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 11 | N 454 | | |

document headed with "VitaCare Living" and "Physician Plan of Care." A fax date of the record was documented as 06/17/2024 (approximately 5 months prior to the survey). The record documented a line for "Code Status" where "DNR" was handwritten. The document did not identify its author.

As part of the same interview, Surveyor interviewed Administrator A regarding Resident 2's DNR status. Administrator A reported s/he was able to find old paperwork in Resident 2's binder, prior to when s/he began working with the provider, that identified on various forms that Resident 2 was a DNR status. However, Administrator A confirmed s/he was unable to find a DNR order within Resident 2's paper records or electronic record. Administrator A reported s/he was not aware that Resident 2's DNR order was not in his/her record. Administrator A reported s/he had just started auditing resident files last week.

Surveyor reviewed the documents Administrator A found as part of Resident 2's paper records. This included the following:

- Provider assessment dated 07/18/2023, with a section titled "CODE STATUS" and a line under that heading documenting, "DNR"
- Provider assessment dated 12/01/2023, with a section titled "CODE STATUS" and a line under that heading documenting, "DNR"
- (Historic) provider face sheet dated 02/02/2024 with a line documenting, "DNR."

Surveyor reviewed current face sheets for Residents 2 and 3, where both were identified as having a DNR status.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 12<br><br>On 11/18/2024, at approximately 7:56 a.m., Surveyor interviewed Case Manager F, from Resident 2's managed care organization (MCO) care team. Case Manager F denied that Resident 2 had DNR order and confirmed that there were no records s/he was aware of that identified Resident 2 as having a DNR order. As part of the interview, Case Manager F reported s/he also followed up with Resident 2's nurse case manager, who confirmed s/he was unable to find any DNR order as part of Resident 2's medical record.<br><br>On 11/18/2024, at approximately 2:02 p.m., Surveyor interviewed Nurse G, from Resident 3's hospice agency. Nurse G confirmed that Resident 3 had a DNR order, which was signed on 10/22/2024 and entered into his/her medical record on 10/24/2024 (approximately 3 weeks prior to Surveyor's onsite investigation). Nurse G offered to fax the DNR order to the provider.<br><br>On 11/18/2024, Surveyor reviewed outside hospice records obtained for Resident 3. The records contained evidence of a DNR order, signed by his/her medical provider on 10/22/2024.<br><br>Example 3 - Required information related to Resident 1's death<br><br>On 11/12/2024, Surveyor reviewed a list provided by Administrator A of residents who were discharged from the provider since 09/01/2024 due to voluntary discharge, involuntary discharge, or death. One resident, Resident 1, was identified as having been discharged on 10/04/2024 due to passing away.<br><br>On 11/12/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider | N 454 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 13 | N 454 | | |

on 02/10/2023. Resident 1's face sheet identified him/her being discharged from the provider on 10/04/2024. Surveyor reviewed Resident 1's observation notes from 08/01/2024 - 11/12/2024 and observed the last entry being on 10/04/2024 at 9:43 a.m., which documented, "[Resident 1] was discharged from the system. Discharge reason: Deceased. Notes: Deceased -- Notes: Discharging resident."

The entry immediately prior to that was made on 09/30/2024 at 10:30 a.m., which documented occurrences of staff having to assist Resident 1 with his/her supplemental oxygen.

There was nothing in Resident 1's record that identified the date, time, and circumstances of Resident 1's death, including the name of the person to whom his/her body was released.

At approximately 10:30 a.m., Surveyor interviewed Administrator A. Administrator A reported that Resident 1's death was "a shock." Administrator A reported that Resident 1 previously had been hospitalized but upon his/her return to the provider still seemed sick for a bit. Administrator A reported that it was approximately 2 weeks after that that Resident 1 passed away. Administrator A confirmed that Resident 1 had passed away at the facility.

At approximately 12:18 p.m., Surveyor interviewed Administrator A again. When asked about information specific to Resident 1's passing, Administrator A reported s/he had an e-mail from when s/he notified Resident 1's family member, Family Member D, and his/her MCO case manager about Resident 1's passing. Administrator A forwarded the e-mail to Surveyor, which Surveyor then reviewed. The e-mail was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | C 12/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 454 | Continued From page 14 | N 454 | | |

sent on 10/01/2024 at 8:59 a.m. and documented, "Hi Team, I am reaching out to you guys this morning to let you know I just received a phone call from my staff that [Resident 1] has passed away this morning. They Found [sic] [him/her] during morning medication pass." When asked for more information regarding Resident 1's passing, Administrator A reported s/he was not on site that day. Administrator A reported that Former Caregiver E went into Resident 1's room to administer his/her morning medications and found Resident 1 not breathing. Administrator A reported that Former Caregiver E then called him/her, and s/he instructed Former Caregiver E to contact emergency medical services (EMS). Administrator A reported that it was his/her understanding that sometime after EMS response is when Resident 1 was pronounced dead. Administrator A reported s/he believed it was the local fire department/EMS as well as law enforcement who came out. Administrator A reported the coroner also came out but s/he did not know the identity of the person.

At approximately 1:15 p.m., Surveyor interviewed Administrator A again. Administrator A reported s/he did not have any other information regarding Resident 1's passing but wasn't sure if s/he had any other e-mail exchanges about it. Surveyor gave Administrator A a deadline of 5:00 p.m. that day to send any additional information the provider had related to Resident 1's passing. Nothing further was provided.