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 _____	R 05/30/2024

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 05/30/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Lilac Springs Assisted Living LLC, a community-based residential facility (CBRF) located in Lake Mills, WI. As a result of the survey, 2 deficiencies were identified. Both deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023, and SOD ZOLI11, dated 01/23/2024. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 22	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 received his/her insulin in the dosage prescribed by his/her practitioner. Resident 1 received the incorrect dosage of sliding scale insulin on 20 occasions between 05/01/2024 - 05/30/2024.	N 352		

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

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N 352	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023, and SOD ZOLI11, dated 01/23/2024. Findings include: On 05/30/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 10/27/2023 with diagnoses including type II diabetes mellitus. Resident 1's prescriptions included the following: - Insulin lispro 100 units/mL pen (Humalog 100 unit/mL KwikPen): "Inject subcutaneously in the morning based on sliding scale: Less than 100 = 0 units; 100-200 = 4 units, 201 300 [sic] = 6 units; greater than 300 = 8 units." - Insulin lispro 100 units/mL pen (Humalog 100 unit/mL KwikPen): "Inject subcutaneously at noon based on sliding scale:.." The same sliding scale as above was documented. - Insulin lispro 100 units/mL pen (Humalog 100 unit/mL KwikPen): "Inject subcutaneously in the evening based on sliding scale:.." The same sliding scale as above was documented. - Insulin lispro 100 units/mL pen (Humalog 100 unit/mL KwikPen): "Inject subcutaneously at bedtime based on sliding scale: Less than 200 = 0 units; 200-250 = 2 units; 251-300 = 3 units; greater than 300 = 4 units." Surveyor reviewed Resident 1's medication administration record (MAR) from 05/01/2024 - 05/30/2024 and observed the following 20 discrepancies: - 05/01/2024 (9:11 p.m.): Bedtime blood sugar	N 352		

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N 352	Continued From page 2	N 352		

documented as 247 (within parameters for 2 units of insulin), 6 units documented as administered

- 05/04/2024 (8:38 p.m.): Bedtime blood sugar documented as 203 (within parameters for 2 units of insulin), 6 units documented as administered

- 05/05/2024 (9:01 p.m.): Bedtime blood sugar documented as 341 (within parameters for 4 units of insulin), 8 units documented as administered

- 05/07/2024 (9:18 p.m.): Bedtime blood sugar documented as 255 (within parameters for 3 units of insulin), 6 units documented as administered

- 05/09/2024 (9:14 p.m.): Bedtime blood sugar documented as 233 (within parameters for 2 units of insulin), 6 units documented as administered

- 05/09/2024 (12:09 p.m.): Blood sugar documented as 147 (within parameters for 4 units of insulin), 3 units documented as administered

- 05/10/2024 (9:01 p.m.): Bedtime blood sugar documented as 236 (within parameters for 2 units of insulin), 6 units documented as administered

- 05/11/2024 (4:43 p.m.): Blood sugar documented as 128 (within parameters for 4 units of insulin), 3 units documented as administered

- 05/13/2024 (9:41 p.m.): Bedtime blood sugar documented as 310 (within parameters for 4 units of insulin), 8 units documented as administered

- 05/15/2024 (9:03 p.m.): Bedtime blood sugar documented as 202 (within parameters for 2 units of insulin), 6 units documented as administered

- 05/16/2024 (3:36 p.m.): Blood sugar

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N 352	Continued From page 3	N 352		

documented as 233 (within parameters for 6 units of insulin), 4 units documented as administered

- 05/18/2024 (8:53 p.m.): Bedtime blood sugar documented as 276 (within parameters for 3 units of insulin), 6 units documented as administered

- 05/19/2024 (11:51 a.m.): Blood sugar documented as 207 (within parameters for 6 units of insulin), 3 units documented as administered

- 05/20/2024 (9:09 p.m.): Bedtime blood sugar documented as 213 (within parameters for 2 units of insulin), 6 units documented as administered

- 05/21/2024 (8:57 a.m.): Blood sugar documented as 204 (within parameters for 6 units of insulin), 4 units documented as administered

- 05/22/2024 (9:13 p.m.): Bedtime blood sugar documented as 239 (within parameters for 2 units of insulin), 6 units documented as administered

- 05/23/2024 (12:08 p.m.): Blood sugar documented as 158 (within parameters for 4 units of insulin), 3 units documented as administered

- 05/27/2024 (11:41 a.m.): Blood sugar documented as 202 (within parameters for 6 units of insulin), 3 units documented as administered

