| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 0018831 | A. BUILDING: _____ B. WING _____ | C 05/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRAIRIE POINTE ASSISTED LIVING AND MEMORY C/ | 286 N WILLSON DR ALTOONA, WI 54720 |

| (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 |
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| N 000 | Initial Comments<br><br>On 05/08/2024, Surveyors conducted a complaint investigation at Prairie Pointe Assisted Living and Memory Care. Data collection continued through 05/16/2024.<br><br>Two of 5 complaints were substantiated.<br><br>Three deficiencies were identified.<br><br>Census: 39 | N 000 | | |
| N 230 | 83.19 Orientation<br><br>Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following:<br>(1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Caregiver F received orientation training prior to performing job duties.<br><br>Findings include:<br><br>The definition of "employee" under DHS 83.02(22) states, "Employee" means any person who works for a CBRF (community based | N 230 | | |

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

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| N 230 | Continued From page 1 | N 230 | | |

residential facility) or for an entity that is affiliated with the CBRF, or that is under contract to the CBRF, who is under direct control of the CBRF or corporation affiliated with the CBRF and who receives compensation subject to state and federal employee withholding taxes.

On 05/08/2024, Surveyor requested review of the staff schedule for actual hours worked, including the months of February through March 2024.

Caregiver F was listed on the schedule on 02/21/2024 and 02/24/2024, and was identified as a contracted agency employee.

On 05/14/2024 at approximately 2:30 PM, Surveyor interviewed Caregiver G. Caregiver G stated s/he was responsible for "showing [Caregiver F] around" on 02/21/2024, as it was his/her first day working at the facility. Caregiver G stated s/he did not provide any orientation training and informed Surveyor they do not typically do any training with employees from an agency staff.

On 05/15/2024 at approximately 12:00 PM, Surveyor interviewed Caregiver F and asked if s/he received orientation on his/her first day working at the facility on 02/21/2024. Caregiver F stated s/he did not receive any orientation training and stated, "I felt comfortable doing cares because I've done it before." Caregiver F stated s/he arrived for his/her shift on 02/21/2024, met with the nurse, received a tour of the facility, and was introduced to the residents. Caregiver F stated s/he provided personal cares to residents on 02/21/2024 and 02/24/2024, including transfers on residents with an assessed need for use of a mechanical lift.

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| N 230 | Continued From page 2<br><br>On 05/15/2024 at approximately 12:20 PM, Surveyor interviewed Agency Personnel (AP) H and asked if the staffing agency provides any training for staff prior to working at a facility. AP H stated, "Agency staff are required to get any orientation and training through the facility they are picking up shifts at. The contract states that agency staff can go in up to one hour prior to their first shift worked at the facility to receive any orientation training required by the facility. I don't know specifically if [facility name] requires that but I know some do."<br><br>On 05/15/2024, Surveyor requested Caregiver F's record. The record did not contain documentation for any of the following orientation requirements:<br><br>(1) Job responsibilities.<br>(2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property.<br>(3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible.<br>(4) Emergency and disaster plan and evacuation procedures under s. DHS 83.47 (2).<br>(5) CBRF policies and procedures.<br>(6) Recognizing and responding to resident changes of condition.<br><br>On 05/16/2024 at approximately 11:45 AM, Surveyor discussed the above concern with Chief Operating Officer (COO) A, Administrator B, Nurse Supervisor D and Clinical Educator E. COO A stated they did recognize Caregiver F did not receive orientation, and informed Surveyor they did not have a process in place to ensure contracted agency staff employees received orientation prior to performing job duties. COO A stated all employees will receive orientation prior to performing job duties going forward. | N 230 | | |

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| 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 prompt and adequate treatment after increased bleeding from the rectum.<br><br>Findings include:<br><br>On 01/19/2024, the department received a complaint alleging a resident's change in condition was not promptly assessed.<br><br>On 05/08/2024 at approximately 2:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/17/2023. Resident 1 was his/her own decision maker and had diagnoses that included mild cognitive impairment, anemia, gastro-esophageal reflux disease, history of gastric ulcer, mixed irritable bowel syndrome, hemorrhoids, and history of anus and rectum hemorrhage.<br><br>Surveyor reviewed Resident 1's progress notes, which read, in part:<br><br>12/21/2023 at 4:00 PM written by Nursing Supervisor (NS) C - "This writer was informed that resident was experiencing rectal bleeding. It was noted that resident had 3 garbage bags full of bloody wipes and toilet full of bright red blood. | N 353 | | |

