

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2022
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NAME OF PROVIDER OR SUPPLIER NOBLE SENIOR LIVING AT WEST ALLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 WEST GREENFIELD AVENUE WEST ALLIS, WI 53214
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N 000	Initial Comments On 06/22/2022, Surveyors completed a standard survey and 7 complaint investigations at Noble Senior Living at West Allis. As a result, 13 deficiencies were identified. Four complaints were substantiated. Three complaints were unsubstantiated. Census: 104	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, record review, and interview, the provider did not comply with all laws governing the Community Based Residential Facility (CBRF), as evidenced by 13 deficient practices. On 04/13/2020, the provider was issued a probationary license and on 04/13/2021 the provider was issued a regular license as class semi ambulatory to serve up to 136 residents with primary diagnoses of advanced age, emotionally disturbed/mental illness, developmentally disabled, and irreversible dementia/Alzheimer's. Findings include: On 06/22/2022, Surveyors completed a standard survey and 7 complaint investigations. As a result, 4 complaints were substantiated, and the following 13 deficiencies were identified:	N 196		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 196	<p>Continued From page 1</p> <p>83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.14(2)(e) Notify Within 7 Days Of Administrator Change 83.26(2) Orientation, Continuing Education Documented 83.35(1)(a) Pre-Admission and Ongoing Assessments 83.35(3)(d) Service Plans Updated Annually or on Changes 83.35(3)(f) Staff Access to Assessment and ISP 83.37(1)(b) Medication Label Permanently Attached 83.37(1)(g) Disposition of Medications 83.37(1)(ii) Proof-Of-Use Record 83.37(2)(e) Other Administration Given Or Delegated by RN 83.38(1)(g) Health Monitoring 83.47(2)(d) Fire Drills 83.47(2)(e) Other Evacuation Drills</p> <p>On 06/02/2022 at 11:00 a.m., Surveyors conducted an exit interview with Administrator A, Director of Wellness (DOW) B and Assistant Director of Wellness (ADOW) C. Surveyors observed Licensee N was not involved in the exit interview.</p> <p>On 05/24/2022, at 3:40 PM, Surveyor interviewed Director of Wellness (DOW) B regarding ISPs. DOW B reported s/he began employment at the facility in December 2021 and when s/he started s/he identified approximately 100 ISPs, for the residents residing in the facility, needed to be updated or written. DOW B reported they were unable to locate many ISPs and was unsure if they had been completed at all.</p> <p>On 05/24/2022, at 4:30 PM, Surveyor interviewed Administrator A. Administrator A reported s/he</p>	N 196		

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N 196	Continued From page 2 was new to the facility and began employment on 12/10/2021. When s/he started, s/he identified nearly all ISPs for approximately all 100 residents in the facility were outdated or they did not have one included in their files. Administrator A reported s/he and his/her team had been working to get all of the ISPs up to date. Administrator A reported the company who owned the facility had a representative visit the facility one time since Administrator A began employment in December 2021. Administrator A reported s/he did not have regular contact with Licensee N.	N 196		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on interview and record review, the provider did not notify the Department of a change in Administrator. Administrator A reported s/he began employment as administrator of the facility on 12/10/2021. Findings include: On 05/24/2021, at 9:12 AM, Surveyors entered the facility to complete a survey. Surveyors met with Administrator A for the entrance conference. Administrator A reported s/he had been the administrator of the facility since 12/10/2021. Administrator A reported s/he sent information s/he needed to send to the corporate office, and s/he stated the corporate office should have informed the Department of the change in administration.	N 200		

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N 200	Continued From page 3 On 05/24/2021, Surveyor reviewed Department records and found no evidence the provider submitted notification to the Department of the change in administrator.	N 200		
N 284	83.26(2) Orientation, continuing education documented Employee orientation and hours of continuing education shall be documented in the employee ' s file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all orientation training and continuing education training was documented for 2 of 6 employees reviewed. Medication Aide (MA) F and MA G did not have evidence of continuing education training in 2021. Findings include: On 05/25/2022, Surveyor reviewed employee files and identified the following: -MA F was hired on 01/03/2020. MA F's file did not contain evidence of continuing education training in 2021. -MA G was hired on 01/03/2020. MA G's file did not contain evidence of continuing education training in 2021. On 06/02/2022, at 11:43 AM, Surveyor interviewed Administrator A, DOW B, and ADOW C, regarding continuing education training documentation. Administrator A confirmed s/he could not locate documentation MA F's and MA G's continuing education training for 2021. Administrator A reported the provider utilized a contracted company in 2021 to keep up with	N 284		

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N 284	Continued From page 4 continuing education training for all staff. Administrator A was unsure why there was no documentation of continuing education in 2021 for MA F and MA G. Administrator A reported s/he began employment with the provider on 12/10/2021 and has already begun the process of providing employee continuing education and documenting their participation for 2022. The provider no longer utilizes a contracted company to keep up with continuing education training for staff.	N 284		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess residents after falls for 3 of 3 residents (Resident 17, Resident 19, and Resident 21) reviewed who had documented falls. Resident 19 was diagnosed with an injury to the head and a hip fracture after a fall. Resident 21 had repeat falls. Findings include:	N 381		

