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{N 000}	Initial Comments On 02/13/2024, with information gathered through 02/22/2024, the Bureau of Assisted Living, Southern Regional Office conducted three complaint investigations and verification visit of statement of deficiency (SOD) Y77R14 at Auberge At Brookfield Memory Care Community, located at 1105 Davidson Rd in Brookfield, WI. Two citations of noncompliance were issued, 1 of which was a repeat violation of noncompliance. One of 3 complaints was substantiated. Census: 39 Under statuatory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{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 observation, interview, and record review, the provider did not comply with department issued special orders in regard to statement of deficiency [SOD] Y77R14, as issued to the provider on 11/28/2023. The provider did not ensure SOD Y77R14 and a copy of the Notice and Order letter were sent to Resident 2's Legal Representative V and case manager, Resident 7's Legal Representative EE and case manager, Resident 8's Legal Representative FF, and Resident 9's Legal Representative GG within 7 days of the provider's	N 196		

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

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receipt of the department's special order on 11/28/2023.

The findings included:

On 11/28/2023 at 09:05 A.M., the department issued the provider SOD Y77R14 with an accompanying "Notice and Order" letter including a "Notice of Special Orders."
The "Notice and Order" letter included "SPECIAL ORDERS." A special order included, "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 [the facility]: 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for Resident 2, Resident 7, Resident 8, and Resident 9 with a copy of SOD Y77R14 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the Department representatives upon request."

On 02/13/2024, Surveyors conducted a verification visit of SOD Y77R14, including a review of the department issued orders. At approximately 8:00 A.M., Surveyor conducted an interview with Facility Nurse Y. Facility Nurse Y told Surveyor Administrator E was on leave until 02/19/2024. Surveyor requested Facility Nurse Y to provide Surveyor with any evidence a copy of SOD Y77R14 and a copy of the Notice and Order

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letter were provided to the legal representatives and/or case managers for Resident 2, Resident 7, Resident 8, and Resident 9, as required.

On 02/13/2024 at 11:34 A.M., Surveyor conducted an interview with Facility Nurse Y. Facility Nurse Y told Surveyor s/he communicated with Administrator E and was told Administrator E was not aware of SOD Y77R14 and the department issued notice and orders. At 11:45 A.M., Facility Nurse Y told Surveyor s/he had not seen SOD Y77R14 and the department issued Notice and Order letter. Surveyor observed Facility Nurse Y retrieve a document from his/her desk top as Facility Nurse Y told Surveyor s/he had the Notice and Order letter issued with SOD Y77R14 but had not read all of it. Facility Nurse Y told Surveyor the legal representatives and/or case managers for Resident 2, Resident 7, Resident 8, and Resident 9 were not provided with a copy of SOD Y77R14 and the Notice and Order letter, as required.

On 02/21/2024 at 2:42 P.M., Surveyor conducted an interview with Administrator E. Administrator E told Surveyor SOD Y77R14 and a copy of the Notice and Order letter were not sent to Resident 2's Legal Representative V and case manager, Resident 7's Legal Representative EE and case manager, Resident 8's Legal Representative FF, and Resident 9's Legal Representative GG following receipt of the department's special order #2 on 11/28/2023, as required. Administrator E told Surveyor the department's special order #2 was overlooked, "an error on [Administrator E's] end." Administrator E told Surveyor s/he was drafting a letter for each recipient, as ordered, and would be sending SOD Y77R14 and a copy of the Notice and Order letter to Resident 2's Legal Representative V and case manager,

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N 196	Continued From page 3 Resident 7's Legal Representative EE and case manager, Resident 8's Legal Representative FF, and Resident 9's Legal Representative GG on this day by certified mail. Administrator E said s/he would place the certified mail receipts in the facility's survey binder as evidence of following the department's order #2. On 02/21/2024 at 5:12 P.M., Surveyor received an email from Administrator E. Administrator E's email included, "[Administrator E] just mailed out letters [as required] and checked email as [Administrator E] was on vacation [from] 11/21 - [until] 11/29/2023."	N 196		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment 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. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 10 was provided with prompt and adequate treatment appropriate to Resident 10's needs. On Thursday, 10/26/2023, Resident 10 was initially admitted to the facility with diagnoses including insulin dependent diabetes and a history of stroke (cerebrovascular accident, CVA). Resident 10's Novolin 70-30 (combination of intermediate-acting insulin and fast-acting insulin) prescription was not available and not administered to Resident 10 and Resident 10's	N 353		