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| N 353 | Continued From page 4<br><br>Resident stated that [s/he] first noticed the bleeding prior to lunch and thought it was just [his/her] hemorrhoids from having a bowel movement and it would resolve. The bleeding continued throughout the day. VSS (vital sign score). [Primary Care Practitioner] called and message left. Call placed to daughter and informed [him/her] of the bleeding, [s/he] is in agreement that resident be sent to [emergency room]. Resident left facility with facility transport and went to [emergency room]."<br><br>12/22/2023 at 1:21 PM written by NS C - "Resident returned from ER (emergency room) late evening on 12/21/23. New orders for Hydrocortisone cream to be applied into the rectum two times daily for 14 days. Referral placed for colon and rectal surgery clinic."<br><br>A medical note, dated 12/21/2023, indicated Resident 1 had a history of chronic intermittent rectal bleeding. The note read, in part, "[Resident 1] states [s/he] was having some constipation, took a stool softener, and then had bright red blood per rectum ...Patient was admitted for similar in February during which time [s/he] had an EGD (Esophagogastroduodenoscopy) which demonstrated nonbleeding gastric ulcer and gastritis. Colonoscopy demonstrated internal and external hemorrhoids, rectal prolapse, multiple polyps requiring biopsy, and diverticulosis." The medical note indicated Resident 1's hemoglobin was mildly decreased at 9.2. It was noted Resident 1's condition was stable, s/he was discharged with a new medication, and it was recommended to try Sitz baths. Resident 1 was instructed to return for medical evaluation if bleeding continued over 2 more days, or the bleeding rate increased. | N 353 | | |

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| N 353 | Continued From page 5<br><br>On 05/09/2024 at 1:00 PM, Surveyor interviewed Caregiver I. Caregiver I indicated s/he worked the evening of 12/21/2023. Caregiver I stated Resident 1 rang his/her call button and s/he found Resident 1 sitting on his/her toilet with the bathroom garbage can filled up with bloody wipes. Resident 1 commented to Caregiver I that Resident 1 had started bleeding right before the noon meal and s/he tried to get NS C to come assess at that time. Resident 1 had requested to speak to NS C. Caregiver I stated s/he went to NS C with Resident 1's bleeding concerns and NS C dismissed the concerns by stating it was just Resident 1's hemorrhoids. NS C did not come to assess Resident 1 and Caregiver I returned to Resident 1 in his/her bathroom. Resident 1 was still expressing concern with the abnormal amount of bleeding so Caregiver I went back to NS C again. NS C again dismissed Caregiver I's concerns and NS C stated Resident 1 would be fine once s/he stood up from the toilet and s/he would assess Resident 1 later. Caregiver I went to the nurse's station and asked a more "seasoned staff" to come and assess Resident 1. The other staff did not think Caregiver I was overreacting, and they both went to NS C for a third time. NS C finally came to assess Resident 1's bleeding concerns between 4:00 PM and 5:00 PM. Caregiver I stated that once NS C entered Resident 1's bathroom, s/he stated, "Holy [expletive], that is a lot of blood." Caregiver I stated that by this time, Resident 1 was starting to feel weak and queasy. Resident 1 was sent out before 6:00 PM to be medically evaluated. Caregiver I stated s/he was frustrated with NS C's lack of response to Resident 1's situation and not taking his/her concerns seriously.<br><br>On 05/16/2024 at approximately 11:45 AM, Surveyor discussed the above concern with Chief | N 353 | | |

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| N 353 | Continued From page 6<br><br>Operating Officer (COO) A, Administrator B, NS D and Clinical Educator E. NS D stated staff charting for hemorrhoidal bleeding would be put in as a task or in the medication administration record (MAR) to alert staff each shift. NS D stated staff were provided education upon hire related to bleeding and when to notify management. NS D stated staff were not able to enter progress notes for bowel movements. NS D stated staff would send an internal communication to nursing staff and nursing staff were responsible to enter progress notes in the resident's medical record. Administrator B stated s/he was only made aware when Resident 1 was sent out to be medically evaluated. Administrator B stated they had been aware of some clinical and professional performance issues with NS C and s/he was on a progressive discipline path. Surveyor observed NS C was not part of the exit conference.<br><br>The provider did not ensure Resident 1 received prompt and adequate treatment after increased bleeding from the rectum on 12/21/2023, before the noon meal. Caregiver I made 3 attempts to bring the concerns to NS C before NS C came to assess Resident 1. Resident 1 was medically evaluated and diagnosed with hemorrhoidal bleeding. | N 353 | | |
| N 410 | 83.37(1)(k) Medication error or adverse reaction.<br><br>Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, | N 410 | | |

