STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016351	A. BUILDING: _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN GRAND ASSISTED LIVING SUITES	900 MEADOW LN NEENAH, WI 54956

(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 10/06/2023, with information gathered through 10/11/2023, Surveyor conducted 4 complaint investigations at American Grand Assisted Living Suites. Three deficiencies were identified. Three out of 4 complaints were substantiated. Two of the 3 deficiencies were repeat violations (see Statement of Deficiency (SOD) QP0C14, SOD QP0C13, SOD QP0C12, and SOD YT3V11). Census: 64	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 administer medications in the intervals prescribed by a practitioner for 1 of 1 resident. Resident 1 did not receive his/her scheduled amoxicillin (antibiotic) and Bactrim (antibiotic) from 06/23/2023 to 07/06/2023. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) QP0C12, dated 01/19/2021, and SOD QP0C13, dated 09/16/2021.	N 352		

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

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N 352	Continued From page 1 Findings include: On 07/25/2023, the department received a complaint that alleged residents did not receive prescribed medications. On 10/06/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the facility on 05/27/2022, with diagnoses including dementia, coronary artery disease, chronic bronchitis, and emphysema. Resident 5's "Observations" documented: "06/19/2023 - This morning while staff were getting [Resident 5] up for the day, we noticed that [his/her] tongue was very milky white and [his/her] mouth was also somewhat white, [his/her] lips also have a crusty yellow color to them. When attempting to put dentures in [Resident 5] yelled and said that [his/her] mouth hurt. Staff contacted [agency] and they prescribed an antibiotic as they believe it to be thrush." "Resident sent to [emergency room] due to worsening of symptoms with mouth swelling, resident started to shake after dinner and contacted POA (power of attorney) and POA decided it was best to send resident to hospital." "06/20/2023 - [Resident 5] has been admitted for sepsis due to a UTI (urinary tract infection)." "07/19/2023 - Resident has a 101.2 fever and has the chills. Resident was given PRN (as needed) Tylenol. Resident also has what appears to be dried blood in a ring on the inside/middle of [his/her] lips." "07/21/2023 - When staff went in to get resident up this morning, resident was very warm and	N 352		

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N 352	Continued From page 2	N 352		

sweaty. And not [his/her] usual self. Staff took temperature and it was at 101.6. Resident was also full of bm (bowel movement). ... Staff also felt like resident was in discomfort so PRN (as needed) morphine was also given."
"07/22/2023 - [Spouse] decided [s/he] would like resident sent out to receive IV (intravenous) antibiotics at the hospital. Hospice nurse talked to [spouse] about the antibiotics many not work for [him/her] since [s/he] has been septic for a month. [Spouse] still wanted [him/her] sent to hospital. Resident has been sent to [hospital] ..."

Resident passed away on 07/23/2023.

Resident 5's hospital "Discharge summary," dated 06/23/2023, documented:
"Start taking these medications:
amoxicillin-potassium (one tablet by mouth twice daily for 28 doses) and
sulfamethoxazole-trimethoprim (Bactrim) (one tablet by mouth every day in the morning for 15 doses)."

Resident 5's June 2023 Medication Administration Record (MAR) did not list these prescribed medications.
Resident 5's July 2023 MAR documented that the amoxicillin and Bactrim were administered starting 07/06/2023.

On 10/06/2023, Surveyor interviewed Regional Director of Operations (RDO) A and South Director B. RDO A stated s/he could not recall why there was a delay in Resident 5 receiving the prescribed antibiotics but assumed it was due to him/her being on hospice. RDO A stated s/he did not have hospice documentation. Surveyor stated s/he would request it.

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N 352	Continued From page 3 On 10/09/2023 at 4:20 PM, RDO A emailed Surveyor documentation from Resident 5's primary care physician, dated 07/05/2023, which documented: "Abx (antibiotic) ordered on discharge were never completed. Order today to complete over next 2 weeks." "Was hospitalized for sepsis 06/19-06/23/2023 ... discharged on Augmentin bid (twice a day) x 14 days and Bactrim x 15 days." "MAR review shows neither antibiotic was ever received. [Electronic computer system] review indicates prescriptions were sent to [pharmacy], rather than [preferred pharmacy] and therefore never received." On 10/09/2023 at 4:29 PM, Surveyor responded to RDO A via email and indicated even though the prescriptions were sent to the wrong pharmacy, the provider should have realized Resident 5 did not have the prescribed medications upon discharge from the hospital. As of 10/10/2023 at 4:30 PM, Surveyor did not receive a response. "Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body. Most cases of sepsis start before a patient goes to the hospital. Infections that lead to sepsis most often start in the lung, urinary tract, skin, or gastrointestinal tract. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death." (Source: Centers for Disease Control and Prevention website, What is Sepsis? August 24, 2023, https://www.cdc.gov/sepsis/what-is-sepsis.html,	N 352		

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N 352	Continued From page 4 (retrieval date: 10/09/2023).)	N 352		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on interview and observation, the provider did not ensure that 2 out of 2 shared resident rooms were clean and free from odor. Resident 1/Resident 2's and Resident 3/Resident 4's rooms both had a urine-like scent. Findings Include: On 10/06/2023, at approximately 12:00 PM, Surveyor toured the facility and observed a urine-like scent emanating into the hallway. Surveyor reviewed 32 resident bedrooms that were next to each other and observed: Resident 1 and Resident 2 shared a bedroom. Resident 1/Resident 2's bedroom had a strong urine-like scent. Surveyor interviewed Resident 1 who stated s/he dealt with incontinence, along with Resident 2, and their room was not cleaned on a regular basis. Resident 1 stated, "I can become incontinent, and it will leak onto the floor. I will get yelled at if I try to soak it up with a towel, but they never mop the floor." Surveyor noted the floor had dirt and crumbs throughout and needed to be swept. Surveyor observed a brown circular pattern that had the appearance of spilled coffee that had not been mopped up. The baseboards were missing throughout the room. Resident 1 stated s/he had resided at the facility for	N 489		