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blood glucose (sugar] monitoring supplies were not available at the facility throughout the weekend of 10/27, 10/28, and 10/29/2023. During this time, Resident 10 was documented to have eaten "robustly" while at the facility and no blood glucose monitoring was performed. There was no evidence any care practitioner, including Resident 10's primary care practitioner, or Resident 10's Legal Representative II were notified the facility did not have insulin, as ordered, to administer to Resident 10. On 10/29/2023, Resident 10 became unresponsive at the facility and sent back to the hospital. Resident 10's blood glucose level was checked at 1055 (a dangerously high glucose level) in the emergency room and was admitted to the hospital's intensive care unit with diagnoses including diabetic ketoacidosis (a serious complication of diabetes that can be life-threatening; related to lack of insulin).

Between 11/13/2023 and 11/15/2023, Resident 10 was hospitalized related to experiencing another cerebrovascular accident (CVA). Resident 10 was ordered to receive glargine insulin once daily in the morning, to replace Resident 10's previously prescribed twice daily Novolog 70-30 insulin. Resident 10's glargine was not available and administered to Resident 10 until 10/27/2023. Meanwhile, the facility caregivers continued to inconsistently administer Resident 10's previously ordered Novolog 70-30 insulin. There was no evidence any care practitioner, including Resident 10's primary care practitioner, or Resident 10's Legal Representative II were notified the facility did not have glargine insulin, as ordered, to administer to Resident 10.

The findings were:

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N 353	Continued From page 5 On 10/31/2023, the department received a complaint alleging the provider did not provide treatment appropriate to a resident's diabetic needs. On 02/13/2024 at 10:00 A.M., Surveyor observed Resident 10 in bed with his/her eyes open and conducted an interview with Resident 10. Resident 10 told Surveyor s/he had diagnoses including diabetes, had eaten breakfast on this day, and received his/her morning insulin. Resident 10 told Surveyor s/he enjoyed the meals provided by the facility. On 02/13/2024 at 10:40 A.M., Surveyor conducted an interview with Facility Nurse JJ. Facility Nurse JJ told Surveyor Resident 10 had diagnoses including dementia and diabetes. Facility Nurse JJ told Surveyor Resident 10 required blood glucose checks performed by caregivers 4 times per day and prescribed insulin administered by caregivers. Facility Nurse JJ told Surveyor Resident 10's prescribed insulin was changed during mid-December 2023 and Resident 10's blood glucose levels were more controlled recently. Facility Nurse JJ told Surveyor Resident 10 has a healthy appetite and liked to eat. Facility Nurse JJ told Surveyor Legal Representative II was Resident 10's legal representative. Facility Nurse JJ told Surveyor Resident 10 received his/her prescribed medications through Pharmacy KK. Facility Nurse JJ Pharmacy KK set up Resident 10's electronic medication administration record [MAR] and the facility staff were required to call Pharmacy KK for needed order changes on Resident 10's electronic MAR. On 02/13/2024, Surveyor reviewed Resident 10's	N 353		

