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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING OF WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 On 07/24/2024, with information obtained through 07/26/2024, the Bureau of Assisted Living, Southern Regional Office, conducted 2 complaint investigations and a verification visit at Brightstar Senior Living of Waunakee, a community-based residential facility (CBRF) located in Waunakee, WI. As a result of the survey, 3 deficiencies were identified. One deficiency was a repeat deficiency. See Statement of Deficiency (SOD) PI0512, dated 02/28/2024. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. One complaint was substantiated, one complaint was unsubstantiated. Census: 18	{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 2 of 3 residents received all prescribed medications in the dosage and at intervals prescribed by their practitioners.	N 352		

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

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N 352	Continued From page 1 Resident 4's metoprolol was incorrectly held on 2 occasions from 06/01/2024 - 07/24/2024. Resident 6's scheduled diazepam was marked as being not available on 06/09/2024. On at least 4 occasions between 06/09/2024 and 06/18/2024, the day a refill request was made and filled, Resident 6 did not receive his/her diazepam. On the remaining days in that range, it was not clear if staff had pulled from Resident 6's PRN diazepam supply to administer his/her scheduled dose. Findings include: Example 1 - Resident 4 On 07/24/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 10/01/2019 with diagnoses including hypertension and unspecified heart disease. Resident 4's prescriptions included metoprolol tartrate 25 mg tablets with instructions to, "Take 1/2 tablet (12.5 mg) by mouth twice daily for hypertension. Hold if systolic [blood pressure] < 110..." Surveyor reviewed Resident 4's medication administration records (MARs) from 06/01/2024 - 07/24/2024. Under the entry for Resident 4's metoprolol, there was an additional annotation that corroborated the prescription instructions: "Hold medication if blood pressure top number is less than 110." In reviewing Resident 4's MARs, Surveyor observed the following 2 occasions in which Resident 4's blood pressure was within the parameters to receive his/her metoprolol, but staff documented holding the medication: - 06/28/2024 (8:01 a.m.): Blood pressure recorded as 123/69, metoprolol marked as not	N 352		

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passed due to "other" with the annotation documented, "Systolic was 123."

- 06/30/2024 (7:03 p.m.): "Blood pressure recorded as 113/76, metoprolol marked as not passed due to "other" with no other annotations

At approximately 2:15 p.m., Surveyor interviewed Executive Director A, Nurse D, and Community Director E. All 3 acknowledged Surveyor's concern of the 2 instances above in which Resident 4's metoprolol was held. Nurse D reported s/he wasn't sure why the care staff would have held the metoprolol but confirmed that based on Surveyor's review of Resident 4's systolic blood pressure readings on those dates/times that his/her metoprolol should have been administered.

Example 2 - Resident 6

On 07/24/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 12/13/2023 with diagnoses including unspecified bipolar disorder, generalized anxiety disorder, and post-traumatic stress disorder. Resident 6's prescriptions included diazepam 5 mg tablets with instructions to, "Take 1 tablet by mouth once daily at bedtime" as well as the same medication with the same dosage prescribed on an as-needed (PRN) basis with the instructions, "Take 1 tablet by mouth 1-3 times per day as needed for muscle spasms." Surveyor reviewed Resident 6's MARs from 06/01/2024 - 07/24/2024 and observed the following:

- Under the scheduled diazepam entry: Marked as not passed due to "refused" on 06/09/2024 with the annotation, "Need a refill." The scheduled diazepam was marked as administered on

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N 352	Continued From page 3 06/10/2024 through 06/13/2024, then marked as not passed due to "other" on 06/14/2024 and 06/15/2024 with the following annotations, respectively: "Card not in the box", "Not in cart." It was then marked as administered on 06/16/2024 and 06/17/2024, but marked as not passed on 06/18/2024 due to "other" with the annotation, "Medication not in the cart." - Under the PRN diazepam entries: No documented administrations from 06/09/2024 through 06/18/2024. At approximately 2:15 p.m., Surveyor interviewed Executive Director A, Nurse D, and Community Director E. All 3 acknowledged Surveyor's concern that it appeared staff were not administering Resident 6's diazepam from 06/09/2024 through 06/18/2024 based on the medication not being present in the cart. Nurse D reported s/he did not recall being aware of any issues with Resident 6's diazepam re-ordering or dispensing from the pharmacy. Nurse D reported that it was possible the staff who documented administering Resident 6's diazepam pulled from his/her PRN card but confirmed that based on the documentation s/he had no way to verify that. On 07/26/2024, at approximately 10:00 a.m., Surveyor interviewed Pharmacist O from the pharmacy that dispensed Resident 6's medications. Pharmacist O reported that the pharmacy received a refill request for both Resident 6's PRN and scheduled diazepam on 06/18/2024 from Resident 6's hospice agency, both of which were filled and dispensed on that same day. Pharmacist O reported that there was no evidence of anyone, including from the provider's staff, having requested a refill any earlier that month.	N 352		