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N 381	<p>Continued From page 5</p> <p>On 05/25/2022, Surveyor review resident records and identified the following:</p> <p>Resident 17 Resident 17 was admitted to the facility on 08/21/2020. Resident 17 was discharged on 02/22/2022. Resident 17 had diagnoses including heart failure, hypertension, chronic kidney disease, and dementia. Resident 17's Progress Notes 07/22/2021 through 02/22/2022 identified: -01/04/2022, "Resident had a witnessed fall 1/4/22 at 6am-staff noted resident ambulating down hallway lost balance doing [sic] down onto knees. Resident did not hit [his/her] head. Denies pain or discomfort. Staff noted resident more confused than normal was unable to get off the floor unassisted. No injury noted. Paramedic called and resident transported to [hospital] for evaluation. am @1130Spoke [sic] with discharge planner and resident will return to the community-lab work up and images were normal..." Resident 17's record did not include a post fall assessment.</p> <p>Resident 19 Resident 19 was admitted to the facility on 10/15/2019. Resident 19 was discharged on 05/08/2022. Resident 19 had a diagnosis of dementia. Resident 19 resided on a memory care unit within the facility. Resident 19's record identified an emergency room visit dated 11/09/2021. Resident 19's diagnoses were "Fall...abrasion of head...minor head injury." Resident 19's Progress Notes from 10/22/2021 through 05/09/2022 identified: -No note was created to document the fall on 11/09/2021. -03/02/2022, "On 3/1/22 resident had witnessed</p>	N 381		

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N 381	<p>Continued From page 6</p> <p>fall in dining area at 11700. Resident sitting in dining room chair and fell asleep slide out of chair onto bottom. No injury noted ROM [range of motion] WNL [within normal limits]. Resident assisted from the floor with staff of 2 and gait belt back into the chair. While RN assessing resident during conversation resident dosed [sic] off and again slide out of chair on to [sic] buttock assisted by RN. RN call for EMS [emergency medical services] to transport to Ed [emergency department] for evaluation. Resident returned from...[emergency department]...with no new orders-labs returned normal including UA [urinalysis]-Resident to follow up with PMD [primary physician] in 1 week..."</p> <p>-03/04/2022, "On 03/2/22 at 1915 [sic] care staff noted resident ambulating down hallway with an unsteady gait holding on to [sic] the railing as care staff approaching resident coming from opposite end of the hallway resident fell going down on [his/her] right side. Resident denies pain or discomfort at that time-ROM was WNL-assisted from the floor with staff of 2 and gait belt. Resident assisted to a chair. At that time resident son arrived and resident expressed pain to RLE [right lower extremity]. EMS called and resident transported to [emergency department]. On 3/3/22 received report from [hospital] that resident had a right hip fracture and was in surgery..."</p> <p>Resident 19's record did not include post fall assessments.</p> <p>Resident 21 Resident 21 was admitted to the facility on 09/23/2015. Resident 21's diagnoses included Type 2 Diabetes, chronic kidney disease, and dementia. Resident 21's Progress Notes from 09/22/2021 through 04/22/2022 identified the following:</p>	N 381		

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N 381	<p>Continued From page 7</p> <p>-02/14/2022, "Resident complained of left knee pain. States [s/he] had an unwitnessed fall over the weekend and did not report the fall to any staff. Resident states [s/he] lost [her/his] balance in the TV room and was able to get up on her/his own. Left knee not swollen and no bruising noted. Resident requested not to be sent to emergency department (ED) at this time ...Resident requested to send out around 3:30 p.m., as pain was not improving. Resident went to [hospital] for evaluation and returned with no new orders. MD updated as well as sister and case worker."</p> <p>-03/13/2022, "On 03/13/2022 at 4:50 a.m., resident placed call light on and staff noted resident in bathroom on buttocks. Reports after toileting self lost balance going down on [her/his] buttock. Staff noted resident did not have sock or shoes on. Staff unable to assist resident from the floor. EMS called and responded and assisted with getting resident up. No injuries noted. Education provided to resident to apply gripper socks/shoes prior to transferring to prevent further falls. Resident verbalized understanding."</p> <p>-03/29/2022, "Resident was out to the back and on [her/his] way back and lost [her/his] balance and fell to the ground. Resident was able to get up with assistance. No injury noted. Resident able to ambulate independently with cane back to the community." Resident 21's record did not include post fall assessments.</p> <p>On 06/02/2022, at 11:25 AM, Surveyor interviewed Administrator A, Director of Wellness (DOW) B, and Assistant Director of Wellness (ADOW) C, regarding what kind of follow up was completed after a resident fell. Administrator A reported the process the provider utilized was a physical assessment of the resident's health.</p>	N 381		

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N 381	Continued From page 8 Administrator A reported the nurse will triage whether the resident was sent out for medical attention or if they stayed within the facility and were monitored for changes there. Administrator A reported the provider asked the resident about what they were doing at the time of the fall to identify if they could put an intervention in place to ensure they do not fall again. Administrator A confirmed the provider did not complete a post fall assessment to include in the resident's record after each fall. Administrator A reported the provider did not utilize incident reports to document their investigation of falls.	N 381		
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 each resident received updated Individual Service Plans (ISPs) annually for 6 of 7 residents (Resident 4, Resident 16, Resident 18, Resident 19, Resident 20, and	N 389		

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N 389	<p>Continued From page 9</p> <p>Resident 21) reviewed and did not ensure 3 of 3 residents' ISPs (Resident 18, Resident 19, and Resident 21), which were updated in 2022, included signatures of the residents' legal representative and/or managed care organization (MCO) case management team.</p> <p>Findings include:</p> <p>On 03/30/2022, the Department received a complaint alleging legal representatives were not included in the ISP process.</p> <p>On 05/25/2022, Surveyor reviewed resident records and identified the following:</p> <p>Resident 4 Resident 4 was admitted to the facility on 09/20/2007. Resident 4 was discharged on 01/10/2022. Resident 4's Move In Record (MIR), not dated, identified Resident 4 had an MCO case management team and a guardian. Resident 4 had diagnoses including schizophrenia, hypertension, type 2 diabetes mellitus, and complete amputation at level between hip and knee. Resident 4's record included a temporary care plan, dated 07/29/2018. Resident 4's record did not include did not include any ISPs since 2018.</p> <p>Resident 16 Resident 16 was admitted to the facility on 08/14/2017. Resident 16 was discharged on 12/21/2021. Resident 16's MIR, not dated, identified Resident 16 had an MCO case management team and a family member listed as "responsible party." Resident 16 had resided on a memory care unit within the facility. Resident 16 had diagnoses including dementia, hypertension, congestive heart failure, epilepsy, type 2 diabetes</p>	N 389		