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facility record, as provided by Facility Nurse Y and Facility Nurse JJ. Resident 10 was admitted to the facility for the first time on Thursday, 10/26/2024 from a local hospital with diagnoses including dementia with agitation, diabetes, hypertension, a history of cerebrovascular accident (CVA), a history of suicidal ideation, and a history of homicidal ideation.
Resident 10's hospital history and physical documentation included Resident 10's hospital admission date of 08/22/2023 related to, "[Resident 10]...brought to the ED [emergency department] by [local law enforcement] on a Chapter 55 hold. Per chart review, [Resident 10] threatening [his/her] life and [his/her legal representative's] life, [Resident 10] was asking for a knife so [s/he] can "end it." The documentation included Resident 10's diabetes with long-term and current use of insulin was "poorly controlled." Resident 10's hospital discharge medication list and hospital pharmacist discharge medication note dated 10/24/2023 at 3:18 P.M. included, "Prescriptions were sent/given to: E-prescribed to accepting facility's LTC pharmacy (including [Resident 10's] PTA [prior to admission] medications that have not changed)" and "This [medication] list is being written in advance of discharge so the facility can obtain medications for [Resident 10]." Resident 10's hospital discharge medication list included a "Novolin 70-30 FlexPen" insulin prescription. The prescription included, "Inject 22 units in the morning with breakfast and 8 units at night with dinner into the skin." Resident 10's hospital discharge medication list included prescriptions for a blood glucose monitor, blood glucose test strips, and insulin pen needles.
Resident 10's facility charting notes included an "admission note" documented on 10/26/2023 at 12:26 P.M. by Facility Nurse Y including,

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N 353	Continued From page 7 "[Resident 10] arrived at 11:45 A.M. via ambulance in stretcher. 1 [one] w/c [wheelchair] assist to bed. 1 [one] assist with incontinent [sic] care and dressing from hospital gown. Ambulating < [less than] 500 ft [feet] using walker and SBA [stand-by assist], 1 full assist with w/c mobility to the dining room for lunch. [Resident 10] is pleasantly alert and cooperative." The documentation included Resident 10's vital signs without documentation of Resident 10's blood glucose level monitoring and no mention of Resident 10's prescribed insulin. A charting note documented on Friday, 10/27/2023 at 1:56 P.M. by Facility Nurse Y included, "[Resident 10] is alert and resistant initially to have meals but easily redirected. Consumed 100 % of breakfast and lunch. [Legal Representative II] visiting today." The documentation included Resident 10's vital signs but no documentation of Resident 10's blood glucose level monitoring and administration of prescribed insulin. A charting note documented on Saturday, 10/28/2023 at 7:00 P.M. by Facility Nurse Y included, "Staff report that [Resident 10] is alert and out for meals" and "Completing 100% of meals." The documentation did not include monitoring of Resident 10's blood glucose levels and administration of prescribed insulin. A charting note documented on Sunday, 10/29/2023 at 10:44 A.M. by Facility Nurse Y included, "10:25 A.M. staff called to report [Resident 10] unresponsive to verbal or tactile stimulation. [Legal Representative II] was present...staff unable to get a blood sugar reading. 911 was called and report was given to the paramedics. [Resident 10] was transported by stretcher and ambulance to [local hospital] for further evaluation and treatment." A charting note documented on Sunday,	N 353		

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N 353	Continued From page 8 10/29/2023 at 11:03 A.M. by Former Caregiver X included, "Staff and [Nurse Y] contacted pharmacy numerous times concerning [Resident 10] meds [medications] Friday, 10/27/2023 and Saturday, 10/28/2023 and Sunday 10/29/2023. We [the facility] have other meds [but] still no insulin." Resident 10's charting notes between 10/26/2023 and 10/29/2023 did not include documentation any facility staff contacted any pharmacy, including Pharmacy KK, any physician/practitioner, including Resident 10's primary care physician/practitioner, or Legal Representative II regarding Resident 10's insulin prescription. A charting note documented on Monday, 10/30/2023 at 8:53 A.M., by Nurse Y included, "Writer spoke with [Pharmacy Staff LL] at [Pharmacy KK] who reports leaving multiple messages for [Legal Representative II] about billing for the insulin and medications. [Pharmacy Staff LL] reports that [Legal Representative II] has not returned [his/her] calls. [Pharmacy Staff LL] did send medications to cover [Resident 10] over the weekend as [s/he] stated [s/he] would with the exception of [his/her] insulin." Surveyor reviewed documentation of "Blood Sugar for [Resident 10]" as received from Nurse JJ. There was no documentation of Resident 10's blood glucose/sugar monitoring between Resident 10's admission to the facility on 10/26/2023 and Resident 10's hospitalization on 10/29/2023. On 02/13/2024 at 1:40 P.M., Facility Nurse JJ told Surveyor no blood glucose checks were documented between 10/26/2023 and 10/29/2023 because Resident 10's blood glucose was not monitored by caregivers during that time frame. Surveyor reviewed Resident 10's medication administration records [MARS] between Resident	N 353		

