STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	R 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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
M 000	INITIAL COMMENTS On 04/09/2024, with information obtained through 04/16/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Yasmins Loving Care, an adult family home (AFH) located in Madison, WI. As a result of the survey, 2 deficiencies were identified. Both deficiencies are repeat deficiencies from Statement of Deficiency (SOD) H3DR11, dated 01/09/2024. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 4	M 000		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's	M 262		

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

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M 262	Continued From page 1 wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 of 2 emergency exits for the home were ramped to grade with a hard surfaced pathway and handrails for residents who experienced difficulties walking. This is a repeat deficiency. See Statement of Deficiency (SOD) H3DR11, dated 01/09/2024. Findings include: The provider is licensed to serve up to 4 ambulatory residents in the client groups of irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, terminally ill, advanced aged, and developmentally disabled. On 04/09/2024, at approximately 1:15 p.m., Surveyor interviewed Caregiver C. Caregiver C reported that none of the provider's 4 residents used a wheelchair, but that Resident 7 occasionally used a 4-wheeled walker for ambulating and Resident 1 switched between using a cane and 4-wheeled walker for ambulating throughout the day. At approximately 4:17 p.m., Surveyor observed the home's exits with Licensee A. While walking through the home, Surveyor observed Resident 1 ambulating with a 4-wheeled walker throughout the kitchen, dining area, and hallway. Surveyor observed the service door exit, which was 1 of 2 exits ramped to grade from the home. The final part of this exit pathway consisted of a ramp in the garage leading to the service door, which was	M 262		

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M 262	Continued From page 2 elevated approximately 5-6" from the ground on both sides of the door, and then another ramp from the door leading outside the home (see Photos 1 and 2). The ramps did not have a landing and one side of the ramp in the garage, where the door swung open, did not have a handrail. Licensee A reported that his/her family had built the ramp. Licensee A reported that they were unable to have a handrail on one side of the ramp due to being in the way of the door swing when it opened. On 04/16/2024, at approximately 11:33 a.m., Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of the specific ramp construction requirements involving landings but would review them. Licensee A reported that s/he wasn't aware of other solutions regarding the handrail for the area of the ramp where the door opened, but would try to request a waiver. Licensee A reported that s/he wanted to be licensed to accept nonambulatory residents.	M 262		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by:	M 462		

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M 462	Continued From page 3	M 462		

Based on record review and interview, the provider did not ensure that 2 of 4 residents who required assistance with prescription medication received assistance for managing their medications, including communicating effectively with their respective medical providers regarding medication regimens and discrepancies.

Staff assisted with Resident 1's medication management and administration, however, there was no evidence that they assisted in communicating with his/her medical provider regarding 2 scheduled medications that s/he was prescribed but were not on hand - his/her daily fiber 51.7% powder or Spiriva Respimat inhaler.

Staff assisted with Resident 7's medication management and administration, however, there was no evidence that they assisted in communicating with his/her medical provider regarding 5 PRN medications that s/he was prescribed but were not on hand - an albuterol inhaler, Mylanta Extra Strength (an antacid prescribed for gastrointestinal upset), diclofenac gel (a topical gel prescribed for pain), ibuprofen, and loperamide (prescribed for loose stools).

This is a repeat deficiency. See Statement of Deficiency (SOD) H3DR11, dated 01/09/2024.

Findings include:

Example 1 - Resident 1

On 04/09/2024, at approximately 1:30 p.m., Surveyor reviewed Resident 1's medications and medication administration records (MARs), dated 03/25/2024 - 04/09/2024, with Caregiver C. Caregiver C confirmed the provider assisted Resident 1 with medication management and

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M 462	Continued From page 4	M 462		

administration. While comparing Resident 1's observed on hand medications to his/her MAR, Surveyor observed the following:

- Daily fiber 51.7% powder was listed on the MAR with a start date of 07/11/2023 and instructions to, "Mix 1 teaspoonful with 8 oz of water. Drink twice daily for constipation or loose stools." Staff documented an "R" twice for each day from 03/25/2024 through the morning administration entry of 04/09/2024.

- Spiriva Respimat 2.5 mcg inhaler was listed on the MAR with a start date of 02/14/2024 and instructions to, "Inhale 2 puffs into the lungs daily ..." Staff documented an "R" for each daily administration from 03/25/2024 through 04/09/2024.

Surveyor did not observe either medication in the provider's medication storage area for Resident 1.

While observing the medications, Surveyor interviewed Caregiver C. Caregiver C confirmed the provider did not have either medication on hand. Caregiver C reported that s/he thought Resident 1 had started refusing to pay for the fiber around March 2024. Caregiver C reported that the "R" documented on the MARs indicated that the resident refused the medication. Caregiver C reported s/he was not sure if Resident 1's medical provider had ever been provided the information that s/he was not taking daily fiber powder. Regarding Resident 1's inhaler, Caregiver C reported that staff had marked "refusals" because it was thought that Resident 1's inhaler had ended. Caregiver C reported s/he was unaware of any order from Resident 1's medical provider showing the

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medication was discontinued.