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N 389	<p>Continued From page 10</p> <p>mellitus, and a history of falling. Resident 16's record included an ISP, dated 09/14/2017. Resident 16's record did not include any additional ISPs since 2017.</p> <p>Resident 18 Resident 18 was admitted to the facility on 09/29/2021. Resident 18's MIR, not dated, identified Resident 18 had an MCO case management team. Resident 18 had diagnoses including Alzheimer's Disease, hypertension, and chronic kidney disease. Resident 18 resided on a memory care unit within the facility. Resident 18's record contained an ISP dated 04/01/2022 and was not signed by Resident 18 or MCO case management team. There were no ISPs for 2021.</p> <p>Resident 19 Resident 19 was admitted to the facility on 10/15/2019. Resident 19 was discharged on 05/08/2022. Resident 19's MIR, not dated, identified Resident 19 had an MCO case management team. Resident 19 had a diagnosis of dementia. Resident 19 resided on a memory care unit within the facility. Resident 19's record included an ISP dated 12/20/2019. Resident 19's record included an ISP, dated 02/02/2022, which was not signed by Resident 19 or MCO case management team. There were no ISPs for 2020 or 2021.</p> <p>Resident 20 Resident 20 was admitted to the facility on 08/12/2016. Resident 20 was discharged on 12/14/2021. Resident 20's MIR, not dated, identified Resident 20 had an MCO case management team. Resident 20 had diagnoses including major depressive disorder, Parkinson's disease, hypertension, congestive heart failure, and type 2 diabetes mellitus. Resident 20's record</p>	N 389		

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N 389	<p>Continued From page 11</p> <p>contained ISPs dated 08/07/2018, 11/22/2019, and 04/29/2021. Resident 20's record did not contain an ISP for 2020.</p> <p>Resident 21 Resident 21 was admitted to the facility on 09/23/2015. Resident 21's MIR, not dated, identified Resident 21 had an MCO case management team. Resident 21 had diagnoses including congestive heart failure, dementia, major depressive disorder, hypertension, chronic kidney disease, and type 2 diabetes mellitus. Resident 21's record included an ISP dated 04/01/2022 and it was not signed by Resident 21 or the MCO case management team. There were no ISPs from admission until the ISP dated 04/01/2022.</p> <p>On 05/24/2022, at 3:40 PM, Surveyor interviewed Director of Wellness (DOW) B regarding ISPs. DOW B reported s/he began employment at the facility in December 2021 and when s/he started s/he identified approximately 100 ISPs, for the residents residing in the facility, needed to be updated or written. DOW B reported they were unable to locate many ISPs and was unsure if they had been completed at all.</p> <p>On 05/24/2022, at 4:30 PM, Surveyor interviewed Administrator A regarding ISP process. Administrator A reported s/he was new to the facility and began employment on 12/10/2021. When s/he started, s/he identified nearly all ISPs for approximately all 100 residents in the facility were outdated or they did not have one included in their files. Administrator A reported s/he and his/her team had been working to get all of the ISPs up to date.</p> <p>On 06/02/2022, at 11:30 AM, Surveyor</p>	N 389		

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N 389	Continued From page 12 interviewed Administrator A, DOW B, and Assistant Director of Wellness (ADOW) C, regarding the ISP process. DOW B further clarified they attempted to obtain signatures from residents and responsible parties on the ISPs, but they had difficulty with contacting some of the MCO case management teams to obtain signatures. DOW B reported they attempted to obtain signatures from the residents, the residents' guardians and powers of attorney, and they mail them to them and request them to mail the signed ISPs back, but often they do not receive them. DOW B confirmed they had not documented their attempts in the residents' records. Administrator A confirmed s/he had provided Surveyors with all the ISPs they had.	N 389		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all staff who provided resident care and services had continual access to the resident's assessment and Individual Service Plan (ISP) for 2 of 2 residents (Resident 18 and Resident 21) reviewed who were residing in the facility at the time of the survey. Findings include: On 05/24/2022, Surveyor reviewed resident records located in the Wellness Office in the basement of the facility and identified the following:	N 391		

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N 391	<p>Continued From page 13</p> <p>-Resident 18 was admitted to the facility on 09/29/2021. Resident 18 had diagnoses including Alzheimer's Disease, hypertension, and chronic kidney disease. Resident 18 resided on a memory care unit within the facility. Resident 18's record did not contain an annual assessment or ISP.</p> <p>-Resident 21 was admitted to the facility on 09/23/2015. Resident 21 had diagnoses including congestive heart failure, dementia, major depressive disorder, hypertension, chronic kidney disease, and type 2 diabetes mellitus. Resident 21's record did not contain an annual assessment or ISP</p> <p>On 05/24/2022, at 3:40 PM, Surveyor interview Director of Wellness (DOW) B regarding staff access to ISPs. DOW B reported staff did not have access to ISPs. DOW B reported staff utilized a care card to care for the resident and a resident assignment log to know how to adequately care for the residents. Surveyor requested Resident 18's and Resident 21's annual assessment and ISP.</p> <p>On 05/25/2022, Surveyor received the following via email: -Resident 18's annual assessment dated 03/26/2022, and an ISP dated 04/01/2022. -Resident 21's annual assessment dated 03/25/2022, and an ISP dated 04/01/2022.</p> <p>On 06/02/2022, at 11:30 AM, Surveyor interviewed Administrator A, DOW B, and Assistant Director of Wellness (ADOW) C, regarding staff access to resident assessments and ISPs. Administrator A confirmed staff did not have access to assessments. Administrator A reported the assessments and ISPs were completed in an electronic record keeping system</p>	N 391		