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10's admission to the facility on 10/26/2023 and Resident 10's hospitalization on 10/29/2023, including Resident 10's prescription for Novolin 70-30 insulin. On 10/26/2023, there was no documentation of administration of 8 units of Novolin 70-30 insulin with dinner following Resident 10's admission to the facility, the MAR was blank on this date. On 10/27/2023 and 10/28/2023, caregiver documented "medication not available" for 22 units of Novolin 70-30 insulin with breakfast and 8 units of Novolin 70-30 insulin with dinner. On 10/29/2023, caregiver documentation included "medication not available" for 22 units of Novolin 70-30 insulin with breakfast.

On 02/13/2024, Surveyor reviewed Resident 10's facility record, as provided by Facility Nurse Y and Facility Nurse JJ. A charting note documented on 10/30/2023 at 6:44 P.M.. by Facility Nurse Y included, "Conference with [Legal Representative II] today. [Legal Representative II] was able to speak with [Pharmacy KK] regarding medications, insulin and billing for medications...[Legal Representative II] will supply the insulin and supplies from a private pharmacy due to the excessive cost at [Pharmacy KK]."

On 02/13/2023, Surveyor conducted an interview with Facility Nurse Y. Facility Nurse Y told Surveyor Resident 10 had no health insurance to cover the cost of Resident 10's medication prescriptions when admitted to the facility on 10/26/2023. Facility Nurse Y told Surveyor s/he completed Resident 10's pre-admission assessment and did not know if the facility was aware of Resident 10 not having prescription insurance before or after Resident 10's initial admission to the facility. Facility Nurse Y said s/he was told by Pharmacy KK staff that the

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pharmacy could not do anything about Resident 10's insulin until Legal Representative II decided about paying for Resident 10's insulin. Facility Nurse Y said Resident 10 was not administered any insulin and no blood glucose checks were performed, as ordered, after s/he was admitted on 10/26/2023 until s/he was hospitalized on 10/29/2023. Facility Nurse Y told Surveyor s/he became aware of the situation over the weekend between 10/26/2023 and 10/29/2023, but there was no other option for the facility to obtain Resident 10's insulin and blood glucose monitoring supplies, as ordered, and they were the responsibility of Legal Representative II. Facility Nurse Y told Surveyor Legal Representative II was not at the facility to ask about Resident 10's insulin and s/he was not answering his/her phone. Based on review of Resident 10's charting notes, Legal Representative II visited Resident 10 at the facility on Friday, 10/27/2023 and Sunday, 10/29/2023.

On 02/21/2023 at 12:09, Surveyor conducted an interview with Pharmacy Staff HH. Pharmacy Staff HH told Surveyor Pharmacy KK received Resident 10's E-scribe prescriptions, including Novolin 70-30, from the hospital on 10/25/2023 without any payee or legal representative contact information. Pharmacy Staff HH told Surveyor Pharmacy KK staff attempted to call the facility seeking Legal Representative II's information three times without a response from the facility. Pharmacy Staff HH told Surveyor Pharmacy KK received a call from Facility Nurse Y on 10/26/2023. Pharmacy Staff HH said Facility Nurse Y sent the same information Pharmacy KK had for Resident 10, but did not send any contact information for Legal Representative II or insurance information, as requested. Pharmacy Staff HH said Pharmacy KK placed a "will call" on

