STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510386	A. BUILDING: _____ B. WING _____	C 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LACROSSE MC	**3161 E AVENUE SOUTH LA CROSSE, WI 54601**

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N 000	Initial Comments On 01/08/2025, Surveyor conducted a complaint investigation at Brookdale La Crosse MC. The complaint was substantiated. Two deficiencies were identified. Census: 27	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately safeguard residents from misconduct, investigate misconduct, or document an investigation of misconduct, when	N 158		

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

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N 158	Continued From page 1 there were 2 allegations of misappropriation of Resident 1's scheduled Hydrocodone medication between September 2024 and November 2024. Resident 1's Hydrocodone medication was removed from its original packaging and replaced with an unknown medication in September of 2024. The provider did not investigate the missing medication until sometime in December 2024, after the second incident occurred. The provider did not report the first incident of misappropriation to the department. The provider did not provide documentation that an investigation occurred. Resident 1's Hydrocodone medication went missing sometime between October 2024 and November 2024. The pages from the narcotics logbook were torn out on the corresponding dates when the medication went missing. The provider did not begin a formal investigation until approximately 10 days after the allegations were made. The provider did not report misappropriation to the department within 7 calendar days from the date the CBRF (community based residential facility) knew or should have known about the second incident of misappropriation. Findings include: On 11/26/2024, the department received a complaint related to misappropriation of resident property. EXAMPLE 1 On 11/26/2024, at approximately 3:30 PM, Surveyor interviewed Power of Attorney (POA) J via phone. POA J stated there was an incident in September 2024 when 3 of Resident 1's	N 158		

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Hydrocodone pills went missing. POA J stated an employee noticed the medications were tampered with and reported it to the provider but they did not contact the police. POA J stated it was determined 3 Hydrocodone pills were taken and replaced with Tylenol. POA J stated that incident was not reported to him/her and it was only discovered after the second incident of missing medications took place in November 2024.

At approximately 4:00 PM, Surveyor received an email from POA J with a police report and supplemental information related to his/her concerns.

At approximately 4:15 PM, Surveyor reviewed the provider's department file and did not see evidence the incident was reported to the department.

On 01/08/2025, at approximately 12:30 PM, Surveyor interviewed District Director (DD) A, Licensed Practical Nurse (LPN) B, and Health Director (HD) C. When asked about any allegations of misappropriation around September 2024, LPN B stated 3 of Resident 1's Hydrocodone pills had been popped out of original packaging and replaced with a different pill. When asked if an investigation was conducted regarding the incident, DD A stated s/he did not believe there was an investigation at that time. DD A stated it was after the second allegation that it was brought to the attention of staff at the district level. DD A stated s/he remembered one of the caregivers referencing it and believed it was reported to the health and wellness director at the time. DD A stated it did not appear the health and wellness director followed up on the allegations. DD A stated Clinical Director (CD) D was asked to look into

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the concerns and they "tried to do backtracking" sometime in December 2024. When asked if the allegations were reported to the department, LPN B stated s/he was not sure they were reported.

At approximately 2:00 PM, Surveyor reviewed records for Resident 1, including the police report and investigation summary. A police report, dated 11/18/2024, described an investigation related to the second incident of Resident 1's missing medications. Under a section titled, "Contact with [ED I]" it stated, in part, "I asked [ED I] if this has happened before. [S/he] indicated yes, in August or September of 2024 they had a narcotic go missing. However, it was only three pills at that time."

At approximately 2:20 PM, Surveyor interviewed CD D. CD D stated LPN B reported the situation regarding the 3 missing Hydrocodone pills to Health Director (HD) K. CD D stated HD K no longer worked for the provider and it appeared nothing else happened after it was reported to HD K. CD D stated LPN B felt it was handled appropriately. When asked if the allegations were reported to the department, CD D stated s/he was not aware of them being reported. When asked if misappropriation was identified, CD D stated it was, and that "someone took the meds (medications) and replaced them." CD D stated they did not have any idea who took the medications. CD D stated s/he did not become aware of those allegations until December 2024. When asked if the POA was notified of the allegations, CD D stated there was nothing in the chart about the POA being notified.