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| N 410 | Continued From page 7<br>supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not document all errors in the administration of Resident 2's medication.<br><br>Findings include:<br><br>On 01/11/2024, the department received a complaint alleging a resident received the wrong medications.<br><br>On 05/08/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 05/09/2023. Resident 2 had diagnoses that included type 2 diabetes mellitus, major depressive disorder, paroxysmal atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, and spinal stenosis. Resident 2 was his/her own decision maker. Resident 2 discharged from the facility on 01/09/2024.<br><br>The individual service plan (ISP), dated 08/02/2023, indicated Resident 2 had a risk for falls due to an unsteady gait. The ISP indicated Resident 2 used a walker for all transfers, and with ambulation independently. Resident 2 had his/her medications managed by the provider.<br><br>Surveyor reviewed nurse progress notes initially received at 11:45 AM, which indicated the | N 410 | | |

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following:

07/27/2023 at 4:58 PM written by Nursing Supervisor (NS) C - "Call placed to [doctor's] office and message left for nurse to return call regarding resident receiving incorrect medication. Awaiting return call."

07/28/2023 at 11:16 AM written by Nursing Supervisor (NS) D - "Notified that resident had a fall during the night. [S/he] was noted to be hallucinating and believed that there was someone in [his/her] room and went to confront this person landing on knees. [S/he] was able to be assisted from floor with staff assist and hoyer [sic]. No apparent injury. [S/he] had received incorrect medication on shift prior. [Doctor] has been updated of both medication concern and incident."

07/28/2023 at 12:30 PM written by NS C - "Call received from RN (registered nurse) ...Informed of wrong medication given to resident on 7/27 and also informed of fall on NOC (overnight) shift and hallucinations. RN requested that fax be sent with above information for [doctor] to review. Fax sent to [doctor]. Awaiting return fax."

07/31/2023 at 8:32 AM written by NS C - "Signed fax received from [doctor] ...No new orders."

On 05/08/2023 at 2:08 PM, Surveyors requested additional details for the medication error incident on 07/27/2023.

Surveyors reviewed additional nurse progress notes received at 3:10 PM, which indicated the following:

Late entry: 07/27/2023 at 4:59 PM written by NS

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C - "Resident received medication that was intended for resident in room 207. Resident received Metformin 1000mg, Preservision AREDS, and Lyrica 100mg."

Late entry: 07/28/2023 at 11:16 AM written by NS C - "Post fall assessment: Resident denies pain. No apparent injury noted. Resident able to move all four extremities freely. Resident was encouraged to use call pendant for assistance and if [s/he] were to be experiencing any further hallucinations. Staff were instructed to inform nurse if resident voices experiencing hallucination."

A communication dated 07/27/2023 at 4:29 PM between NS C and a triage nurse read, in part, "Nurse from assisted living calls to report med (medication) error. No symptoms for triage. Transferred back to clinic scheduler to assist in sending team a message."

A physician notification fax dated 07/28/2023 from NS C to Resident 2's doctor read, "On 07/27/2023. Resident received the following medications in error: Lyrica 100mg, Metformin 1000mg, and Preservision AREDS. Resident has orders for Metformin 500mg and Lyrica 50mg. The Metformin 1000mg was given at the time [his/her] Metformin 500mg would have been given, the Lyrica 100mg was given at approximately 1545 (3:45 PM) and [s/he] takes Lyrica 50mg at bedtime. [S/he] has orders for Preservision AREDS in AM, meaning [s/he] received this medication twice on that date. Residents VS (vital signs) were stable following incident. At approximately 1930 (7:30 PM), resident began feeling 'woozy in the head' and very tired. [S/he] was not given the Lyrica 50mg at bedtime, but received [his/her] bedtime

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medication as prescribed. At approximately 0330 (3:30 AM), resident was found on the floor. Resident stated that [s/he] saw someone sitting in the chair in [his/her] room and [s/he] lunged out of bed. There was not anyone else in the room. No injury noted. Denies increased pain. Today, resident remains tired, but alert when woken. No further adverse effects noted. Please note and advise of any new orders." The doctor acknowledged the notification on 07/31/2023 and had no further orders.