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N 391	Continued From page 14 and caregiving staff did not have access to the electronic record keeping system. DOW B reported since the on-site visit on 05/25/2022, they began to implement a binder on each floor of each residents' ISP which was printed for staff to have access. Administrator A and DOW B reported they will also print out and add each residents' assessment information to the binder.	N 391		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observations and staff interview the provider did not ensure medications coming from a licensed pharmacy were labeled to ensure proper and safe usage. In 3 of 6 medication carts of the facility, inhalers and eye drops were discovered in the medication carts without a resident name or pharmacy label. In 1 of 6 medication rooms of the facility, an opened insulin pen was discovered in the medication refrigerator without a resident name or pharmacy label. In 3 of 6 medication carts of the facility, opened insulin pens were discovered in the medication	N 401		

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N 401	<p>Continued From page 15</p> <p>carts without a resident name or pharmacy label.</p> <p>Findings include:</p> <p>On 05/24/2022 between 12:15 p.m. and 1:45 p.m., Surveyor and Assistant Director of Wellness B observed the facility's medication storage system. Surveyor observed the facility had 1 medication cart and 1 medication refrigerator located on the second, third, fourth, fifth, sixth, and seventh floors.</p> <p>Second floor medication cart contained 2 bottles of Durezol 0.05% eye drops, with no resident name or pharmacy label. Medication cart contained an opened Lantus Solostar and an Novolog insulin pen, with no resident name or pharmacy label.</p> <p>Third floor medication cart contained 2 fluticasone/salmeterol inhalers, 1 Advair inhaler, 1 Spirea handihaler, 2 Trelegy inhalers, and 1 Breo Ellipta inhaler, with no resident name or pharmacy label.</p> <p>Third floor medication refrigerator contained a Novolog 70/30 insulin pen, with no resident name or pharmacy label.</p> <p>Fourth-floor medication cart contained an opened Lantus Solostar insulin pen, an opened Lispro insulin pen and 2 opened Lantus insulin pens, with no resident name or pharmacy label.</p> <p>Sixth floor medication cart contained 1 Trelegy Ellipta inhaler, with no resident name or pharmacy label.</p> <p>On 05/24/2022 at 1:45 p.m., Surveyor interviewed Assistant Director of Wellness B. Assistant</p>	N 401		

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N 401	<p>Continued From page 16</p> <p>Director of Wellness B verified the inhalers, eye drops, and insulin pens did not contain a resident name or pharmacy label and stated, "The box of insulin pens are stored in the refrigerator and contain a pharmacy label on the outside of the box. When staff remove an insulin pen from the box there is no resident name or pharmacy label on the individual pen..." Assistant Director of Wellness B stated s/he would work on a system to ensure proper labeling of medications.</p> <p>On 06/02/2022 at 11:00 a.m., Surveyors conducted an exit interview with Administrator A. Surveyors informed Administrator A of the above findings. Administrator A verified s/he was aware medications are to be labeled. Administrator A stated [Wellness Coordinator I] was responsible for auditing the medication carts on a weekly basis. Administrator A stated, "We have added additional information to the audit tool to ensure medications are labeled."</p>	N 401		
N 406	<p>83.37(1)(g) Disposition of medications.</p> <p>Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the</p>	N 406		

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N 406	<p>Continued From page 17</p> <p>pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.</p> <p>This Rule is not met as evidenced by: Based on observation, staff interview, and record review the provider did not establish an effective procedure for the proper destruction and disposal of discontinued and outdated medications. Discontinued or outdated medications were observed stored along with the residents' non-expired medications in 5 of 6 medication carts. This had the potential to negatively affect 104 residents in the facility.</p> <p>In 3 of 6 medication carts of the facility, opened insulin pens were discovered in the medication cart and contained no dates to determine the specific expiration date of the medication. In 1 of 6 medication refrigerators contained an insulin pen with no pharmacy label. Additionally, 5 of 6 medication carts contained unlabeled, expired, or discontinued medications.</p> <p>Findings include:</p> <p>"...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert...The following tables address specific expiration or beyond-use dating</p>	N 406		

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N 406	<p>Continued From page 18</p> <p>guidelines that apply to insulin products...Insulin storage for Pens... Lispro insulin pen: label expiration date 28 days when seal is punctured Novolog insulin pen: label expiration date 28 days when seal is punctured... Lantus Pen: label expiration date 28 days when seal is punctured..." (DQA Publication-01904, Insulin Storage Guide, 02/2017)</p> <p>An article published by the FDA (Food and Drug Administration) dated 03/1/2016 and titled, "Don't Be Tempted to Use Expired Medications" indicated, "The expiration date can be found printed on the label or stamped onto the bottle or carton, sometimes following 'EXP.' It is important to know and stick to the expiration date on your medicine. Using expired medical products is risky and possibly harmful to your health. ... Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength..."</p> <p>On 05/24/2022 between 12:15 p.m. and 1:45 p.m., Surveyor reviewed the facility's 6 medication carts and 6 refrigerated medication storage system with Assistant Director of Wellness B. The medication carts and refrigerators were located on the second, third, fourth, fifth, sixth, and seventh floors of the facility. Surveyor observed outdated/expired medications in 4 of 6 medication carts for 6 residents (Residents 1, 2, 7, 11, 12, and 13). Surveyor observed outdated/expired medications in 1 of 6 medication refrigerators for Resident 7. Surveyor observed 3 Basaglar insulin pens for discharged resident (Resident 4). Surveyor observed discontinued and expired medications stored along with the residents' non-expired medication in the medication cart and refrigerator. The following was found:</p>	N 406		
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N 406	<p>Continued From page 19</p> <p>Second Floor Medication Cart: 1 in-use Lantus Solostar insulin pen. The pen did not document an open or expired date to determine the specific expiration date of the medication for Resident 1. 1 in-use Novolog Flex insulin pen. The pen did not document an open or expired date to determine the specific expiration date of the medication for Resident 2.</p> <p>Third Floor Medication Refrigerator: 1 bottle of Latanoprost 0.005% eye drops with expiration date of 10/31/2021 for Resident 7. 3 Basaglar insulin pens prescribed to a resident not on the current resident roster (Resident 4) with dispensed date of 10/20/2021.</p> <p>Fourth Floor Medication Cart: 1 in-use Lantus Solostar insulin pen. The pen did not document an open or expired date to determine the specific expiration date of the medication for Resident 11. 2 in-use Lantus Solostar insulin pens. The pens did not document an open or expired date to determine the specific expiration date of the medication for Resident 12. 1 in-use Lispro insulin pen. The pen did not document an open or expired date to determine the specific expiration date of the medication for Resident 12.</p> <p>Sixth Floor Medication Cart: 1 Albuterol Sulfate HFA 90 mcg inhaler with expiration date of 01/31/2022 for Resident 13. 1 bottle of Nitroglycerin 0.4 mg tablets with expiration date of 01/31/2022 for Resident 13.</p> <p>Seventh Floor Medication Cart: 1 tube of Triamcinolone 0.1% cream prescribed</p>	N 406		

