STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

(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 06/14/2023, Surveyor conducted a standard survey at Lilac Springs Assisted Living LLC. Seven deficiencies were identified. Census: 20	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on observation, record review and	N 239		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	06/23/2023

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N 239	Continued From page 1	N 239		

interview, the provider did not ensure 1 of 3 employees obtained all department approved training as required.

Caregiver C did not have training in fire safety within 90 days after starting employment.

Caregiver C did not have training in first aid and choking within 90 days after starting employment.

Findings include:

On 06/14/2023, Surveyor conducted a review of 3 employees to verify compliance with department approved training requirements. Surveyor reviewed the employee record of Caregiver C and noted the following concerns:

Fire Safety

The records for Caregiver C, hired 02/28/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 06/15/2023, at approximately 12:30 p.m., Surveyor interviewed Caregiver C, who was working at the time of the survey. Caregiver C stated s/he had received training in fire safety by his/her previous employer but was not sure if it was the department approved training. At approximately 2:00 p.m., Surveyor interviewed Administrator A. Administrator A confirmed the provider did not have evidence Caregiver C had completed or met an exemption for fire safety training.

On 06/14/2023, Surveyor verified Caregiver C was not on the Community-Based Care and Treatment training registry for fire safety.

First Aid and Choking

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N 239	Continued From page 2 The records for Caregiver C, hired 02/28/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 06/15/2023, at approximately 12:30 p.m., Surveyor interviewed Caregiver C, who was working at the time of the survey. Caregiver C stated s/he had received training in first aid and choking by his/her previous employer but was not sure if it was the department approved training. At approximately 2:00 p.m., Surveyor interviewed Administrator A. Administrator A confirmed the provider did not have evidence Caregiver C had completed or met an exemption for first aid and choking training. On 06/14/2023, Surveyor verified Caregiver C was not on the Community-Based Care and Treatment training registry for first aid and choking.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 243	Continued From page 3 Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed, obtained all training as required within 90 days after starting employment. Caregiver D did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver D did not have training in required	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 243	Continued From page 4 client groups within 90 days after starting employment. Findings include: On 06/14/2023, Surveyor conducted a review of 3 employees initial training to verify compliance with all employee training requirements. Surveyor reviewed the employee record of Caregiver D and noted the following concerns: Recognizing, Preventing, Managing and Responding to Challenging Behaviors The records for Caregiver D, hired 02/06/2023 did not contain evidence of training or meeting an exemption for challenging behaviors training. On 06/14/2023, at approximately 2:00 p.m., Surveyor interviewed Administrator A. Administrator A confirmed the provider did not have evidence Caregiver D completed or met an exemption for challenging behaviors. Client Group The facility was licensed to provide care and services to residents within the client groups of terminally ill, advanced age and irreversible dementia/Alzheimer's. The records for Caregiver D, hired 02/06/2023 did not contain evidence of training or meeting an exemption for client group training. On 06/14/2023, at approximately 2:00 p.m., Surveyor interviewed Administrator A. Administrator A confirmed the provider did not have evidence Caregiver D completed or met an exemption for client group.	N 243		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 5 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 his/her quetiapine and sliding scale humalog as ordered. Findings include: On 06/14/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 08/29/2022 with diagnoses including diabetes and dementia. Surveyor reviewed Resident 1's prescription for quetiapine fumarate 100 mg tab to take twice daily at 8:00 a.m. and 8:00 p.m. with a start date of 04/07/2023 and an order for humalog 100 units/ml kwikpen to inject subcutaneously in the morning, noon, evening and bedtime based on sliding scale: <151=0UN; 151-200=4UN; 201-250=7UN; 251-300=10UN; 301-350=12UN; 351-400=15UN; >400=16UN and call MD with a start date of 03/07/2023. Surveyor reviewed Resident 1's May and June 2023 medication administration record (MAR) which documented the following occurrences when the insulin administered did not follow physician's orders: 05/26/2023 8:00 p.m. BS 362, 12 units administered. Order indicates 15 units needed. 06/07/2023 12:00 p.m. BS 164, 0 units administered. Order indicates 4 units needed.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 6 06/07/2023 4:00 p.m. BS 179, 0 units administered. Order indicates 4 units needed. Resident 1 did not receive his/her 8:00 a.m. or 8:00 p.m. quetiapine femarate 100 mg tab starting from 06/10/2023 to 06/14/2023. At the time of the survey, Resident 1 had missed 9 doses of his/her prescribed quetiapine and the provider did not have the medication available for administration. On 06/14/2023, at 12:23 p.m., Surveyor interviewed Caregiver E, who was administering medications during the time of the survey. Surveyor asked Caregiver E if Resident 1's quetiapine was available for administration. Caregiver E stated that not having medications is usually not a problem, but that his/her quetiapine has not been available for a few days now. At 12:35 p.m., Surveyor interviewed Care Coordinator B in regards to Resident 1's quetiapine not being available for administration. Care Coordinator B stated that due to insurance, Resident 1's physician has to re-order his/her medications every month. Care Coordinator B stated s/he did not receive documentation that Resident 1's quetiapine had been renewed or reinstated, so 4 days after the last quetiapine order ended, s/he destroyed the remaining medication. Care Coordinator B stated that today is the first time s/he was made aware that Resident 1's quetiapine was re-ordered on 06/10/2023 and was not available for administration and stated s/he will contact the pharmacy to fill the order.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