The July 2023 medication administration record (MAR) indicated staff charted that Resident 2 received his/her scheduled regular evening doses of Lyrica 50 mg and Metformin 500 mg on 07/27/2023.

On 05/08/2024 at 3:33 PM, Surveyors interviewed Administrator B about the additional nurse progress notes received at 3:10 PM. Administrator B stated the two entries by NS C were entered into Resident 2's progress notes on the day of survey (05/08/2024). Administrator B agreed the progress notes were too vague and now they were aware of what needed to be included in the progress notes for the future. Administrator B stated NS C added in the details Surveyors requested. Administrator B clarified incident reports staff fill out were not part of residents' medical records and were considered internal communication and used for quality assurance (QA) purposes.

On 05/08/2024 at 3:39 PM, Surveyors interviewed NS C with Administrator B present, and asked if the two progress note entries received at 3:10 PM were added in today. Initially NS C stated the two progress note entries were not entered on the day of survey but on the date of the incident. Surveyor

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asked why the two progress note entries were not provided initially with the other progress notes. NS C stated they must not have been pulled for some reason with the other progress notes. Surveyor clarified what Administrator B stated about the two progress note entries being added on the day of survey. NS C clarified s/he had entered the two progress note entries on the day of survey and was told by Chief Operating Officer (COO) A to enter the progress note dates for the date of the incidents (07/27/2023, and 07/28/2023) and not on the day of survey when they were added. NS C stated that for Resident 2's medication error (receiving the wrong medications), s/he did leave a message for the physician, who responded the next day. NS C stated staff were educated to monitor Resident 2 overnight and update management with any changes. Surveyor asked NS C to clarify how frequently staff were to check on Resident 2 during the night. NS C stated staff normally checked on residents every 2 hours, so staff were expected to check on Resident 2 more frequently than that. NS C stated s/he had directed staff not to give Resident 2's evening scheduled medications after the incident. Two of the wrong medications Resident 2 received were higher doses of his/her regular scheduled medications.

On 05/09/2024 at 1:00 PM, Surveyor interviewed Caregiver I. Caregiver I stated hallucinations for Resident 2 were abnormal. Caregiver I stated that when a resident would have an incident, staff would fill out a paper incident report form that described the incident in detail. Staff would put the paper incident form in the nurse's office for review and staff would not document the incident in the resident's medical record. Caregiver I stated the nurses were responsible for entering the information into the resident's medical record

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018831 | A. BUILDING: _____ B. WING _____ | C 05/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRAIRIE POINTE ASSISTED LIVING AND MEMORY CA | 286 N WILLSON DR ALTOONA, WI 54720 |

| (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 410 | Continued From page 12<br>after the fact.<br><br>On 05/16/2024 at approximately 11:45 AM, Surveyors discussed the above concern with COO A, Administrator B, NS D and Clinical Educator E. NS D stated that in the situation where Resident 2 received the wrong medication, staff would have immediately called the on-call nurse to discuss the situation. NS D stated staff were not able to enter progress notes for incidents but would send an internal communication to nursing staff. NS D stated nursing staff would assess the incident and do a root cause analysis. Nursing staff were responsible for documenting the incident in the medical record. COO A acknowledged complete incident details were not getting into the medical record and stated education would be provided to make sure this happened in the future. NS D confirmed Resident 2's MAR was marked as given for the scheduled medications due after the incident. NS D stated staff were instructed not to give Resident 2 his/her scheduled medications and thought it was marked as given by mistake but did not know for sure with the lack of documentation related to this incident. Surveyors discussed concern regarding the late entry progress note written by NS C on the day of survey (05/08/2024), backdated to 07/27/2023 and 07/28//2023. Clinical Educator E stated s/he was in the room when NS C was looking for direction and COO A did not direct NS C to back date the progress note to the date of the incident.<br><br>The provider did not document all errors in the administration of Resident 2's medication when Resident 2 received another resident's medication on 07/27/2023 and the details were not recorded in Resident 2's medical record. | N 410 | | |