STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111056	A. BUILDING: _____ B. WING _____	C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN CROSSINGS AT HUNTER RIDGE	626 MONROE ST BEAVER DAM, WI 53916

(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 08/07/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Sylvan Crossings at Hunter Ridge, a community-based residential facility (CBRF) located in Beaver Dam, WI. As a result of the survey, 1 deficiency was identified. This is a repeat deficiency. See Statement of Deficiency (SOD) V0S814, dated 01/03/2024, SOD V0S813, dated 08/08/2023, SOD V0S812, dated 02/17/2023, and SOD V0S811, dated 07/01/2022. The complaint was substantiated. Census: 20	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 Resident 1's insulin was held when his/her blood sugar was 49 on the evening of 07/01/2024. During this incident, Resident 1 had repeatedly refused his/her insulin but staff administered it. Resident 1 was also prescribed a glucose oral gel to be administered for hypoglycemia, however, this was not on hand	N 352		

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

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N 352	Continued From page 1 at the facility. Resident 1 was taken to the emergency department that evening for concerns of hypoglycemia. This is a repeat deficiency. See Statement of Deficiency (SOD) V0S814, dated 01/03/2024, SOD V0S813, dated 08/08/2023, SOD V0S812, dated 02/17/2023, and SOD V0S811, dated 07/01/2022. Findings include: On 08/07/2024, Surveyor conducted a complaint investigation into concerns of insulin administration and diabetes management. At approximately 12:38 p.m., Surveyor requested records from Executive Director A. Executive Director A reported that on 07/01/2024, a new owner took over operating the facility and by extension, the provider's electronic record systems had changed. Executive Director A reported that some information provided would be from the old owner's records and some from the new owner's records. At approximately 1:50 p.m., Surveyor interviewed Resident 1. When asked about any recent hospitalizations or emergency room visits, Resident 1 replied that s/he went to the emergency department in July one time for "very low" blood sugar. Resident 1 reported that on this occasion his/her blood sugar level was so low that it "could've killed me." Resident 1 reported fear and concerns for what could have happened to him/her. Resident 1 reported that earlier on the evening of that incident a medication passer, who didn't speak any English, was administering medications. Resident 1 reported that this medication passer took his/her blood sugar,	N 352		

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N 352	Continued From page 2 which was somewhere around 35-45. Resident 1 reported that at this low a level s/he should not have been administered any insulin. Resident 1 reported that the medication passer had given him/her orange juice or some other sugary beverage in attempts to increase his/her blood sugar but then afterwards began preparing Resident 1's insulin. Resident 1 reported s/he repeatedly told the medication passer "No!" and "No shot!" but the medication passer injected it anyways. Resident 1 reported that s/he didn't think the medication passer understood him/her due to having limited English understanding and speaking abilities. Resident 1 reported that s/he typically has to use the medication passer's personal cell phone for any language translation but the medication passer didn't attempt to use his/her phone during that incident for further clarification or communication of what had happened. Resident 1 reported that after the injection s/he couldn't recall if any staff did anything to try to increase his/her blood sugar and reported that s/he had been feeling sleepy during the entire evening. Resident 1 reported that at some point after the injection his/her family member, Family Member B, arrived to the facility to take him/her to the emergency department, where s/he was given orange juice and sugary snacks. Resident 1 reported that after approximately 3 hours, his/her blood sugar levels had increased back to regular levels. On 08/07/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 10/24/2023 with diagnoses including type 2 diabetes mellitus with diabetic neuropathy. Resident 1's medical provider orders and prescriptions included - Blood sugars to be checked before meals and	N 352		

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N 352	Continued From page 3	N 352		

at bedtimes (4 times daily)
- Lantus SoloStar 100 unit/mL pen with instructions to, "Inject 45 unit subcutaneously at bedtime..."
- Glucose oral gel 15 gm/32mL, with a start date of 06/26/2024 and instructions to, "Give 15 gram by mouth as needed for hypoglycemia (may repeat once if blood sugar less than 70)."

Surveyor reviewed Resident 1's medication administration records (MARs) from 07/01/2024 - 08/07/2024 and observed 1 occasion in which Resident 1's blood sugar level was under 70 - around 8:00 p.m. on 07/01/2024. One entry, under his/her blood sugar reading entries, documented that at around 8:00 p.m. that evening his/her blood sugar was 39. A separate entry for his/her 8:00 p.m. Lantus injection documented that at around 8:00 p.m. that evening his/her blood sugar was 49. Under the Lantus entry, Caregiver C initialed off on administering Resident 1's Lantus. The entries for Resident 1's glucose gel were blank, indicating that it was not administered at any time.