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the record for the facility to notify the pharmacy with information requested for Resident 10. Pharmacy Staff HH said s/he was unable to locate any documentation Pharmacy KK was contacted by the facility after 10/26/2023 regarding Resident 10's Novolin 70-30 insulin. Pharmacy Staff HH told Surveyor Pharmacy KK did not receive any contact information for Legal Representative II from the facility until Monday, 10/30/2023. Pharmacy Staff HH told Surveyor Pharmacy KK never filled and delivered Resident 10's Novolin 70-30 insulin order because the order was not authorized by Legal Representative II. Pharmacy Staff HH said Pharmacy KK did not know if the facility had a supply available or went with a different pharmacy to fill the Novolin 70-30 prescription. Pharmacy Staff HH said Pharmacy KK did profile Resident 10's Novolin 70-30 insulin prescription so it showed up within the facility's electronic medication administration record (MAR), but did not fill the prescription and deliver it to the facility.

On 02/21/2023 at 1:34 P.M., Surveyor conducted an interview with Legal Representative II. Legal Representative II told Surveyor Resident 10 did not have prescription insurance when Resident 10 was admitted to the facility on 10/26/2023, but was not sure if the facility was aware of this information. Legal Representative II told Surveyor it was his/her understanding Resident 10 did not receive insulin for a few days following admission to the facility because s/he was admitted at the end of the week and the pharmacy did not deliver all of Resident 10's medications to the facility until after the weekend. Legal Representative II told Surveyor s/he became aware Pharmacy KK had Resident 10's medication orders, including insulin, sent from the hospital before Resident 10 was admitted to the

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N 353	Continued From page 12 facility on 10/26/2023 but did not have enough information from the facility to send Resident 10's insulin to the facility before the weekend. Legal Representative II said s/he was not contacted by the facility staff, including management, over the weekend after Resident 10 was admitted to the facility. Legal Representative II told Surveyor s/he became aware the facility caregivers did not have Resident 10's insulin, as prescribed, over the weekend but no one told the facility management until 10/29/2023. Legal Representative II told Surveyor s/he arrived at the facility on 10/29/2023 and Resident 10 was in a state of unresponsiveness. Legal Representative II said s/he had seen this happen to Resident 10 when Resident 10 lived at home with Legal Representative II and Resident 10's blood sugar was too high. Legal Representative II said approximately 3 caregivers were gathered around Resident 10 in Resident 10's room and they appeared scared because they were "frozen." Legal Representative II said s/he had to ask one of the caregivers to check Resident 10's blood sugar. Legal Representative II said s/he overheard a caregiver call Facility Nurse Y on the phone and the caregiver told him/her Resident 10 did not have any insulin over the weekend because it was not available at the facility. Legal Representative II said s/he overheard Facility Nurse Y respond in a way that made Legal Representative think Facility Nurse Y was not aware of no insulin at the facility for Resident 10. Legal Representative II said the caregiver could not get a blood sugar reading on a monitor and that usually meant Resident 10's blood sugar was too high to register. Legal Representative II said 911 was called and the emergency medical technicians had an issue getting Resident 10's blood sugar before it was checked in the emergency room over 1000.	N 353		

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Legal Representative II said s/he recalls having a conversation with Facility Nurse Y about this incident regarding Resident 10's insulin. Legal Representative II said Facility Nurse Y was kind, apologetic, and took responsibility for not having the insulin available at the facility. Legal Representative II said Facility Nurse Y said the facility would make changes to how medication orders/prescriptions were processed and s/he said s/he thought Facility Nurse Y said s/he would be responsible for checking new orders in the future.
Legal Representative II said s/he never refused to pay for any medication, including Resident 10's Novolin 70-30 and if anyone misunderstood that, it was a major misunderstanding on their part. Legal Representative II said if s/he would have been made aware Resident 10's insulin was not available at the facility after his/her admission, s/he would have driven over to the facility with whatever was needed for Resident 10.