EXAMPLE 2

On 11/26/2024, at approximately 3:30 PM,

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N 158	Continued From page 4 Surveyor interviewed POA J via phone. POA J stated s/he received a call on 11/14/2024 from Resident 1's medical provider. Resident 1's medical provider informed POA J that Resident 1's staff called to refill Resident 1's Hydrocodone medication on 11/08/2024, and again on 11/12/2024. POA J stated s/he was not aware of any concerns at that time and was not notified of medications being missing. POA J stated it was his/her understanding that Resident 1's last dose of Hydrocodone was given on 11/04/2024. POA J stated s/he met with LPN B on 11/15/2024. LPN B reported s/he did not know anything, and the provider was starting an investigation. POA J stated s/he met with ED I and ED I did not become aware of the situation until 11/14/2024. On 01/08/2025, at approximately 12:30 PM, Surveyor interviewed DD A, LPN B, and HD C. When asked about allegations of misappropriation, DD A stated that in early November, Resident 1's Hydrocodone medication was reported to be out of stock by 2 separate medication passers. It was also reported that pages of the narcotic logbook were missing and/or blank. DD A stated there was some initial confusion on whether the medication was out of stock or missing. LPN B stated s/he understood the medication to be out of stock and put in a new order for the medication. LPN B stated s/he did not check the medication cart or the narcotics logbook before requesting the new order. DD A stated that when it was identified the pages of the narcotic logbook had been torn, it prompted staff to look into it further. DD A stated the pages were torn out on 11/05/2024. DD A stated they believed Resident 1 received his/her last dose of the medication on 11/04/2024. DD A stated Resident 1 was to receive scheduled Hydrocodone 3 times daily. DD A stated they were concerned to	N 158		

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discover that narcotic counts were not being done by staff as required by the provider. DD A stated nobody admitted to taking the medications and they did not identify who did. DD A stated they could not provide the date of when the POA was notified of the allegations. Surveyor asked LPN B when s/he notified management about the allegations, and s/he stated, "right away." When asked to clarify the date in which s/he reported the allegations, s/she stated s/he did not know. DD A stated ED I called him/her on 11/14/2024 regarding the allegations and DD A started assisting with the investigation on 11/15/2024.

At approximately 2:00 PM, Surveyor reviewed records for Resident 1 including the police report and investigation summary.

Resident 1 was admitted on 07/29/2024 and had an activated power of attorney.

An "Incident Investigation," dated 11/14/2024, included the following summary of allegations: "Prescribed narcotic medication, specifically Hydrocodone, for [Resident 1] was reported to be out of stock or missing to [LPN B,] by Medication Technicians [Caregiver E] and [Caregiver F,] separately, on 11/5/24. It was additionally reported on this day that the pages in the Narcotic Book/Log corresponding to this medication had been removed." Under a section titled, "Associate Interviews," there was a section detailing an interview with LPN B. Under an interview summary, it read, in part, "Interview by [ED I]: [LPN B] reported medication as missing on 11/14/2024. LPN stated that the medication had not been given for about a month and it was last refilled/delivered on 10/18/2024 ..." An additional interview with LPN B was conducted on 11/25/2024, and read, "[LPN B] was asked if s/he

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was certain of the timeline of events relayed in previous interviews. [LPN B] stated [s/he] is certain that someone, although [s/he] cannot recall who, informed [him/her] on 11/4 during 1st shift that the meds were out and needed to reorder [sic]. [S/he] admits [s/he] forgot to follow up on the issue that day and someone, again [s/he] does not recall who, mentioned again that the meds were out and that is when [s/he] put the request in to the physician." Under a section titled, "Summary of Findings," it read, "An unknown quantity of Hydrocodone pills prescribed for [Resident 1] are unaccounted for - substantiated. Narcotic records related to the Hydrocodone in question were tampered with and are unaccounted for - substantiated. Procedures related to counting narcotics were not properly followed - substantiated. Investigation efforts are unable to identify and [sic] individual or individuals responsible for the narcotics being unaccounted for." Under a section titled, "Timeline," it read, "11/4/24 - 11/5/2024 - timeframe in which narcotics went missing. 11/14/2024 - ED (Executive Director) notified of situation and investigation began."

