STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	R 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 09/27/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Hamilton Park Place, a community-based residential facility (CBRF) located in Portage, WI. As a result of the survey, 4 deficiencies were identified. Three of the 4 deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) WHTX11, dated 05/25/2022, SOD WHTX12, dated 12/12/2022, and SOD WHTX13, dated 05/09/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 22	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on interview and record review, the licensee did not ensure the CBRF and its operation complied with all laws governing it. The licensee did not ensure that special orders issued from the Department on 07/13/2023 with Statement of Deficiency (SOD) WHTX13 were followed. Findings include:	N 196		

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

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N 196	Continued From page 1 On 9/27/2023, Surveyor reviewed Department records for the provider and observed a "Notice and Order" letter, issued on 07/13/2023, which included the following under the "SPECIAL ORDERS" heading: "Based on the results of the Department ' s investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Hamilton Park Place: "1. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee will comply with the requirements specified by Wis. Admin. Code § DHS 83.32(3)(h), and ensure each resident's right to 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. The licensee will develop (or review/revise) written procedures and staff training (as appropriate) to address: "Medication Management, including how the facility will document medication orders, medication administration, missed/refused doses; and ensure residents receive medications at the intervals and dosages prescribed. Refer to: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm "Diabetes Management, to include standards of practice for the assessment, care planning, and provision of services for residents with diabetes. Additional information and resources addressing diabetes can be located on the department website:	N 196		

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N 196	Continued From page 2 https://www.dhs.wisconsin.gov/diabetes/index.htm "Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request." On 09/27/2023, at approximately 12:30 p.m., Surveyor requested from Director M all evidence of the provider's compliance with the special orders above. At approximately 2:15 p.m., Surveyor interviewed Director M and Interim Administrator H. Interim Administrator H reported that the special orders were not addressed. Interim Administrator H reported that the provider was busy addressing a lot of staffing changes since the last SOD was issued and that the special orders were overlooked. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 196		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication	{N 352}		

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{N 352}	Continued From page 3 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 1 of 2 residents reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 2 received the incorrect amount of sliding scale insulin on 4 administrations between 09/01/2023 - 09/27/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) WHTX11, dated 05/25/2022, SOD WHTX12, dated 12/12/2022, and SOD WHTX13, dated 05/09/2023. Findings include: On 09/27/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 08/22/2022 with diagnoses including type 1 diabetes mellitus. Resident 2's prescriptions included the following: - Humalog 100 units/mL KwikPen with a start date of 07/17/2023 and instructions to "inject per sliding scale before breakfast and lunch: 200-250 give extra 2 units; 251-350 give 4 extra units; 351-450 give 6 extra units; 451-499 give 8 extra units if >500 give 10 extra units."	{N 352}		

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{N 352}	Continued From page 4 - Humalog 100 units/mL KwikPen with a start date of 06/30/2023 and instructions to "inject per sliding scale with supper: 200-250 give extra 2 units; 251-350 give 4 extra units; 351-450 give 6 extra units; 451-499 give 8 extra units if >500 give 10 extra units." - Humalog 100 units/mL KwikPen with a start date of 07/18/2023 and instructions to "inject 4 units subcutaneously 2 times a day before meals..." In reviewing the medication administration records (MARs) for Resident 2, this order was applied with administration times to correlate with breakfast (8:00 a.m.) and lunch (11:30 a.m.). - Humalog 100 units/mL KwikPen with a start date of 07/17/2023 and instructions to "inject 4 units subcutaneously every evening with supper..." Surveyor reviewed Resident 2's medication administration record (MAR) from 09/01/2023 - 09/27/2023. Surveyor observed that staff at times appeared to document dosage consistent with the total number of insulin units administered (between Resident 2's scheduled and sliding scale insulin) and at times staff documented only the number of sliding scale insulin units administered. Surveyor observed the following 4 administrations that did not correlate with what should have been administered: - 09/13/2023 (breakfast): Blood sugar documented as 338, 6 units documented as administered (should have been either 8 units if the total was documented or 4 units if just sliding scale was documented) - 09/14/2023 (breakfast): Blood sugar	{N 352}		