On 10/31/2023, Surveyor received and reviewed Resident 10's hospital emergency room history and physical documentation dated 10/29/2023. The documentation included, "[Resident 10] presenting today with unresponsiveness. Reportedly, [Resident 10] is at [facility], [s/he] has been there for 3 days and [the facility] did not have [his/her] insulin so [the facility] did not give it to [Resident 10]. [Resident 10] has been eating robustly over the last 3 days and when [the facility/caregivers] went to wake [him/her] up this morning [s/he] was unresponsive."

On 02/13/2024, Surveyor reviewed Resident 10's hospital discharge summary dated 11/03/2023, as provided by Facility Nurse Y and Facility Nurse JJ. The documentation included, "In the ED [emergency department, on 10/29/2023]...

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[his/her] blood glucose level was 1,055...[s/he] was started immediately on IV [intravenous] fluids, insulin per DKA [diabetic ketoacidosis; a serious complication of diabetes that can be life-threatening; related to lack of insulin] protocol and admitted to the ICU [intensive care unit] for DKA and hyperosomolar state [a condition in which blood has a high concentration of sodium, glucose [sugar], and other substances]. [Resident 10] was treated in the ICU per DKA protocol....[s/he] had Ng-tube [nasogastric] placed for nutrition and medications as well, initially. [Resident 10] continued to improve, was weaned off the insulin drip and started subcutaneous insulin, mentation improved, Ng-tube removed, [Resident 10] back to baseline mental status, eating well, transferred to floors [general]." The documentation included, "Today [11/03/2023].... [Resident 10] will be discharged back to memory-care facility. [Resident 10] needs close follow-up with [his/her] PCP [primary care practitioner] to titrate insulin." The documentation included, "Discharge with Novolin, as in medication list." Resident 10's discharge summary medication prescriptions included, "Novolin 70-30 FlexPen...Inject 18 units in the morning with breakfast and 5 units at night with dinner into the skin."

On 02/13/2024, Surveyor reviewed Resident 10's facility record, as provided by Facility Nurse Y and Facility Nurse JJ. A charting note documented on Friday, 11/03/2023 at 2:02 P.M. by Facility Nurse Y included, "[Resident 10] arrived [by] ambulance [and] stretcher at 1:40 P.M. today." The documentation included, "[Pharmacy KK], PCP [primary care practitioner], and [Legal Representative II] aware of return and hospital orders received."
A charting note documented on Friday 11/03/2023

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N 353	Continued From page 15 at 8:45 P.M. by Facility Nurse Y included, "Change of condition. 8:40 P.M., transfer to [local hospital] via 911. Staff called [Facility Nurse Y] at 8:00 P.M. to report [Resident 10's] blood sugar was > 500 and [s/he] was agitated as seen by spitting out [his/her] bedtime medications at staff. Call placed to PCP w/o [without] response. [Administrator E] updated and [Legal Representative II]. Writer gave E.R. [emergency room] nurse phone report on [Resident 10's] discharge from [hospital] today and discharge orders that decreased [his/her] insulin... 911 reported [Resident 10's] blood sugar > 600 before transport. 911 responders were cross with nursing staff [facility caregivers] alleging that [Resident 10's] blood sugar wouldn't [sic] be elevated if [s/he] received [his/her] prescribed 5 units of [Novolin] 70-30 insulin at supper, despite staff reporting that the insulin was in fact administered as ordered." A charting note documented on Friday 11/03/2023 at 11:32 P.M. by Facility Nurse Y included, "[Facility Nurse Y] spoke with [hospital] ER nurse who reports that when [Resident 10] arrived [his/her] blood sugar reading was 450. [Resident 10] was treated with 3 units of insulin and [his/her] blood sugar dropped 100 points. [The hospital staff] did not observe any agitated behavior and found [Resident 10] pleasant, cooperative, and smiling. [The hospital] is discharging [Resident 10] back to the community [facility] with an order faxed to [Pharmacy KK] to increase [his/her] insulin to 20 units at breakfast and 6 units at supper." A charting note documented on 11/07/2023 at 1:43 P.M. included, "Sliding scale insulin order received from MD [medical doctor] [and] pharmacy." A charting note documented on 11/08/2023 at 3:30 P.M. addressed a change insulin prescription received, "Increase Novolog 70-30 to	N 353		