A police report, dated 11/18/2024, read, in part, "I am asking that further follow up be conducted by the Investigative Services Bureau to attempt to locate who is responsible for taking the narcotic controlled substance that was prescribed to [Resident 1.] ...[Resident 1], however, did run out and that the 28 day cycle that was supposed to start on 10/20/2024 [sic] was consumed by 11/04/2024 and there is approximately a rough estimate of 34 Hydrocodone pills missing (325 mg each.)"

A self-report, dated 11/27/2024, was submitted to the department by the provider. It included a

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N 158	Continued From page 7 summary of the second allegation of the missing Hydrocodone with an incident date of 11/05/2024. Based on record review and interview, the provider did not immediately safeguard residents from misconduct when 2 allegations of misappropriation were reported. The provider did not investigate the first allegation until months later and did not report the incident to the department. The provider did not investigate the second allegation until approximately 10 days after concerns were reported and did not report the allegations to the department within 7 days. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 158		
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 Resident 1 received all medications in the dosages and at intervals prescribed by a practitioner. Resident 1 did not receive 32 doses of his/her scheduled Hydrocodone medication in November 2024 . Findings include:	N 352		

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N 352	Continued From page 8 The provider is licensed to care for 33 residents in the client groups of irreversible dementia/Alzheimer's disease and advanced aged. On 11/26/2024, the department received a complaint alleging residents were not receiving their prescribed medications. At approximately 3:30 PM, Surveyor interviewed Power of Attorney (POA) J via phone. POA J stated the provider was investigating staff misconduct and someone had stolen Resident 1's Hydrocodone pain medication. POA J stated Resident 1 was scheduled for the medication 3 times daily and had been prescribed the medication for many years. POA J stated Resident 1 did not receive the medication for approximately 11 days and experienced significant withdrawal symptoms as a result. On 01/08/2025, at approximately 12:30 PM, Surveyor interviewed District Director (DD) A, Licensed Practical Nurse (LPN) B, and Health Director (HD) C. When asked about Resident 1's Hydrocodone medication, DD A stated there was an investigation conducted that found Resident 1 had an unknown amount of Hydrocodone pills unaccounted for. DD A stated they believed the Hydrocodone was last administered to Resident 1 on 11/04/2024. LPN B stated the Hydrocodone was re-ordered and administration was resumed on 11/15/2024. At approximately 1:10 PM, Surveyor requested Resident 1's records, including the most recent Individual Service Plan (ISP) and the last 3 months of medication administration records (MAR.)	N 352		

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N 352	Continued From page 9 Resident 1 was admitted on 07/29/2024 and had his/her medications managed by the provider. The November 2024 MAR indicated the following medication was not signed off as administered for the following dates and times: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG: Give 1 tablet by mouth three times a day for chronic pain. 11/05/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/06/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/07/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/08/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/09/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/10/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/11/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/12/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/13/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/14/2024: 8:00 AM, 2:00 PM and 8:00 PM. 11/15/2024: 8:00 AM and 2:00 PM. On 11/08/2024, at approximately 3:00 PM, Surveyor interviewed HD C. Surveyor asked HD C to review the November 2024 MAR and clarify when Resident 1's Hydrocodone was given. HD C stated a check mark meant the medication was given, and each entry should include staff initials. HD C stated it appeared Resident 1's Hydrocodone was not given between 11/05/2024 and 11/15/2024. There were no check marks on the corresponding dates. HD C stated it appeared it was last given on 11/04/2024 and administration was resumed at 8:00 PM on 11/15/2024. HD C stated the nurses may not have been guided as well as they should have been. HD C stated s/he would hold staff accountable and required tasks would be completed moving forward.	N 352		

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N 352	Continued From page 10 Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	N 352		