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{N 352}	Continued From page 5 documented as 244, 10 units documented as administered (should have been either 6 units if the total was documented or 2 units if just sliding scale was documented) - 09/18/2023 (supper): Blood sugar documented as 271, 2 units documented as administered (should have been either 8 units if the total was documented or 4 units if just sliding scale was documented) - 09/24/2023 (breakfast): Blood sugar documented as 338, 6 units documented as administered (should have been either 8 units if the total was documented or 4 units if just sliding scale was documented) At approximately 2:15 p.m., Surveyor interviewed Interim Administrator H and Director M. Both acknowledged Surveyor's concern that Resident 2 received the incorrect amount of insulin on the 4 occasions above. Interim Administrator H reported s/he would look further into it and address insulin administration with staff. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 352}		
{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.	{N 408}		

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{N 408}	Continued From page 6 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not 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 that the individual service plan (ISP) for Resident 8, who was prescribed as-needed (PRN) Lorazepam and was administered it 8 times across 26 days, included a rationale for use and detailed description of the behaviors indicating the need for its administration. This is a repeat deficiency. See Statement of Deficiency (SOD) WHTX13, dated 05/09/2023. Findings include: On 09/27/2023, at approximately 12:50 p.m., Surveyor reviewed the medication cart with Caregiver N. Surveyor observed a medication card with a pharmacy label indicating that the card contained 14 Lorazepam 0.5 mg tablets, prescribed to Resident 8, with a dispensed date of 09/21/2023. The card had 1 tablet popped out with "9/24" handwritten next to the popped out tablet pack.	{N 408}		

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{N 408}	Continued From page 7 On 09/27/2023, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 03/24/2023 with diagnoses including dementia and delirium. Resident 8's prescriptions included the following: - Lorazepam 0.5 mg tablet, active from 05/31/2023 - 09/20/2023, with instructions to "take 1 tablet by mouth 2 times a day as needed for anxiety." - Lorazepam 0.5 mg tablet, active from 09/20/2023 through current, with instructions to "take 1 tablet by mouth once daily as needed for anxiety." Surveyor reviewed Resident 8's medication administration record (MAR), dated 09/01/2023 - 09/26/2023, and observed the following 8 administrations with the associated reasons for administration documented: - 09/04/2023 (2:15 a.m.): "Resident is very anxious tonight." - 09/07/2023 (7:47 p.m.): "Is anxious and is getting up every 45 seconds to go with family." - 09/12/2023 (11:07 p.m.): "Very anxious tonight and keeps wondering[sic] around." - 09/14/2023 (5:16 p.m.): "A lot of up and down, a lot of confusing memories from past which is making anxiety worse for resident." - 09/14/2023 (9:24 p.m.): "Too anxious to go to sleep." - 09/17/2023 (7:30 p.m.): "Anxious trying to wonder[sic] outside to go with people who are not here." - 09/20/2023 (7:38 p.m.): "To[sic] anxious to sit or even lay down." - 09/24/2023 (6:49 p.m.): "Is trying to get up and leave the building to go on adventures with people who are not present."	{N 408}		

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{N 408}	Continued From page 8 For each administration of Resident 8's Lorazepam, a line in his/her MAR documented, "Given for Intended Use/according to Isp[sic]?" with the response of "Yes" recorded. Surveyor then reviewed Resident 8's current ISP (not dated). There was no evidence of a rationale for use and detailed description of the behaviors indicating the need for his/her PRN Lorazepam administration. At approximately 2:15 p.m., Surveyor interviewed Interim Administrator H and Director M. Surveyor discussed the concern that Resident 8's ISP did not include a rationale for use and the detailed description of behaviors indicating the need for his/her PRN Lorazepam administration. Interim Administrator H reviewed Resident 8's ISP and confirmed s/he could not find information about Resident 8's PRN Lorazepam use. Interim Administrator H reported that it was Former Nurse J's job to have updated Resident 8's ISP with this information since it was discussed during the last survey. Interim Administrator H reported that it was frustrating that Former Nurse J did not do this.	{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	{N 415}		

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{N 415}	Continued From page 9	{N 415}		

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 that medication dosages were documented in a consistent way to verify the dosage administered for 1 of 2 residents reviewed.