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N 489	Continued From page 5 approximately 5 months and had not seen anyone come in and clean his/her room. Surveyor noted Resident 1/Resident 2's bathroom floor appeared sticky and could be mopped. Resident 3 and Resident 4 shared a bedroom. Resident 3/Resident 4's bedroom had a strong urine-like scent. Surveyor observed Resident 4 in his/her bed. As Surveyor walked through Resident 3's side of the room towards Resident 4's, the urine-like scent became stronger. Surveyor observed baskets of laundry sitting around Resident 4. Surveyor noted the floor had dirt and crumbs throughout and needed to be swept and the bathroom floor appeared sticky and could be mopped. On 10/06/2023, at approximately 4:00 PM, Surveyor interviewed Regional Director of Operations A and South Director B. Regional Director of Operations A stated incontinence was an ongoing problem in that hallway, and s/he would discuss the concerns with his/her staff. Regional Director of Operations A stated that laundry was completed on a regular basis and daily for those residents who deal with incontinence, but this process would be discussed with staff again to ensure compliance. On 10/11/2023 at 6:00 PM, Surveyor interviewed Resident 6's Power of Attorney (POA) C. Surveyor stated s/he had been informed POA C provided a lot of the housekeeping and laundry cares for Resident 6. POA C stated Resident 6 shared a room with another resident and they do not have a washer and dryer in their room. POA C stated there was not enough staff to ensure laundry, let alone housekeeping, was completed timely.	N 489		

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Y3234	Continued From page 6	Y3234		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident was treated with courtesy, respect and full recognition of the resident's dignity and individuality. Resident 1 experienced incontinence and was not assisted when staff members observed the episode. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) QP0C14, dated 03/18/2022, SOD QP0C12, dated 01/19/2021, and SOD YT3V11, dated 11/02/2018. Findings include:	Y3234		

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Y3234	Continued From page 7 On 10/06/2023, at approximately 12:00 PM, Surveyor interviewed Resident 1 who stated s/he dealt with incontinence. Resident 1 stated, "I can become incontinent, and it will leak onto the floor." Surveyor observed Resident 1's bed which had a white thin blanket folded into fourths, a white chuck pad laid out and a blue chuck pad folded into fourths lying on Resident 1's bed. On 10/06/2023, at approximately 1:45 PM, Surveyor walked past Resident 1's room and observed him/her sleeping in his/her wheelchair. The door was open to his/her room and s/he could easily be seen by anybody walking past the room. Surveyor noted that there was a pool of a liquid substance that appeared to be urine under Resident 1's wheelchair. Surveyor stood in the hallway to determine if staff would become aware of Resident 1's situation. Surveyor observed two staff members walk past Resident 1's room. The staff looked into the room and kept on walking, exiting the building. At approximately 1:52 PM, South Director (SD) B walked up to Surveyor to bring him/her some documentation. Surveyor asked SD B to walk to Resident 1's room with him/her. SD B looked into Resident 1's room and immediately stated, "Oh my." Surveyor explained that s/he had observed 2 staff members walk by, look into the room, and keep walking, exiting the building. SD B stated that s/he would discuss the concern with the staff immediately. On 10/06/2023, at approximately 2:05 PM, Surveyor was sitting in Regional Director of Operations (RDO) A's office and observed SD B discuss the prior observation of Resident 1 with RDO A. RDO A stated there is protocol to follow and SD B stated s/he would fill out the proper forms.	Y3234		

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Y3234	Continued From page 8 On 10/06/2023, Surveyor reviewed Resident 1's record. Resident 1 moved into the facility on 06/06/2023 with diagnoses including major depressive disorder, generalized anxiety disorder, obstructive sleep apnea and chronic kidney disease, Stage 3. Resident 1's "Care Plan," dated 06/27/2023, documented: "Toileting: Provide full assistance with toileting. Assist with dressing and undressing, toileting and clean up. [Resident 1] is completely incontinent of urine. [S/he] does not know when [s/he] has to go. [S/he] needs assistance with cleaning up and changing [his/her] Depends. Throughout the night [Resident 1] needs to be changed. Wake [him/her] up and ask [him/her] to get up and use the toilet at least 2 times throughout the night." On 10/06/2023, at approximately 3:00 PM, Surveyor observed Resident 1 sleeping in his/her bed. On 10/06/2023, at approximately 3:30 PM, Surveyor interviewed RDO A and SD B. RDO A and SD B stated staff had been redirected. SD B explained that Resident 1 had an incontinence issue and it appeared that s/he was consistently urinating. SD B had asked Resident 1's primary physician to review possible medication options to assist Resident 1 with his/her bladder urgencies. RDO A and SD B stated when staff see a resident that has experienced an incontinence episode, that resident should be assisted immediately. On 10/09/2023, Surveyor was informed, the department received a complaint that alleged residents were being left to sit in their urine when experiencing incontinence episodes.	Y3234		

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Y3234	Continued From page 9 On 10/11/2023 at 6:00 PM, Surveyor interviewed Resident 6's Power of Attorney (POA) C. Surveyor asked if s/he had observed Resident 6 or any other resident who needed assistance, due to incontinence, and did not receive assistance in a timely manner. POA C stated s/he had observed residents sitting in urine and feces multiple times due to lack of staff. Cross Reference: N0489 DHS 83.44(2)(a) Rooms Clean and Free From Odors	Y3234		