- 05/27/2024 (9:23 p.m.): Bedtime blood sugar documented as 139 (within parameters for 0 units of insulin), 4 units documented as administered

- 05/29/2024 (9:49 p.m.): Bedtime blood sugar documented as 232 (within parameters for 2 units of insulin), 6 units documented as administered

At approximately 12:51 p.m., Surveyor

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N 352	Continued From page 4 interviewed Administrator G. Administrator G reported that him/herself as well as his/her lead, Lead Caregiver J, had been auditing medication administration records since the last survey to ensure correct medication administration. Administrator G reported that since the last survey a training was conducted with staff regarding diabetes management. Administrator G reported that s/he had not seen or heard any recent concerns within the last month regarding insulin administration, but acknowledged Surveyor's concerns regarding the above errors.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes 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 record review and interview, the provider did not ensure that the individual service plan (ISP) for Resident 7 was updated to reflect changes in his/her fall prevention interventions, ambulation, hospice involvement, and basic activities of daily living.	N 389		

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N 389	Continued From page 5 This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023, and SOD ZOLI11, dated 01/23/2024. Findings include: On 05/30/2024, at approximately 9:20 a.m., Surveyor toured the facility. Surveyor observed Resident 7's room, which contained a hospice bed with bilateral quarter rails in the up position. His/her bathroom contained a Broda-style shower chair in the shower and a Hoyer lift in the bathroom. At approximately 11:20 a.m., Surveyor interviewed Caregiver I about resident care needs. Caregiver I reported that Resident 7 typically transferred with a Hoyer lift and the assistance of 2 staff, due in part to him/her having a prior lower extremity ampuation. Caregiver I reported that Resident 7 had been using a regular Broda chair for awhile. Caregiver I reported that the Broda-style shower chair observed by Surveyor was used during all of Resident 7's showers and that his/her hospice team completed all his/her showers. Caregiver I reported that Resident 7 had bedrails that were typically in the up position due to him/her using them for bed mobility, and that they were used by Resident 7 since his/her admission. Caregiver I reported that staff also used a bed alarm with Resident 7 due to him/her frequently attempting to get out of bed without requesting the assistance that s/he required. At approximately 12:30 p.m., Surveyor observed lunch. During lunch, Surveyor observed Resident 7 sitting in his/her Broda chair slowly eating food at the table. Caregiver H approached Resident 7	N 389		

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and asked how s/he was doing with the meal. Surveyor then interviewed Caregiver H, who reported that Resident 7 occasionally required staff assistance with meals and so s/he would typically check in to see how much Resident 7 was able to eat on his/her own before offering assistance.

On 05/30/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 03/27/2024. Surveyor observed 5 incident reports of incidents that had occurred since Resident 7's admission. In each of the reports, staff documented notifying Resident 7's hospice agency. Surveyor observed Resident 7's observation notes from 04/01/2024 - 05/30/2024, and observed an entry on 04/17/2024 at 3:30 p.m. that documented, "[Resident 7] now has a Broda chair. it [sic] fits [him/her] very well..." Surveyor reviewed Resident 7's current individual service plan, dated 05/30/2024, and observed the following:

- Under the "Transferring" section: Hoyer lift use documented but no information regarding Resident 7 requiring the assistance of 2 staff for transfers

- Under the "Hospice Services" section, Surveyor observed that the listed hospice organization name and contact information was different than the hospice organization listed as being involved from Resident 7's incident reports

- No information regarding Resident 7's Broda chair use

- No information regarding Resident 7's bed rails or bed alarm

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N 389	Continued From page 7 - No information regarding Resident 7's needs for bathing, dressing, toileting, grooming - Under the "Eating" section, the following was documented: "Resident is able to eat (independently, with assistance, with supervision) - resident can/cannot cut food, use silverware appropriately/large handled silverware, and has (no) current concerns for choking/swallowing." The section did not contain information regarding Resident 7's required occasional staff assistance. At approximately 12:51 p.m., Surveyor interviewed Administrator G. Administrator G confirmed that the hospice agency information in Resident 7's ISP was incorrect, and that the hospice agency information from his/her incident reports was correct. Administrator G reported that the hospice agency information in Resident 7's ISP must have been automatically filled since a lot of residents use that hospice organization. Administrator G reported that s/he was already aware that Resident 7's ISP was not updated to reflect his/her current needs and services. Administrator G reported that when s/he took over the building a lot of previous documentation were lost for residents and resident care plans were not current. Administrator G reported that since taking over s/he has been working to get care plans up to date.	N 389		