| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019281 | A. BUILDING: _____ B. WING _____ | C 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **4 SEASONS AFH 3** | **800 MARTIN RD BLOOMER, WI 54724** |

| (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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| M 000 | INITIAL COMMENTS<br><br>On 01/29/2025, Surveyor conducted a complaint survey at 4 Seasons AFH 3. Data was collected through 01/30/2025.<br><br>The complaint was substantiated.<br><br>One deficiency was identified.<br><br>Census: 3 | M 000 | | |
| M 582 | 88.10(3)(q) Medications<br><br>Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not honor Resident 1's right to refuse medications.<br><br>Staff disguised Resident 1's medication in peanut butter, which caused Resident 1 to choke. The incident led to his/her death.<br><br>Findings include:<br><br>On 11/14/2024, the Department received a complaint that alleged a resident received his/her medications in bread and peanut butter which | M 582 | | |

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

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| M 582 | Continued From page 1<br>caused him/her to choke.<br><br>On 11/13/2024, the provider submitted a self-report to the Department. The report read, in part: "On 11/12/24 at 9:03 staff prepared [Resident 1's] medications and then [his/her] snack (1 slice of bread with peanut butter folded into a sandwich). A few minutes after (approx. 9:07 PM), [s/he] sat down at [his/her] spot at the table and began to eat [his/her] snack. [Resident 1] got up from the table and walked away and the staff noticed [s/he] had a large bite of [his/her] snack in [his/her] mouth. Staff tried to redirect [Resident 1] back to sit down, however they were unsuccessful and [Resident 1] continued towards [his/her] bedroom. Staff followed to assess [Resident 1] and noticed signs of choking. Staff called 911 and called [House Lead (HL) B] at 9:10 PM. In the meantime staff stayed next to [Resident 1] and encouraged [Resident 1] to try to cough and patted [him/her] on the back as [s/he] was still conscious and alert. [HL B] called [Licensee A] and I went to the home to assist while awaiting EMS (emergency medical services). Staff and [Licensee A] performed the heimlich [sic] maneuver. [Licensee A] placed a 2nd call to 911 at 9:17 PM because we could hear the sirens but no one had arrived at the home yet. [Licensee A] and Staff continued to try to provide airway clearing until EMS arrived. 2 deputies from Chippewa County arrived first, and at that point took over life saving [sic] efforts. They tried the heimlich [sic] and then began chest compressions. First responders and an ambulance arrived and took over and transported [Resident 1] to [hospital] in Bloomer. I followed the ambulance to the hospital and waited in the waiting room. [House Manager (HM) C] called [Guardian D] from [corporation] to inform [him/her] of the incident. Shortly before 10 pm, a | M 582 | | |

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nurse arrived in the waiting room to tell me, the hospital provided life saving [sic] measures, however these were unsuccessful. [S/he] informed me that they had made guardian contact as well before they stopped any life saving measures ... [Resident 1] was pronounced deceased ... Staff immediately called 911 and used the skills they learned from training to try to intervene while calling for additional support. In addition to the current required trainings that are provided to all staff, I am going to explore more in depth training for choking, looking into CPR (cardiopulmonary resuscitation) certification for staff and do research on any if [sic] there are any department and FDA (Food and Drug Administration) approved anti choking devices to have present in all homes and available for trained staff member to use in case of emergencies." This report was signed by Licensee A.

On 01/29/2025 at approximately 1:00 p.m., Surveyor interviewed Licensee A and HL B. Licensee A told Surveyor Resident 1's medications were crushed, except for his/her Depakote, which could not be crushed. S/he said staff would administer Resident 1's medications with his/her snack. Licensee A said Resident 1 would take his/her medications as s/he chose. Sometimes Resident 1 would mix his/her medications into his/her food on his/her own. For example, if his/her medications were in yogurt, s/he may dump his/her yogurt into the spaghetti. Licensee A said staff were instructed to give Resident 1 food and his/her medications at the table and to tell Resident 1 here [sic] is your food and medications and give Resident 1 time to eat and take his/her medications.

On 01/29/2025, Surveyor reviewed Resident 1's

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record.

On 03/13/2024, Resident 1 was admitted to the facility. S/he had multiple diagnoses, including moderate intellectual disabilities, disorder of teeth and supporting structures, unspecified psychosis, and unspecified mood disorder.