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N 353	Continued From page 16 22 units in AM [morning] and [8] units at HS [evening] and continue with SS [sliding scale] insulin as ordered." A charting note documented on 11/13/2023 at 11:30 A.M. by Former Caregiver MM including, "While in group activity [Resident 10] was observed trying to use [his/her] left arm/hand to rest [his/her] head on. [Resident 10] was observed having a hard time holding [his/her] hand to [his/her] head. Staff members reported [Resident 10] went unresponsive after that. [Legal Representative II] was with [Resident 10] when event occurred and 911 was called to facility." A charting note documented on 11/13/2023 at 12:06 P.M. included, "Updated [nurse practitioner] about [Resident 10] being taken to hospital." Resident 10's hospital discharge summary dated 11/15/2023 included, "Presented to the hospital [on 11/13/2023] after a few moments of unresponsiveness." Resident 10's discharge diagnoses dated 11/15/2023 included, "Primary Problem: CVA (cerebral vascular accident)." Resident 10's discharge orders included a change in insulin prescription. The prescription included, "Insulin glargine [a long-acting insulin]...insulin pen...inject 22 units under the skin every morning. Takes about 1 hr [hour] after arising in the am [morning]." A charting note documented on 11/15/2023 at 3:09 P.M. by Facility Nurse Y included, "[Resident 10] returned at 3 P.M. today via [ambulance]...to continue sliding scale insulin orders..." This charting note did not address Resident 10's new prescription for glargine insulin to replace Novolog 70-30 insulin. Resident 10's November 2023 MAR included Resident 10's new prescription of glargine insulin, as ordered on 11/15/2023, which should have replaced Resident 10's Novolog 70-30 insulin	N 353		

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prescription. Between 11/15/2023 and 11/26/2023, no doses of Resident 10's glargine were documented as administered, as ordered daily. Meanwhile, Resident 10's November 2023 MAR included caregiver documentation of continuing to administer Resident 10's Novolog 70-30 insulin, as ordered twice daily, unless otherwise documented, between 11/15/2023 and 11/26/2023. The documentation included:
* 11/16/2023: "[Resident 10's morning dose of] Novolog Flex 70-30 Pen withheld per [prescription]" and no glargine documented as administered; no evening Novolog 70-30 administered;
* 11/17/2023: Novolog 70-30 morning dose administered, no evening dose administered. No glargine administered, as ordered;
* 11/18/2023 and 11/19/2023: Novolog morning and evening doses administered. No glargine administered, as ordered;
* 11/20/2023: Novolog 70-30 morning dose administered, no evening dose administered. No glargine administered, as ordered;
* 11/21/2023: Novolog 70-30 morning and evening doses administered. No glargine administered, as ordered;
* 11/22/2023: Novolog 70-30 morning dose administered, no evening dose administered. No glargine administered, as ordered;
* 11/23/2023: "[Resident 10's morning dose of] Novolog Flex 70-30 Pen withheld per [prescription]. Meds [medications] canceled, not given" and no glargine documented as administered; no evening Novolog 70-30 administered;
* 11/24/2023 and 11/25/2023: Novolog 70-30 morning doses administered, no evening doses administered. No glargine administered, as ordered;
* 11/26/2023: "[Resident 10's morning dose of]