While interviewing Caregiver C, Surveyor reviewed Resident 1's medical provider orders, which included the daily fiber 51.7% powder and the Spiriva Respimat inhaler with the same start dates and instructions as documented above. Caregiver C confirmed s/he did not have any other documentation on hand to show medical provider communications or orders for Resident 1.

At approximately 3:43 p.m., Surveyor interviewed Licensee A. Licensee A confirmed that staff did not notify Resident 1's medical provider regarding him/her not taking the fiber powder but reported s/he planned to call him/her later. Licensee A reported that his/her understanding of the inhaler was that it was to be received for 2 weeks, but s/he wasn't sure if the order was current. Licensee A confirmed s/he didn't have any medical provider order or documentation showing that the inhaler was discontinued or indicating that it was no longer a current medication. Licensee A reported that s/he would call Resident 1's medical provider and find out more information.

Example 2 - Resident 7

On 04/09/2024, at approximately 3:10 p.m., Surveyor reviewed Resident 7's medications and medication administration records (MARs), dated 03/25/2024 - 04/09/2024, with Caregiver C. Caregiver C confirmed the provider assisted Resident 7 with medication management and administration. While comparing Resident 7's observed on hand medications to his/her MAR, Surveyor observed the following:

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- PRN aluminum hydroxide; Magnesium Hydroxide; Simethicone (Brand name: Mylanta Maximum Strength, an antacid medication) was listed on the MAR with an order date of 10/02/2023 and instructions to take 20 mL every 8 hours as needed for gastrointestinal upset

- PRN diclofenac 1% gel was listed on the MAR with an order date of 10/02/2023 and instructions to apply 2 grams topically to an affected area every 6 hours as needed for pain

- PRN loperamide 2 mg capsules were listed on the MAR with an order date of 10/02/2023 and instructions to take 1 capsule every 4 hours as needed for loose stools

- PRN albuterol inhaler was listed on the MAR with an order date of 10/02/2023 and instructions to inhale 2 puffs every 4 hours as needed

- PRN ibuprofen was listed on the MAR with an order date of 09/28/2023 and instructions to take 2 tablets every 6 hours as needed for mild pain.

Surveyor did not observe any of the above medications in the provider's medication storage area for Resident 7.

While observing the medications, Surveyor interviewed Caregiver C. Caregiver C confirmed the provider did not have any of the above medications on hand for Resident 7. Caregiver C reported s/he did not know about Resident 7's Mylanta antacid medication or his/her diclofenac gel. Caregiver C reported that Resident 7's ibuprofen had recently run out and s/he thought it was discontinued by his/her medical provider. Caregiver C reported s/he was unaware of any order from Resident 7's medical provider showing

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the ibuprofen was discontinued. During this interview, Resident 7 approached Surveyor and Caregiver C. Caregiver C asked Resident 7 if s/he knew what happened to his/her inhaler. Resident 7 replied that s/he used to have it on hand but that it ran out so s/he threw it away.

At approximately 3:15 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of Resident 7 no longer having his/her inhaler. Licensee A reported s/he was unsure why the provider did not have Resident 7's Mylanta antacid medication, diclofenac gel, or loperamide on hand. Licensee A confirmed s/he didn't have any medical provider order or documentation showing that Resident 7's ibuprofen was discontinued or indicating that it was no longer a current medication. During the interview, Licensee A was observed making a phone call, who s/he told Surveyor was a representative from Resident 7's pharmacy. Licensee A was heard attempting to clarify on the phone call which medications from Resident 7's medication list were still current. Surveyor heard Licensee A ask Resident 7 if s/he would take his/her PRN inhaler if the prescription was refilled. Resident 7 reported that s/he would.

ADDITIONAL INTERVIEW:

At approximately 3:43 p.m., Surveyor interviewed Licensee A again. Licensee A acknowledged Surveyor's concern that that the above medications were not on hand for residents despite having current orders for their administration. Licensee A acknowledged Surveyor's concern that the medications thought by him/her and Caregiver C to be discontinued did not have any supporting evidence of such by the residents' medical providers. Licensee A

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M 462	Continued From page 8 reported s/he was thinking about contracting with a consultant to help him/her with these issues regarding residents' medications. On 04/16/2024, at approximately 11:33 a.m., Surveyor interviewed Licensee A again. Licensee A reported that s/he had hired a consultant to help with residents' medication management. Licensee A reported that s/he had called residents' pharmacies and confirmed that the provider's staff were to be tracking residents' medications and managing their re-order when the medications were running low if they were not cycled medications.	M 462		