Between 09/01/2023 - 09/27/2023, staff inconsistently documented the amount of insulin administered to Resident 2. Two of 5 staff documented only the amount of sliding scale administered in accordance with the medication administration record (MAR) entries for each meal time administration, and 3 of 5 staff documented the total amount of insulin administered to Resident 2 (between his/her scheduled dose and sliding scale units) in the sliding scale entries.

This is a repeat deficiency. See Statement of Deficiency (SOD) WHTX11, dated 05/25/2022, SOD WHTX12, dated 12/12/2022, and SOD WHTX13, dated 05/09/2023.

Findings include:

On 09/27/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 08/22/2022 with diagnoses including type 1 diabetes mellitus. Resident 2's prescriptions included the following:

- Humalog 100 units/mL KwikPen with a start

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{N 415}	Continued From page 10	{N 415}		

date of 07/17/2023 and instructions to "inject per sliding scale before breakfast and lunch: 200-250 give extra 2 units; 251-350 give 4 extra units; 351-450 give 6 extra units; 451-499 give 8 extra units if >500 give 10 extra units."

- Humalog 100 units/mL KwikPen with a start date of 06/30/2023 and instructions to "inject per sliding scale with supper: 200-250 give extra 2 units; 251-350 give 4 extra units; 351-450 give 6 extra units; 451-499 give 8 extra units if >500 give 10 extra units."

- Humalog 100 units/mL KwikPen with a start date of 07/18/2023 and instructions to "inject 4 units subcutaneously 2 times a day before meals..." In reviewing the medication administration records (MARs) for Resident 2, this order was applied with administration times to correlate with breakfast (8:00 a.m.) and lunch (11:30 a.m.).

- Humalog 100 units/mL KwikPen with a start date of 07/17/2023 and instructions to "inject 4 units subcutaneously every evening with supper..."

Surveyor reviewed Resident 2's medication administration record (MAR) from 09/01/2023 - 09/27/2023, and observed that his/her scheduled Humalog (4 units prior to all meals) had its own set of entries that correlated with each meal time where staff initialed off on administering Resident 2 his/her scheduled dose. Surveyor observed that his/her sliding scale Humalog had its own set of entries correlating with each meal time. Within each entry for Resident 2's sliding scale Humalog administration, the MAR documented, "How many units did you give to [Resident 2]?" where staff appeared to document the number of insulin units

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administered. Surveyor observed that 2 of 5 staff, including Caregivers N and O, appeared to document units consistent with the amount of sliding scale insulin only in accordance with the relevant meal time entry. Surveyor observed that 3 of 5 staff, including Caregivers P, Q, and R, appeared to document units consistent with the total amount of insulin administered to Resident 2 between both his/her scheduled and sliding scale doses, however, there were no annotations indicating such. On 3 occasions when Resident 2's blood sugar was not within parameters for sliding scale insulin administration (below 200), but was still within parameters for receiving his/her scheduled dose, Caregiver Q appeared to initial in the scheduled dose entries in addition to documenting 4 insulin units administered in his/her sliding scale entries, including on 09/13/2023 (supper), 09/14/2023 (supper), and 09/15/2023 (supper). Although Caregiver R appeared to document units consistent with the total amount of insulin (scheduled plus sliding scale) administered in Resident 2's sliding scale entries any time his/her sliding scale insulin was administered, on 3 occasions when Resident 2's blood sugar was not within parameters for sliding scale insulin administration, Caregiver R documented administering 0 units (consistent with just documenting sliding scale), including on 09/01/2023 (breakfast), 09/17/2023 (breakfast), and 09/22/2023 (breakfast).

At approximately 2:15 p.m., Surveyor interviewed Interim Administrator H and Director M. Both acknowledged Surveyor's concern that, without staff consistently documenting the sliding scale units administered to Resident 2 , the number of sliding scale units actually administered to him/her was unable to be verified in the MAR. Interim Administrator H reported they would

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{N 415}	Continued From page 12 address the concern with staff. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 415}		