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Novolog Flex 70-30 Pen withheld per [prescription]" and evening Novolog 70-30 administered. No glargine administered, as ordered.
A charting note documented on 11/20/2023 at 9:01 A.M. by Facility Nurse Y included, "[Legal Representative II] visit today." The documentation included, "We discussed the insulin changed from the [hospital] stay and that [Resident 10's practitioner] in agreement to change to a long acting insulin. [Legal Representative II] reports that [Resident 10] does not have insurance and the last insulin order was $600 out of pocket. [Legal Representative II] has the order for the long-acting insulin [glargine] and will price it against [Pharmacy KK] and [other pharmacy] and will make the decision in the next 2 days on if [Resident 10] can afford it. [Legal Representative II] reports that [Resident 10] is applying for [public funding] on December 1st at which time [s/he] will have medicaid to pay for medications."
A charting note documented on 11/27/2023 at 8:25 A.M. by Former Caregiver MM included, "[Resident 10's] new insulin arrived and given to [Resident 10]."
Resident 10's November 2023 MAR included Resident 10's prescription of glargine insulin, as ordered on 11/15/2023, was initially administered on 11/27/2023 at 8:00 A.M. and continued to be administered daily every morning while no further Novolog 70-30 doses were administered through the end of November 2023.

On 02/13/2023 at 2:15 P.M., Surveyor conducted an interview with Facility Nurse Y. Facility Nurse Y told Surveyor Resident 10's glargine insulin was not administered from 10/15/2023 through 11/26/2023 if it was not documented within Resident 10's MAR. Facility Nurse Y told

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Surveyor Resident 10's practitioner was notified of the delay in switching Resident 10's Novolog 70-30 to glargine insulin, as ordered on 11/15/2023. Facility Nurse Y told Surveyor Legal Representative II may have said go ahead and give glargine to Resident 10 on 11/27/2023.

On 02/21/2023 at 12:09, Surveyor conducted an interview with Pharmacy Staff HH. Pharmacy Staff HH told Surveyor Pharmacy KK received Resident 10's prescription for glargine insulin on 11/15/2023 to replace Resident 10's previously ordered Novolog 70-30. Pharmacy Staff HH said Pharmacy KK did change the profile for Resident 10's glargine insulin to show up within the facility's electronic medication administration record (MAR), but did not receive authorization from Legal Representative II to fill the prescription and deliver it to the facility until 11/24/2023. Pharmacy Staff HH told Surveyor Pharmacy KK did not know if the facility had a supply of glargine to administer to Resident 10 or if it was filled by another facility between receipt of the prescription on 11/15/2023 and 11/24/2023.

On 02/21/2023 at 1:34 P.M., Surveyor conducted an interview with Legal Representative II. Legal Representative II told Surveyor s/he had no idea why Resident 10's glargine was delayed after it was prescribed in November 2023. Legal Representative II said s/he recalled a discussion with Pharmacy KK about the price difference between generic and brand name insulin but s/he was not aware that it had been "on hold" between the pharmacy and the facility.

On 02/21/2023 at 2:42 P.M., Surveyor conducted an interview with Administrator E. Administrator E told Surveyor the facility had changed their policy on admissions since Resident 10's insulin

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incident in October/November 2023. Administrator E told Surveyor the facility did not want to admit new residents near the end of the week. Administrator E said the hospital wanted to discharge Resident 10 on Thursday, 10/26/2023 and the facility had to admit Resident 10. Administrator E told Surveyor s/he did not believe Pharmacy KK delivered medications to the facility on weekends and that s/he had been aware of this since s/he started employment at the facility in August 2022.

On 02/21/2023, Surveyor reviewed Pharmacy KK's website, "[Pharmacy KK]wisconsin.com." Pharmacy KK's website included services for assisted living facilities including, "Regular [and] emergency deliveries. 24 [hours a day]/7 [days a week]/365 [days of the year] availability. Emergency planning."

On 02/22/2023, Surveyor conducted an interview with Facility Nurse Y. Facility Nurse Y told Surveyor s/he believed Legal Representative II did supply Resident 10's Novolin 70-30 insulin to the facility from a different pharmacy after Resident 10 returned from the hospital on 11/03/2023. Facility Nurse Y told Surveyor Pharmacy KK did supply Resident 10's glargine insulin near the end of November 2023. Surveyor discussed Surveyor's review of Pharmacy KK's website regarding services regarding emergency deliveries and emergency planning. Facility Nurse Y replied, " Not always the case."

Summary: The provider did not ensure Resident 10 was provided with prompt and adequate treatment appropriate to Resident 10's needs.