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N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that at least 1 qualified resident care staff was present in the community-based residential facility (CBRF) when 1 or more residents were present. On 14 overnight (NOC) shifts from 05/01/2024 - 07/24/2024, there was not a qualified resident care staff on shift to pass medications. Findings include:	N 397		

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N 397	Continued From page 5 The provider is licensed to serve up to 39 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. According to Wis. Admin Code § DHS 83.02(42) "Qualified resident care staff" is defined as "an employee who has successfully completed all of the applicable training and orientation under subch. IV." Within subchapter IV, requirements for orientation training, department-approved training, all employee training, and task-specific training are described. On 07/24/2024, Surveyor conducted a complaint investigation into allegations of medications not being passed by NOC shift staff due to lack of medication administration training and registered nurse (RN) delegation. On 07/24/2024, Surveyor reviewed a sample of 3 residents, all of whom were prescribed as-needed (PRN) medications, which included the following: 1) Resident 4, who had diagnoses including heart failure and was documented as receiving hospice services - Albuterol HFA 18 gm inhaler, active since 12/29/2022, with instructions to, "Inhale 2 puffs by mouth every 4 hours as needed for shortness of breath or wheezing..." - Chest congestant 100 mg/5 mL, active since 02/15/2024, with instructions to, "Take 15 mL by mouth 3 times daily as needed for cough." - Hyoscyamine 0.125 mg tablets, active since 04/15/2024, with instructions to, "Take 1 tablet by mouth every 2 hours as needed...purpose: hospice related respiratory congestion." - Lorazepam 0.5 mg tablets, active since 03/06/2024, with instructions to, "Take 1 tablet by mouth every 4 hours as needed for anxiety,	N 397		

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N 397	Continued From page 6 restlessness, or nausea..." - Morphine sulfate 15 mg tablets, active since 09/11/2023, with instructions to, "Take 1/2 tablet (7.5 mg) by mouth every 4 hours as needed for pain or dyspnea..." 2) Resident 6, who had diagnoses including generalized anxiety disorder, cerebral palsy, and spondylosis - Hydroxyzine 25 mg tablets, active since 05/27/2024, with instructions to, "Take 1 tablet 3 times daily as needed for anxiety." - Diazepam 5 mg tablets, active since 03/01/2024, with instructions to, "Take 1 tablet by mouth 1-3 times per day as needed for muscle spasms." - Arnica relief cream, active since 04/10/2024, with instructions to, "Apply to painful areas of body each morning and 1 time later in the day as needed." - Hydromorphone 2 mg tablets, active since 06/13/2024 with instructions to, "Take 1 tablet by mouth every 4 hours as needed for pain." - Hyoscyamine 0.125 mg tablets, active since 06/13/2024, with instructions to, "Take 1 tablet by mouth every 4 hours as needed for congestion or bladder spasms." - Calcium antacid 500 mg chew, active since 07/08/2024, with instructions to take "1 tablet by mouth 3 times daily as needed for heartburn / [gastrointestinal upset]." 3) Resident 7, who had diagnoses including unspecified eye pinguecula [small growth on the eye that can cause symptoms of redness, dry eye, or irritation] - Acetaminophen 500 mg caplets, active since 03/21/2024, with instructions to, "Take 2 tablets by mouth every 6 hours as needed for pain." - Ibuprofen 200 mg tablets, active since	N 397		