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N 406	<p>Continued From page 20</p> <p>for Resident 22. Not currently on Resident 22's physician orders</p> <p>On 05/24/2022 at approximately 1:45 p.m., Surveyor asked Assistant Director of Wellness B if s/he was aware in-use insulin pens were to be dated when opened. Assistant Director of Wellness B stated s/he was aware in-use insulin pens should be dated when opened. Assistant Director of Wellness B verified each insulin pen was currently in use. Assistant Director of Wellness B verified the above expired medications. Assistant Director of Wellness B stated, "The medication carts are audited weekly. The expired medications should have been removed." Assistant Director of Wellness B stated discharged resident's medications should be removed.</p> <p>On 06/02/2022 at 11:00 a.m., Surveyors conducted an exit interview with Administrator A. Surveyors informed Administrator A of the above findings. Administrator A verified s/he was aware opened and in use insulin syringes should be dated. Administrator A stated [Wellness Coordinator I] was responsible for auditing the medication carts on a weekly basis. Administrator A stated, "We have added additional information to the audit tool to ensure insulin pens are labeled and dated."</p>	N 406		
N 409	<p>83.37(1)(j) Proof-of-use record.</p> <p>Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin 's uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose,</p>	N 409		

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N 409	<p>Continued From page 21</p> <p>signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis.</p> <p>This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not audit, sign, and date the proof-of-use record for schedule II medications on a daily basis in 1 of 1 medication carts. The administrator did not audit, sign and date the proof-of-use records daily.</p> <p>The facility is licensed to serve up to 136 residents who may be developmentally disabled, emotionally disturbed/mental illness, of advanced age, and/or have irreversible dementia/ Alzheimer's.</p> <p>Findings include:</p> <p>On 05/24/2022 between 12:00 p.m. and 1:30 p.m., Surveyor observed the locked narcotic box, within the medication cart on the third floor of the CBRF, with schedule II medications and extra-large sized bag of morphine syringes. Surveyor observed schedule II medications, hydrocodone-acetaminophen 5-325 mg tablets and morphine sulfate oral syringes, for Resident 14. Surveyor observed a schedule II medication, tramadol HCL 50 mg tablets, for Resident 15. Surveyor reviewed a binder that included forms of individual controlled drug use record sheets for each medication as well as 1 audit form titled "3rd Floor ... Shift to Shift Narcotic Count Log ... May 2022." Surveyor reviewed the shift-to-shift count form. Surveyor noted a table that included the following count times: "NOC Shift - Day Shift, Day Shift - PM Shift, PM Shift - NOC Shift." Surveyor</p>	N 409		

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N 409	<p>Continued From page 22</p> <p>noted there were no initials or other documentation to indicate a count or audit was completed on each shift for 23 of 24 days. On 05/01/2022 and 05/2022, no initials or other documentation were noted to indicate a count or audit was completed. There was no documentation on the form to indicate the administrator or designee audited and signed daily to ensure the count was accurate.</p> <p>On 05/24/2022 at approximately 1:35 p.m., Surveyor interviewed Assistant Director of Wellness B who stated the medication passer leaving their shift and the medication passer starting their shift should be counting the schedule II medications and then initialing on the "Count Record" form. Surveyor stated the documentation of the daily narcotic count had multiple dates where there was no documentation to support the audit or count was completed for schedule II medications. Assistant Director of Wellness B verified the form did not always contain signatures or initials documenting a count was completed on the various dates that were blank on the May 2022 form. Director of Wellness B stated, "I will need to remind them to count." Surveyor asked Assistant Director of Wellness B if s/he was aware the administrator or designee were to audit schedule II medication counts daily. Assistant Director of Wellness B stated, "I did not. We will need to start auditing the counts."</p> <p>On 06/02/2022 at 11:00 a.m., Surveyors conducted an exit interview with Administrator A. Surveyors informed Administrator A of the above findings. Administrator A stated s/he was not aware the proof of use records for schedule II medications should be verified daily by her/himself. Administrator A stated [Wellness Coordinator I] was responsible for auditing the</p>	N 409		

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N 409	Continued From page 23 medication carts including schedule II medication count logs on a weekly basis. Administrator A stated, "We have added additional information to the audit tool to ensure schedule II medication logs are complete."	N 409		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers reviewed received supervision and delegation by a registered nurse (RN) for completing delegated nursing tasks of administration of insulin. This had the potential to negatively affect 13 of 13 residents that required assistance with administering insulin from non-licensed staff. Findings include: Chapter N6.03(3) is the Standard of Practice for RN's and addresses the supervision and direction of delegated tasks. The RN may delegate a task based on the educational preparation and demonstrated abilities of the person supervised but must provide direction and assistance, and observe, monitor, and evaluate the effectiveness of the delegated tasks.	N 416		