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N 389	Continued From page 7 Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not update Resident 1's individual service plan (ISP) to include verbal aggression and threatening gestures. Findings include: On 06/14/2023, Surveyor conducted a standard survey. At approximately 10:30 a.m., Surveyor interviewed Care Coordinator B and asked if there were any residents who have aggressive behaviors. Care Coordinator B stated Resident 1 was verbally aggressive and will make threatening gestures. At approximately 12:15 p.m., Surveyor observed Resident 1 in the dining room for lunch with other residents and Resident 1 was yelling and being verbally aggressive towards caregivers and peers.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 389	Continued From page 8 At approximately 12:20 p.m., Surveyor interviewed Caregiver E in regards to Resident 1's behaviors. Caregiver E stated that Resident 1 has a lot of highs and lows and will engage in verbal aggression and often makes threatening gestures to staff like shaking his/her fists or like s/he will cut their neck. Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 08/29/2022 with diagnoses including diabetes and dementia. A progress note, dated 06/05/2023 stated, "Resident became very agitated, waving [his/her] arms and shaking [his/her] fists at staff." Resident 1's ISP, dated 12/16/2022, did not include any aggressive behaviors. At approximately 2:00 p.m., Surveyor interviewed Administrator A and Care Coordinator B. Administrator A stated that s/he was told that falls and elopements needed to be addressed in the ISP but was not aware that behaviors should be included.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 408	Continued From page 9	N 408		

limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) included the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN lorazepam and that it was monitored at least monthly for inappropriate use.

Findings include:

On 06/14/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 08/29/2022 with diagnoses including diabetes and dementia. Resident 1 has a prescription for lorazepam 1 mg tablet to take once daily as needed for agitation or anxiety with a start date of 01/17/2023.

Surveyor reviewed Resident 1's ISP, dated 12/16/2022. The ISP did not include Resident 1's prescription for PRN lorazepam or the rationale for use and a detailed description of the behaviors which indicate the need for administration.

Surveyor reviewed Resident 1's May and June 2023 medication administration record (MAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 408	Continued From page 10 which documents Resident 1 received his/her PRN lorazepam on: 05/01/2023, 05/02/2023, 05/10/2023, 05/14/2023, 05/24/2023 and 06/05/2023. At approximately 1:45 p.m., Surveyor asked Administrator A for the documentation of Resident 1's monthly monitoring of PRN lorazepam use. Administrator A stated s/he does not have that. At approximately 2:00 p.m., Surveyor interviewed Administrator A and Care Coordinator B. Administrator A stated that s/he was unaware that PRN psychotropic medications are required to be monitored on at least a monthly basis and are to be included in the ISP.	N 408		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure caregivers accurately documented in Resident 1's medication	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

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N 415	Continued From page 11	N 415		

administration record (MAR) when s/he did not have his/her prescribed quetiapine available for administration.

Findings include:

On 06/14/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 08/29/2022 with diagnoses including diabetes and dementia. Surveyor reviewed Resident 1's prescription for quetiapine fumarate 100 mg tab to take twice daily at 8:00 a.m. and 8:00 p.m.

Surveyor reviewed Resident 1's May and June 2023 MAR which documented the following:
06/10/2023, 8:00 a.m. - administered
06/10/2023, 8:00 p.m. - "REFUSED-Medication on order"
06/11/2023, 8:00 a.m. - administered
06/11/2023, 8:00 p.m. - "REFUSED-Medication on order"
06/12/2023, 8:00 a.m. - "REFUSED-Other problems"
06/12/2023, 8:00 p.m. - administered
06/13/2023, 8:00 a.m. - administered
06/13/2023, 8:00 p.m. - "REFUSED-Medication on order"
06/14/2023, 8:00 a.m. - "REFUSED-Other problems"

At 12:23 p.m., Surveyor interviewed Caregiver E, who was administering medications during the time of the survey. Surveyor asked Caregiver E if Resident 1's quetiapine was available for administration. Caregiver E stated that not having medications is usually not a problem, but that his/her quetiapine has not been available for a few days now. Surveyor asked how some caregivers are documenting that they were able to administer the medications if it is not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

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N 415	Continued From page 12 Caregiver E stated s/he knows the medication is not in the facility, so it must be a documentation error. At 12:35 p.m., Surveyor interviewed Care Coordinator B in regards to the documentation of Resident 1's MAR. Care Coordinator B confirmed that the medication was not available and that any time the medication was documented as administered was a documentation error.	N 415		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of any furnace or hot water heater in 2 of 2 maintenance rooms. Findings include: On 06/14/2023, at approximately 10:30 a.m., Surveyor toured the environment with Care Coordinator B. Care Coordinator B showed Surveyor the maintenance room on wing 2 which had 2 plastic buckets, and several cardboard boxes within 3 feet of the furnace. Care Coordinator B showed Surveyor the maintenance room on wing 1 which had a large plastic folding table approximately 6 inches in front of the furnace and hot water heater. The plastic table was covered with other combustible materials such as card board, plastic and paper.	N 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 507	Continued From page 13 At approximately 2:00 p.m., Surveyor interviewed Administrator A and Care Coordinator B. Administrator A stated s/he will ensure all combustible materials are removed from both maintenance rooms and moved to another storage area.	N 507		