Surveyor reviewed Resident 1's individual service plans (ISPs) - 1 which was was developed by staff from the previous owner's company that was signed as reviewed on 01/04/2024 and 1 of which was developed by staff from the new owner's company on 07/11/2024. Resident 1 was documented as having an activated power of attorney for healthcare. Resident 1's old ISP, which would have been active during the 07/01/2024 incident above, documented that Resident 1 was "on a sliding scale for [his/her] diabetes," and that s/he required staff assistance to monitor blood sugars four times daily and insulin injections. Resident 1's most recent ISP, dated 07/11/2024, documented that Resident 1

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required assistance for "insulin injections, pens and blood sugar checks, including supplies." Neither ISP contained any guidance or information for how staff were to manage Resident 1 experiencing high or low blood sugars.

On 08/07/2024, Surveyor reviewed documents provided by Administrator A regarding the 07/01/2024 incident. A "Medication Error" form, dated 07/02/2024, documented that Resident 1 experienced a medication error involving a wrong dose and a wrong time of administration. An additional form, titled, "Employee Counseling Record" documented the following:

"On 7/1/2024 the [residential care coordinator] called Director to inform that residents [sic] blood sugar was 39 at bedtime and [s/he] wsa [sic] informed by [Caregiver C] the med passer. Director instructed to give orange juice immediately. Resident was coherent but just did not feel well. Instructed to test again in 15 minutes Blood sugar rose to 49. Director instructed to give more [orange juice] and sweets. [Residential care coordinator] called Director and stated that [Caregiver C] had given reeisident [sic] [his/her] insulin while [s/he] was this low. Director has removed [Caregiver C] from med pass due to the failure of understanding the danger of blood sugar levels. This could have had severe consequences for the resident.

"[Caregiver C] has been removed from med passing due to lack of understanding and the language barrier of medications as demonstrated in this incident. If at such a time that [Caregiver C] can comprehend, read and write English, a refresher med class will be conducted and new delegation by a Nurse."

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N 352	Continued From page 5 At approximately 2:15 p.m., Surveyor interviewed Executive Director A about the 07/01/2024 incident. Executive Director A confirmed that s/he was who typed up the employee counseling form for the incident. Executive Director A reported that Residential Care Coordinator D, referenced from the form, is who called him/her that evening at approximately 9:00-9:15 p.m. to inform him/her about Resident 1's low blood sugar. Executive Director A reported that after Resident 1's blood sugar had risen from 39 to 49 that s/he still instructed Residential Care Coordinator D to ensure orange juice and sweets were given to Resident 1 due to this level being still so low. Executive Director A reported that despite that guidance, which was relayed to Caregiver C, Caregiver C still gave Resident 1 his/her insulin. Executive Director A reported that s/he spoke to Resident 1's family member, Family Member B, who told him/her that s/he was on the phone with Resident 1 when this whole incident took place and could hear Resident 1 saying "no" to the insulin injection and instructing Caregiver C to not give it. Executive Director A confirmed that Resident 1 was taken to the emergency department that evening with low blood sugar concerns and returned later that night. Executive Director A reported that when s/he interviewed Caregiver C the next day about the incident, Caregiver C gave a "blank look" and did not seem to understand the issue with what had happened. Executive Director A reported that it was hard to get a straight answer from him/her about why s/he administered the insulin because s/he would just reply, "["Yes", in a different language]." Executive Director A reported that s/he had also been concerned regarding the aspect that Caregiver C should not have administered any medication that a resident was refusing,	N 352		

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N 352	Continued From page 6 regardless of whether s/he understood the issue with Resident 1's low blood sugar. When asked to clarify about Caregiver C's limited English understanding, Executive Director A reported that Caregiver C did not read or write in English. Executive Director A reported that s/he had been told by the previous owner's staff, Vice President of Training and Compliance E, that Caregiver C was trained in medication administration and was delegated. Executive Director A reported that despite this, s/he had concerns about Caregiver C's ability to know medications, understand what s/he was administering, read any prescription instructions, or be able to read and understand any order changes. Executive Director A stated, "It's been frustrating." During this same interview, Executive Director A reported that after the incident occurred s/he reviewed the provider's medication cart and discovered that Resident 1's prescribed glucose gels were not even on hand. Executive Director A reported s/he wasn't sure if the prescription had ever been filled prior to the incident.	N 352		