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N 416	<p>Continued From page 24</p> <p>On 05/24/2022 between 12:00 p.m. and 1:30 p.m., Surveyor observed the facility's medication carts on each floor with Assistant Director of Wellness B. The medication cart on the second, third, fourth, and fifth floors contained insulin pens. Surveyor asked Assistant Director of Wellness if a RN provided training and performed delegation for the non-licensed staff to administer insulin. Assistant Director of Wellness B verified medication passers were trained by the facility RN to administer insulin and were delegated the task.</p> <p>On 05/25/2022 at approximately 11:00 a.m., Surveyor reviewed training records for Caregiver D and Caregiver E. Caregiver D did not have documentation of being delegated to perform nursing tasks of insulin administration. Caregiver E's record contained an undated blank form signed by a RN for nurse training and delegation of insulin administration.</p> <p>On 06/02/2022 at approximately 11:00 a.m., Surveyors informed Administrator A of the above findings. Administrator A acknowledged that medication passers should have nurse delegation or training for insulin administration. Administrator A stated s/he was not aware nurse delegation for insulin administrator was not included on the training documentation.</p>	N 416		
N 431	<p>83.38(1)(g) Health monitoring.</p> <p>As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of</p>	N 431		

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N 431	<p>Continued From page 25</p> <p>the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure health monitoring for 4 of 7 residents.</p> <p>Resident 16 had diabetes and resided on a memory care floor. Resident 16 did not respond when staff attempted to wake him/her up in the morning on 12/21/2021. Staff did not check Resident 16's blood glucose or attempt to provide morning medications. Resident 16 was found</p>	N 431		

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N 431	<p>Continued From page 26</p> <p>deceased on 12/21/2021 at approximately 12:40 PM.</p> <p>Resident 20 tested positive for COVID-19 on 12/04/2021, was hospitalized on 12/10/2021, and passed away in the hospital on 12/13/2022.</p> <p>Resident 4 had a diagnosis of type 2 diabetes. The provider did not complete daily foot checks. Resident 4 underwent an amputation of the right foot and was unable to return to the facility due to the need for a wheelchair.</p> <p>Resident 21 had diagnoses including diabetes, chronic kidney disease and dementia. The provider did not monitor Resident 21's health regarding pressure sores noted by the hospital, post fall assessments, and post emergency room and hospital visits.</p> <p>Findings include:</p> <p>On 12/22/2021, the Department received a complaint alleging staff did not monitor a resident's health or provide morning medications on 12/21/2021. Staff allegedly did not try to wake him/her up when s/he was unresponsive and was later found deceased in the afternoon.</p> <p>On 12/08/2021, the Department received a complaint alleging the provider did not monitor an infected resident's health when s/he tested positive for COVID-19.</p> <p>Resident 16 On 05/25/2022, Surveyor reviewed Resident 16's record. Resident 16 was admitted to the facility on 08/14/2017. Resident 16 had diagnoses including dementia, hypertension, congestive heart failure, epilepsy, type 2 diabetes mellitus,</p>	N 431		

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N 431	<p>Continued From page 27</p> <p>and a history of falling. Resident 16's most recent Individual Service Plan (ISP) in the record, dated 08/18/2018 (from prior to the change of ownership), identified Resident 16 required staff to administer all medications due to cognitive impairment. A review of Resident 16's Medication Administration Record (MAR) for the period of 11/20/2021 through 12/30/2021, identified Resident 16 was scheduled to receive repaglinide 1 milligram (mg) at 7:00 AM. Further review of the MAR identified, Resident 16 was scheduled to receive aspirin 81 mg, brilinta 90 mg, isosorbide mononitrate extended release 30 mg, levetiracetam 1000 mg, and lisinopril 2.5 mg at 8:00 AM. Further review of the MAR identified; Resident 16 was scheduled to receive repaglinide 1 mg at 11:00 AM. All corresponding boxes on the MAR for 12/21/2021 for the medications scheduled for 7:00 AM, 8:00 AM, and 11:00 AM were blank. There were no notations indicating the medications were offered and refused. Further review of Resident 16's record identified physician's orders for the medications were not included in the record. Resident 16 required staff to check his/her blood glucose level prior to breakfast and received insulin in the evening. There was no documentation indicating staff had checked Resident 16's blood glucose level on 12/21/2021.</p> <p>On 06/21/2022, Surveyor received the paramedic report for Resident 16, dated 12/21/2021, and authored by the paramedic team. Review of the document identified "...Upon arrivals, crews found one female PT [patient] lying on [his/her] right side in bed. PT as [sic] rapidly assessed and found lividity on [his/her] right side as well as rigor that had set in to [sic] [his/her] jaw and beginning in the extremities, fixed pupils with no respiration and no pulse. PT was found to be beyond</p>	N 431		

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N 431	<p>Continued From page 28</p> <p>medical care and was beyond resuscitation. PD [police department] was dispatched to the scene. No trauma or suspicious activity was suspected or noted. Caregiver stated [s/he] was last seen alert at 2200 the night before. Caregivers called in to wake the PT for breakfast at 0830, but stated [s/he] commonly slept in late and does not like to be woken up by staff so they let [him/her] remain in bed. They then checked on [him/her] for lunch and found [him/her] to be deceased. 10-99 [cardiac arrest] was called at 1257. ME [medical examiner] was contacted and given all information, [ME M] approved of report and 10-99, PD referred to contact at a later time after investigation..."</p> <p>"Rigor mortis is the post-mortem stiffening of muscles caused by the depletion of adenosine triphosphate (ATP) from the muscles, which is necessary for the breakdown of actin-myosin filaments in the muscle fibers...Smaller muscles over the face - around the eyes, around the mouth, etc. are the muscles where rigor mortis first appears, followed by rigor mortis of the muscles in the hands and upper limbs and finally appears in the large muscles of the lower limbs. Rigor mortis appears approximately 2 hours after death in the muscles of the face, progresses to the limbs over the next few hours, completing between 6 to 8 hours after death." (Source: National Library Of Medicine Website, Methods of Estimation of Time Since Death, May 15, 2022, https://www.ncbi.nlm.nih.gov/books/NBK549867/ (retrieval date - June 22, 2022).)</p> <p>On 05/24/2022, Surveyor reviewed a document titled "Investigation Notes: [Resident 16] unexpected passing," not dated. Surveyor identified "...The caregiver assigned to the resident that day [PMA H] stated s/he had been in</p>	N 431		