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N 397	Continued From page 7 03/05/2024, with instructions to, "Take 1-4 tablets by mouth every 8 hours as needed." - Polyvinyl alcohol 1.4% solution, active since 03/05/2024, with instructions to, "Instill 1 drop in both eyes twice daily as needed." On 07/24/2024, Surveyor reviewed the staff schedule from 05/01/2024 through 07/24/2024 as well as department-approved training records for the provider's staff who worked NOC shifts in that same timeframe. The staff schedule documented that NOC shift occurred from 10:00 p.m. until 6:30 a.m. Surveyor observed the following 5 staff who worked NOC shifts and were not trained in medication administration: Former Caregiver P, Former Caregiver Q, Caregiver R, Caregiver S, and Caregiver T. On 07/24/2024, Surveyor verified that all 5 staff (Former Caregiver P, Former Caregiver Q, Caregiver R, Caregiver S, and Caregiver T) were not on the Community-Based Care and Treatment training registry for medication administration. In reviewing the staff schedule, Surveyor observed the following 10 NOC shifts in which there were no staff working who were trained in medication administration: - NOC shift from 05/03/2024 - 05/04/2024 (Former Caregiver P, Caregiver R, and Caregiver S working) - NOC shift from 05/04/2024 - 05/05/2024 (Caregiver T working) - NOC shift from 05/07/2024 - 05/08/2024 (Former Caregiver P and Caregiver S working) - NOC shift from 05/08/2024 - 05/09/2024 (Former Caregiver Q and Caregiver S working) - NOC shift from 05/18/2024 - 05/19/2024 (Former Caregiver P and Caregiver T working) - NOC shift from 05/21/2024 - 05/22/2024 (Former Caregiver P, Caregiver R, and Caregiver	N 397		

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N 397	Continued From page 8 S working) - NOC shift from 05/22/2024 - 05/23/2024 (Former Caregiver P and Caregiver S working) - NOC shift from 06/08/2024 - 06/09/2024 (Former Caregiver P and Caregiver S working) - NOC shift from 06/21/2024 - 06/22/2024 (Caregiver R and Caregiver S working) - NOC shift from 07/20/2024 - 07/21/2024 (Caregiver U and Caregiver S working) On 07/24/2024, at approximately 12:38 p.m., Surveyor interviewed Nurse D. Nurse D reported that it was the provider's practice to not let staff pass medications until they were both CBRF-trained in medication administration as well as delegated by a nurse. Nurse D reported that the provider required nursing delegation even for topically and orally administered medications (including tablets and capsules). At approximately 12:43 p.m., Surveyor interviewed Community Director E. Community Director E corroborated Nurse D's report that staff were not allowed to pass medications until they were both CBRF-trained in medication administration as well as delegated by a nurse to pass medications. Community Director E reported recalling a caregiver, Former Caregiver V, who was employed by the provider and CBRF-trained in medication administration but was not delegated by the nurse to pass medications. Community Director E reported that because of that, Former Caregiver V did not pass medications. In reviewing the staff schedule again, Surveyor observed an additional 4 NOC shifts that there would have been no one qualified to pass medications since Former Caregiver V was not a medication passer:	N 397		

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N 397	Continued From page 9 - NOC shift from 05/05/2024 - 05/06/2024 (Former Caregiver P, Former Caregiver V, and Caregiver S working) - NOC shift from 05/17/2024 - 05/18/2024 (Former Caregiver P and Former Caregiver V working) - NOC shift from 05/19/2024 - 05/20/2024 (Former Caregiver V and Caregiver S working) - NOC shift from 06/09/2024 - 06/10/2024 (Former Caregiver V and Caregiver S working) At approximately 1:35 p.m., Surveyor interviewed Resident 6. Resident 6 reported that it happened "fairly often" that staff on the night shift were not able to pass medications. Resident 6 reported that s/he became aware of this because on some occasions s/he would request a PRN medication for pain or anxiety and be told by staff that they couldn't give them to him/her because they were not able to pass medications. At approximately 2:15 p.m., Surveyor interviewed Executive Director A, Nurse D, and Community Director E. Executive Director A and Community Director E confirmed Surveyor's review that Former Caregivers P, Q, and V, as well as Caregivers R, S, T, and U did not pass medications. All 3 acknowledged Surveyor's concern that for the above 14 NOC shifts, there was not a qualified staff member working. Executive Director A reported s/he was unaware that staff could administer oral and topical medications without having to be delegated by a registered nurse to do so. At approximately 4:35 p.m., Surveyor interviewed Former Caregiver V. Former Caregiver V confirmed that even though s/he was CBRF-trained in medication administration, s/he	N 397		

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N 397	Continued From page 10 did not pass medications on any of his/her worked shifts throughout his/her employment due to the provider's policy that s/he had to be delegated to do so. Former Caregiver V reported that during some of his/her NOC shifts when residents requested PRN medications, such as for pain, staff who were untrained were either still administering the medications or were telling residents they would have to wait until the next shift to receive any medications.	N 397		
{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 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.	{N 431}		

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{N 431}	Continued From page 11	{N 431}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that Resident 6's health was monitored in accordance with his/her medical provider's care plan for the provider's staff to notify the medical provider's clinic for weight gains of 3 lbs in 1 day. Resident 6's weight monitoring was in relation to his/her chronic kidney disease with fluid retention.