Resident 1's individual service plan (ISP), signed 06/24/2024, read, in part: "[Resident 1] refuses medications at times. There is an order to crush medication due to spitting out and meds (medications) placed in applesauce/yogurt." There was a handwritten addition that read, "add food." This was initialed by Licensee A with a date of 06/24/2024. On 01/29/2025, at approximately 1:15 p.m., Licensee A told Surveyor his/her handwritten notes were added during Resident 1's care conference with Resident 1's care team and guardian.

Resident 1's medication administration record (MAR) for November 2024, indicated Caregiver E attempted to administer Resident 1's medications on the evening of 11/12/2024. On 11/11/2024, Caregiver E documented on Resident 1's MAR for the 8:00 p.m. dose of divalproex sodium (Depakote) DR (delayed release) 500 milligrams, the following: "Tried two times and used bread and peanut butter with marshmallow creme [sic]. Second try was yogurt with whipped creme [sic]. Picked it out both times."

On 01/29/2025, Surveyor reviewed Resident 1's medical records from the hospital, dated 11/12/2024. The documentation read, in part: "[Resident 1] was seen in ED (emergency department) 1. There was an IO (intraosseous) in place upon arrival. [S/he] received 3 rounds of epinephrine in the field. [S/he] received an

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additional 3 rounds here. [S/he] was initially in PEA (pulseless electrical activity) per EMS. En route [s/he] converted to asystole. During our resuscitation [s/he] converted back to PEA. Respiratory therapy reported that [s/he] was difficult to ventilate. (His/her) eye gel (i-gel - airway device) was replaced with an endotracheal tube. There is a large amount of foreign substance in [his/her] pharynx and trachea. It had the consistency and odor of peanut butter. The majority of this was removed. [S/he] was able to be ventilated much easier after that [sic] unfortunately [s/he] did not obtain ROSC (return of spontaneous circulation). [S/he] was pronounced dead at 11:17 p.m." The respiratory therapist documented, in part: "Copious huge chunks of peanut butter and bread suctioned from patients [sic] airway and ETT (endotracheal tube). A very large blue pill also removed from patients [sic] airway with globs of bread and peanut butter."

On 01/29/2025 from 2:37 p.m. to 2:51 p.m., Surveyor interviewed Caregiver E on the phone. Caregiver E told Surveyor s/he was working in the facility the night Resident 1 choked. Caregiver E told Surveyor s/he put Resident 1's pill in peanut butter on bread in the middle of the sandwich. Caregiver E said, "I shouldn't have used so much peanut butter." Surveyor asked how much peanut butter s/he used. Caregiver E replied: "A good amount." Surveyor asked if Resident 1 knew his/her pill was in the peanut butter and bread. Caregiver E told Surveyor s/he covered the pill with peanut butter so Resident 1 would not notice it. Surveyor asked if Caregiver E told Resident 1 that his/her pill was on the bread. Caregiver E told Surveyor s/he did not tell Resident 1. S/he said Resident 1 would not take the food if Resident 1 knew his/her pill was in it.

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| M 582 | Continued From page 5<br><br>On 01/30/2025 at approximately 9:30 a.m., Surveyor interviewed Licensee A on the phone. Surveyor told Licensee A concerns that staff had disguised Resident 1's medication in the peanut butter which caused Resident 1 to choke and die. Licensee A was audibly upset. Licensee A said staff have been trained on medication administration and on resident rights, including a resident right to refuse medications. Licensee A told Surveyor s/he was "frustrated" that staff would do that. Licensee A followed the phone interview with an email that read, in part: "In every medication storage room I have refusal rights posted along with all relevant DHS (Department of Health Services) codes, the caregiver manual and resident rights posters. I have provided extensive in person training and coaching to all staff on medication administration and the right to refuse. Between myself [sic] and managers, we do spot checks monthly and pop in during med pass to ensure accuracy and rights. Going forward, I plan to retrain all staff on refusal rights, medication administration and choking. We will also be implementing more frequent spot checks on medication passes."<br><br>Caregiver E did not honor Resident 1's right to refuse medications when Caregiver E attempted to disguise Resident 1's medication in peanut butter in order for Resident 1 to take his/her medication. This caused Resident 1 to choke, which subsequently lead to Resident 1's death. | M 582 | | |