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N 431	<p>Continued From page 29</p> <p>the resident's room at breakfast and [s/he] did not answer when [s/he] was spoken to, [s/he] stated [s/he] assumed [s/he] was sleeping heavily. [S/He] returned again at lunch and again the resident did not respond to [him/her]. At that time [s/he] called the Wellness Coordinator who came up to the room and then notified the ED [Executive Director]. Upon the arrival of 911 resident was pronounced and police took statements from staff..." The investigation notes did not address the lack of medication administration on the MAR or blood glucose checks.</p> <p>On 06/02/2022, at 11:25 AM, Surveyor interviewed Administrator A, Director of Wellness (DOW) B, and Assistant Director of Wellness (ADOW) C, regarding Resident 16's medications and blood glucose check on 12/21/2021. Administrator A confirmed s/he authored the document titled "Investigation Notes: [Resident 16] unexpected passing." Administrator A confirmed the medications were not given to Resident 16 and Resident 16's blood glucose level had not been checked. Administrator A reported PMA H was unable to arouse Resident 16 in the morning of 12/21/2021 and was not able to give medications and did not check Resident 16's blood glucose level. Administrator A reported PMA H believed Resident 16 was sleeping heavily and did not notify the nurse until PMA H checked on Resident 16 when s/he did not go to lunch. Administrator A reported PMA H was trained immediately on recognizing and responding to changes after the incident occurred and was also scheduled to attend new hire orientation the following month. Administrator A reported Resident 16 had diabetes and s/he may not have been able to be aroused due to low blood sugar, which needed attention. Administrator A reported</p>	N 431		

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N 431	<p>Continued From page 30</p> <p>PMA H quit working for the provider in February 2022.</p> <p>Resident 20 On 05/25/2022, Surveyor reviewed Resident 20's record and identified the following: Resident 20 was admitted to the facility on 08/12/2016. Resident 20 was discharged on 12/14/2021. Resident 20 had diagnoses including major depressive disorder, Parkinson's Disease, hypertension, congestive heart failure, and type 2 diabetes mellitus. Resident 20's Progress Notes from 10/31/2021 through 12/14/2021 identified Resident 20 tested positive for COVID-19 on 12/04/2021. The progress note on 12/10/2021 identified "Resident c/o [complained of] SOB [shortness of breath]-per staff appetite and fluid intake has greatly decreased over the past few day [sic]. Resident has been declining all medications. Per staff resident tested positive for Covid on 12/4/22. Resident agreed to be transported to hospital for evaluation..." The progress note on 12/14/2021 identified "Called by daughter, notified resident expired yesterday in hospital." Resident 20's record did not include any information regarding monitoring Resident 20's health after s/he tested positive for COVID-19.</p> <p>On 06/02/2022, at approximately 11:30 AM, Surveyor interviewed Administrator A, Director of Wellness (DOW) B, and Assistant Director of Wellness (ADOW) C regarding Resident 20's health. Administrator A reported s/he had just started employment the day Resident 20 went to the hospital. Administrator A reported s/he did not know what kind of monitoring the previous nurses and director completed with someone who tested positive for COVID-19. Administrator A reported what should have occurred after the positive COVID-19 result was that Resident 20 should</p>	N 431		

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N 431	<p>Continued From page 31</p> <p>have been assessed at least daily by the nurse for his/her condition to monitor symptoms. Administrator A confirmed the health monitoring should have been identified in his/her progress notes. Administrator A confirmed there was no information regarding health monitoring in Resident 20's progress notes between the time s/he tested positive for COVID-19 and his/her being sent to the hospital.</p> <p>Resident 4 On 05/25/2022 at approximately 10:30 a.m., Surveyor reviewed Resident 4's closed record and identified the following: Resident 4 was admitted to the facility on 09/20/2007. Resident 4's diagnoses included Type 2 Diabetes and prior above knee amputation. Resident 4's Progress Notes from 10/05/2021 through 01/06/2022 identified Resident 4 was seen by a podiatrist on 11/09/2021. The note stated, "Resident saw podiatrist today and got her/his toenails cut as well and s/he has a large black spot under her/his foot which looks like it is very infected. So, we got her/him an emergency appointment with her/his primary doctor to see her/his feet at 4 pm because the podiatrist felt s/he should go to the hospital. On 01/06/2022, Administrator A documented, "Call from case manager, [Resident 4] is doing poorly and will not be able to return to community as s/he will need a wheelchair and transfer assist. Resident 4's record contained no documentation or evidence of monitoring her/his skin for open areas or pressure wounds. Resident 4's record contained a treatment record titled "Diabetic Foot Checks" for the months of September 2021, October 2021, and November 2021. The document stated "Foot check q HS [every night at bedtime] to include looking</p>	N 431		