This is a repeat deficiency. See Statement of Deficiency (SOD) PI0512, dated 02/28/2024.

Findings include:

On 07/24/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 12/13/2023 with diagnoses including stage IV chronic kidney disease. Surveyor reviewed Resident 6's observation notes from 05/01/2024 - 07/24/2024 and observed the following entry:

- 05/29/2024 (10:00 a.m.): "Resident had an appointment yesterday with Kidney [sic] doctor. Per after visit summary, '...Please weight yourself daily using same scale, around the same time each day, and either while undressed or in the same type of clothing. Should check weight after urinating but before eating. Contact us if experiencing symptoms of fluid retention (greater than 3 pounds of weight gain in a day or 5 pounds

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{N 431}	Continued From page 12	{N 431}		

in a week, worsening shortness of breath, fatigue, trouble lying flat in bed, abdominal fullness, swell or dry cough...' Resident updated we will continue to monitor and all added to care plan."

Surveyor reviewed Resident 6's medication administration records (MARs) from 06/01/2024 - 07/24/2024, where staff appeared to track Resident 6's daily weights with active dates listed from 05/30/2024 - 07/22/2024. The instructions included in the entry documented, "Please weigh resident daily each morning prior to eating breakfast. Try to keep same amount of clothing on and foot pedals on. Contact clinic if weight is increased by 3 pounds in 1 day or 5 pounds in a week..." In reviewing Resident 6's weights, Surveyor observed the following 6 occasions in which Resident 6 was documented as gaining more than 3 pounds in 1 day:

- Weight on 06/13/2024 (9:00 a.m.) = 231 pounds; weight on 06/14/2024 (8:00 a.m.) = 252 pounds (gain of 21 pounds)
- Weight on 06/17/2024 (7:36 a.m.) = 248 pounds; weight on 06/18/2024 (1:32 p.m.) = 261 pounds (gain of 13 pounds)
- Weight on 06/19/2024 (9:00 a.m.) = 250.1 pounds; weight on 06/20/2024 (8:50 a.m.) = 257 pounds (gain of 6.9 pounds)
- Weight on 06/20/2024 (8:50 a.m.) = 257 pounds; weight on 06/21/2024 (10:10 a.m.) = 261 pounds (gain of 4 pounds)
- Weight on 06/26/2024 (11:22 a.m.) = 251 pounds; weight on 06/27/2024 (1:03 p.m.) = 254 pounds (gain of 3 pounds)
- Weight on 07/13/2024 (9:20 a.m.) = 255 pounds; weight on 07/14/2024 (3:07 p.m.): = 261 pounds (gain of 6 pounds)

No annotations were documented in either of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017372	A. BUILDING: _____ B. WING _____	R-C 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING OF WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 431}	Continued From page 13 above entries of any follow up monitoring, medical provider communication, or actions taken as a result of Resident 6's weight gains. Surveyor reviewed Resident 6's observation notes again but did not see any information regarding the above documented occurrences of weight gain. At approximately 2:15 p.m., Surveyor interviewed Executive Director A, Nurse D, and Community Director E. Nurse D reported that the daily weight monitoring was initiated by Resident 6's kidney doctor due to Resident 6 experiencing increased edema in his/her lower extremities and the medical provider trialing different medications for him/her related to fluid retention. When asked how documented weight gains were handled by staff, Nurse D replied that caregiving staff either notified him/her directly so that s/he could contact Resident 6's medical provider to notify the clinic of Resident 6's weight gains, or s/he him/herself directly reviewed Resident 6's MARs for weight gains and would then contact Resident 6's medical provider about any such occurrences. Nurse D reported that s/he reviewed Resident 6's MARs weekly. When asked if Nurse D was aware of any of the above occasions in which Resident 6 was documented with weight gains, Nurse D reported s/he was not.	{N 431}		