STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016344	A. BUILDING: _____ B. WING _____	R-C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACORN HILL	430 ORBITING DR MOSINEE, WI 54455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{U 000}	INITIAL COMMENTS On 11/28/2023, 11/29/2023 and 12/07/2023, Surveyor conducted 8 complaint investigations and a verification visit. Information was reviewed through 12/14/2023. Three deficiencies were identified. One of 3 deficiencies was a repeat violation. See Statement of Deficiency (SOD) 939O11, dated 11/12/2019. Two of 8 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.	{U 000}		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by:	U 118		

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

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U 118	Continued From page 1 Based on observation, interview, and record review, the provider did not ensure that all Schedule II narcotic medications were locked, secure, and accounted for. The provider is responsible for the medication management of each tenant's medication if that tenant contracts for that service. Findings include: According to Wis. Ch. 89.13(22) medication management includes proper storage of medication. At 9:25 AM, Surveyor requested and received the provider's written procedures for medication destruction. The undated procedure was titled, "Medication Destruction." The procedure outlined what to do when a medication was refused, fell on the floor, or was found. The procedure stated narcotic medications were to be set aside and locked until they could be destroyed by two staff. On 11/28/2023 at 9:30 AM, Surveyor interviewed Director A about the provider's processes to ensure the security and destruction of medications. Director A indicated that since the second medication diversion in September, s/he had introduced a new procedure. The provider had an agreement with their primary pharmacy that no Schedule II narcotics would be delivered unless Director A was in the building to check them in. There would be no after hours or weekend deliveries. Director A wanted to be involved in the counting and storage of this classification of drugs. Director A stated this procedure needed to happen each time a narcotic was brought into the building. Director A stated that if a delivery was an emergency, the staff needed to take a photo of the pharmacy's delivery	U 118		

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U 118	Continued From page 2	U 118		

slip and the actual unit dose card of medication so the director could confirm the delivery and know the count.

Director A also showed Surveyor the large bottle of vinegar that was used as a medium to dissolve the medications. The bottle was in a small storage area that connects the director's office to another office. The doors to the offices and storage area were wide open. The office next door was used by various staff as it had the tenants' records. The room also contained the copy/fax machine used by the staff. Director A stated the doors were only kept open when s/he was in the building. It was observed by Surveyor that Director A was frequently out of his/her office.

In the storage room, there was a 5-drawer horizontal file drawer that in the past had been locked and used to store medication. Director A stated the drawer should only have employee records. The drawer was labeled "Destroy" and "Current." Inside the drawer was a card of medications and 3 bottles of medications. Director A stated those should not be in there and did not know why they were. The card of medications was 30 tablets of the schedule II drug hydrocodone and acetaminophen 5 - 325 for Tenant 2. The bottles had tablets of Eliquis 2.5 milligram (mg), Apixaban 2.5 mg, and a bottle of generic Tylenol.

At 3:30 PM, Director A told Surveyor that the medications were destroyed and gave Surveyor the record for the destruction of the controlled medications. Director A again stated s/he had no idea the medications were in the drawer, when they were put there, or who put them there.

The recent changes in procedure did not ensure

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U 118	Continued From page 3 the proper storage of Schedule II medications as the drugs were unlocked and still accessible by others.	U 118		
U 129	89.23(4)(a)2. SERVICES PROVIDER QUALIFICATIONS. Service Providers. Nursing services and supervision of delegated nursing services shall be provided consistent with the standards contained in the Wisconsin nurse practice act. Medication administration and medication management shall be performed by or, as a delegated task, under the supervision of a nurse or pharmacist. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure each staff member that passed medications was qualified to do so and had the task delegated to them by a registered nurse or pharmacist. This was discovered for 2 of 2 current employees sampled and 3 of 3 past employees sampled. There had been no delegations or registered nurse (RN) oversite for four months prior to the survey. . Findings include: On 11/28/2023 at 8:15 AM, Surveyor observed Caregiver C. Caregiver C gave medications to Resident 3. Caregiver C stated s/he was responsible to pass medications to several	U 129		

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U 129	Continued From page 4	U 129		

residents on one side of the building.

At 9:30 AM, Surveyor interviewed Director A and asked for the delegations for Caregiver C and Caregiver D. Director A indicated that these employees had been delegated to pass medications by RN B. Administrator A stated there were no written delegations as RN B had taken them when s/he left.

At 3:15 PM, Surveyor interviewed Director A. Director A stated that RN E, the corporate nurse, was coming the next day to do the delegations. Surveyor was given a blank form to show what was included in the delegation. Surveyor reviewed the form. The form was used by RN E as documentation of his/her delegations. The form's title was the name of a different provider." The form summarized that the staff had knowledge and demonstrated the ability to pass medications. The form outlined the administration for various non-oral medication but did not include the training and demonstration of oral medications.

On 12/01/2023 at 2:18 PM, Surveyor received an email indicating 3 staff members were delegated by the RN: Caregiver F, G, and H.

On 12/07/2023 at 9:25 AM, Surveyor interviewed Director A. Surveyor requested the background checks, training, and delegations for Caregiver C and D, and Former Caregiver I, J, and K. No delegations were submitted.

On 12/12/2023, Surveyor interviewed Director A. Director A stated that RN E just did the 3 because they were new. Director A stated his/her understanding was that the delegations from RN B were still valid for those employees. Surveyor

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U 129	Continued From page 5 explained the delegation agreements ended when RN B retired and was no longer willing to delegate. Director A stated RN E was delegating for the region for a while now and Director A just went along with what RN E was doing. On 12/12/2023 at 12:35 PM, Surveyor interviewed RN B. RN B confirmed that s/he had rescinded his/her delegations to the facility staff when s/he retired on 08/09/2023. As the delegation is associated with the nurse's license and not the employee, all the employees were left with no nurse delegation to administer medication and perform other medication security and disposition. The delegation of staff ended in August of 2023. Present staff were passing medications without RN delegation. RN delegation should make sure staff members understand and demonstrate the ability to administer medications and understand policies and procedures for medication management.	U 129		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have	U 267		

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U 267	Continued From page 6 the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received all prescribed medications in the dosage and at the intervals prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) 939O11, dated 11/12/2019. Findings include: The Department received a complaint on 09/25/2023, alleging medications were administered after the medications were being discontinued by the physician. On 11/28/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/22/2022. According to a physician's order, dated 09/13/2023, the following medications were discontinued: coenzyme Q10 and amlodipine. According to Resident 1's medication administration record (MAR) for September 2023, Resident 1 received coenzyme Q10 and amlodipine on 09/18/2023, 09/19/2023 and 09/20/2023. On 12/07/2023 at 12:08 PM, Surveyor	U 267		

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U 267	Continued From page 7 interviewed Administrator A. Surveyor asked Administrator A if Resident 1 received coenzyme Q10 and amlodipine after the medications were discontinued on 09/13/2023. Administrator A reported, "I just looked into your question and the best answer that I can give you is that this occurred prior to my start date here. I can see that the meds (medications) were discharged, but then given on a few days after the order was written. For me to give any type of specific reason why that occurred, would be pure speculation. And unfortunately, the staff that passed the meds are no longer employed here..."	U 267		