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 05/15/2024

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 05/13/2024, Surveyor conducted a complaint (x2) investigation and verification visit at Acorn Hill. Data collection continued through 05/15/2024. One complaint was substantiated. One complaint was unsubstantiated. Two of the three deficiencies identified in Statement of Deficiency (SOD) OONJ12 were corrected. One deficiency was identified. The deficiency was a repeat violation, cited for the third time. See SOD 939O11, dated 11/12/2019 and SOD OONJ12, dated 12/14/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 26	{U 000}		
{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 the facility not interfere with the tenant's ability to manage his or her	{U 267}		

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

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{U 267}	Continued From page 1 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 Tenant 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 and SOD OONJ12, dated 12/14/2023. Findings include: The Department received a complaint on 04/19/2024, alleging a tenant was not receiving seizure medication and staff were falsifying medication administration records (MAR). On 05/14/2024, Surveyor reviewed Tenant 1's record. Tenant 1 was admitted on 10/14/2022. Tenant 1's diagnoses included Polyneuropathy, Chronic Venous Insufficiency, Seizure disorder and Atherosclerotic heart disease. According to physician orders and the MAR, on 02/17/2023, Tenant 1 was prescribed Levetiracetam 750 MG Tablet (take 1 tablet by mouth twice daily for seizures); on 11/15/2023, Tenant 1 was prescribed Polyethylene Glycol 3350 Powder (take 17 grams with 8 ounces water daily for constipation). Tenant 1's individual service plan (ISP), dated	{U 267}		

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{U 267}	Continued From page 2 02/01/2023, noted, "Resident requires staff to manage/administer medications." Tenant 1's February 2024 MAR noted that Tenant 1's Polyethylene Glycol was unavailable ("out of medication") on the following dates: 02/11/2024, 02/12/2024, and 02/13/2024. The MAR noted Tenant 1 did not receive a second dose of Levetiracetam on 02/04/2024. Tenant 1's March 2024 MAR noted that Levetiracetam was "out" on 03/03/2024 and the MAR indicated Levetiracetam was not administered from 03/18/2024 to 03/31/2024. According to the March 2024 MAR, on 03/31/2024, regarding Levetiracetam, the facility was "waiting for med (medication) from pharmacy." The March 2024 MAR noted Polyethylene Glycol was not administered in March 2024. Tenant 1's April 2024 MAR noted that Levetiracetam was unavailable ("medication not here") from 04/01/2024 to 04/09/2024. The April 2024 MAR indicated Polyethylene Glycol was not administered in April 2024. Tenant 1's May 2024 MAR noted that on 05/01/2024, regarding Polyethylene Glycol, the facility was "waiting on script from pharmacy." According to observation notes, dated 04/08/2024, Former Administrator (FA) B wrote, "Writer called VA (Veterans Administration) pharmacy to inquire about order for res (resident) med Levetiracetam that was called in by writer to pharmacy on 3/29/24. Writer was informed that med was filled by VA warehouse on 4/6/24 and should be in the mail today, 4/8/24. Writer informed that facility is out of med. VA told writer	{U 267}		

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{U 267}	Continued From page 3	{U 267}		

that they will get a message out to have some sent to facility ASAP (as soon as possible) to bridge gap. Will continue to provide support as needed."

On 05/15/2024 at 10:50 AM, Surveyor interviewed Administrator A via telephone. Administrator A reported that Administrator A started working at the facility on 04/08/2024. Administrator A stated that Tenant 1 was out of his/her seizure medication in February 2024 and March 2024. Administrator A reported that Administrator A ordered Tenant 1's Levetiracetam on 04/08/2024. The Levetiracetam arrived on 04/09/2024 and was administered on 04/10/2024. Administrator A stated, "It takes a while to get medications from the [VA]." Administrator A indicated that FA B would have been responsible for ordering Tenant 1's medication prior to Administrator A's employment on 04/08/2024. Surveyor asked Administrator A about the medication ordering process. Administrator A indicated that medication passers notify Administrator A when residents have two or three medication doses left and Administrator A orders the medication. Regarding Tenant 1, Administrator A stated that after s/he orders medications, the medication usually arrives the next day and the [VA] does a repack of Tenant 1's Levetiracetam and the facility gets the medication from [Pharmacy]. Administrator A reported, "I can see [Tenant 1] was not getting [his/her] seizure medication or Polyethylene Glycol as prescribed in February (2024), March (2024) and April (2024)." Administrator A stated, "I don't think [FA B] was on top of ensuring medications were being ordered; I am doing my best to clean up the mess prior to me starting."

On 05/15/2024 at 3:30 PM, Surveyor interviewed

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{U 267}	Continued From page 4 Administrator A via telephone. Surveyor reviewed Tenant 1's MARs (February 2024 through May 2024) with Administrator A. Administrator A verified the following: Tenant 1's Levetiracetam was ordered on 04/08/2024, arrived on 04/09/2024 and was administered on 04/10/2024. Administrator A confirmed that Tenant 1's Polyethylene Glycol arrived on 05/02/2024. Administrator A verified Tenant 1 went without [his/her] seizure medication the month of February (2024) and March (2024), and Tenant 1 did not receive his/her Polyethylene Glycol on 02/11/2024, 02/12/2024 and 02/13/2024. Administrator A confirmed that Tenant 1 went without his/her Polyethylene Glycol between 03/20/2024 and 03/26/2024. Administrator A indicated that Tenant 1's Polyethylene Glycol ran out on 04/13/2024 and Tenant 1 went the rest of April 2024 without receiving Polyethylene Glycol. Administrator A reiterated that Tenant 1 received his/her seizure medication on 04/10/2024 and Tenant 1's Polyethylene Glycol arrived on 05/02/2024. Administrator A stated, "I see a pattern of falsifying the MAR and those people are no longer working at this facility." Administrator A reported that s/he would be providing the oversight of medication administration moving forward.	{U 267}		