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N 431	<p>Continued From page 32</p> <p>between toes and check heels for redness any open areas. Inform nurse of any abnormalities." Resident 4's foot was checked 09/04/2021, 09/09/2021, 09/10/2021, 10/02/2021, 10/06/2021, 10/14/2021, 11/04/2021, and 11/08/2021. Resident 4's foot was not monitored daily as required.</p> <p>On 06/02/2022, at approximately 11:40 AM, Surveyor interviewed Administrator A, DOW B, and ADOW C regarding health monitoring of Resident 4's foot. Administrator A reported s/he began employment with the provider after Resident 4 was hospitalized due to his/her skin condition of his/her foot. Administrator A confirmed Resident 4 had his/her other foot amputated but was unsure how significant the amputation was since they did not receive documentation from the hospital and the resident had found other living arrangements since s/he required the use of a wheelchair after the amputation. Administrator A confirmed the documentation indicated staff did not check Resident 4's limbs daily as required due to his/her diagnosis of diabetes.</p> <p>Resident 21 Resident 21 was admitted to the facility on 09/23/2015. Resident 21's diagnoses included Type 2 Diabetes, chronic kidney disease, and dementia. Resident 21's Progress Notes from 09/22/2021 through 04/22/2022 identified the following: 09/22/2021, "Resident 21 seen in clinic. Successful change of suprapubic catheter. Return in 4 weeks. 01/23/2022, "Resident resistant to showering particularly when catheter has leaked. Resident on Sunday had urine-soaked clothing and was walking around the building, urine was trailing</p>	N 431		

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N 431	<p>Continued From page 33</p> <p>behind her/him."</p> <p>02/04/2022, "Resident out to see urologist today and suprapubic catheter changed at visit with no concerns. Urine collected at visit for culture. Return in 1 month for catheter change.."</p> <p>02/08/2022, "Resident started on Batrim for urinary tract infection ..."</p> <p>02/14/2022, "Resident complained of left knee pain. States s/he had an unwitnessed fall over the weekend and did not report the fall to any staff. Resident states s/he lost her/his balance in the TV room and was able to get up on her/his own. Left knee not swollen and no bruising noted. Resident requested not to be sent to emergency department (ED) at this time ...Resident requested to sent out around 3:30 p.m., as pain was not improving. Resident went to St. Lukes for evaluation and returned with no new orders. MD updated as well as [family] and case worker."</p> <p>02/21/2022, "Resident in bed when writer entered to administer scheduled medication. Resident difficult to arouse with verbal or physical cures. Blood sugar 32, resident skin cool and moist. 911 call-EMS responded and gave glucose. Resident awake and declining to go to ED for evaluation. Blood sugar 200, dinner gathered and given to resident and s/he consumed 100% of meal. MD and case worker updated."</p> <p>03/07/2022, "New orders to hold insulin if blood sugar less than 80 ..."</p> <p>03/13/2022, "On 03/13/2022 at 4:50 a.m., resident placed call light on and staff noted resident in bathroom on buttocks. Reports after toileting self lost balance going down on her/his buttock. Staff noted resident did not have sock or shoes on. Staff unable to assist resident from the floor. EMS called and responded and assisted with getting resident up. No injuries notes. Education provided to resident to apply gripper socks/shoes prior to transferring to prevent</p>	N 431		

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N 431	<p>Continued From page 34</p> <p>further falls. Resident verbalized understanding." 03/21/2022, "Resident out to see urologist and had suprapubic catheter changed today resident tolerated well. No new orders. Resident does have follow-up appoints 03/29/2022 and 09/28/2022 with cardiovascular MD." 03/25/2022. "Resident returned from West Allis Memorial hospital today. Resident is up and ambulating independently. Vitals stable ...Resident is happy to be back in the community." 03/29/2022, "Resident was out to the back and on her/his way back and lost her/his balance and fell to the ground. Resident was able to get up with assistance. No injury noted. Resident able to ambulate independently with cane back to the community." 04/10/2022. "Resident was complaining of diarrhea and not feeling well, requesting to go to the hospital. Resident went to West Allis hospital for evaluation and is returning with a PRN (as needed) order for loperamide and was given 1 liter of fluid in the hospital." 04/13/2022, "Resident sent to the ED and returned with new orders for Zinc Oxide to buttocks. Resident returned same day." 04/18/2022. "Resident went out to ED on 04/16/2022 for abdominal pain and returned with no new orders. 04/20/2022, "Resident seen by urologist on 04/18/2022 to have suprapubic catheter changed with no concerns. Return in 4 weeks for next change." Resident 21's hospital records from 02/23/2022 through 04/16/2022 identified the following: 02/23/2022, "Patient arrives from assisted living facility via EMS with reports of dizziness and hypotension. Patient began feeling dizzy when s/he woke up this morning like s/he might fall. Upon EMS arrive, patients systolic blood pressure</p>	N 431		

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N 431	<p>Continued From page 35</p> <p>was in the 70's. EMS administered a 1000 cc bolus of normal saline. Patient's systolic blood pressure in the 110s upon arrival. Patient still feeling dizzy after the fluids and has complaints of right knee pain from a fall a couple days ago." Resident 21 was discharged from ED and sent back to the facility.</p> <p>03/25/2022, Resident 21 was hospitalized at St. Luke Medical Center from 03/22/2022 through 03/25/2022. Resident 21's hospital record identified upon admission s/he had a pressure injury wound around her/his suprapubic catheter measuring 1 cm x 0.5 cm with depth of 0.1 cm. Resident 21 had a stage 2 pressure wound on her/his coccyx. Resident 21's discharge diagnoses included colitis/diarrhea with rotavirus, present upon admission and catheter induced urinary tract infection, present upon admission. Discharge instructions included applying barrier cream to both wounds.</p> <p>04/10/2022, Resident was seen in the ER at West Allis Memorial Hospital. ER documents revealed Resident 21 was seen due to complaints of diarrhea. Resident 21 was prescribed loperamide 2 mg. Resident 21's ER report indicated s/he was receiving home health care services for physical therapy and skilled nursing care.</p> <p>04/13/2022, Resident was seen in the ER at West Allis Memorial Hospital. ER documents revealed Resident 21 was diagnosed with peri-rectal skin irritation and contact dermatitis. Resident 21's discharge instructions included Zinc Oxide 6% cream applied twice daily to peri-anal area. "Buttocks area needs to be allowed to get dry, may involve patient laying on side and having a fan blow. Needs to be changed regularly if wet. Use the ointment as prescribed."</p> <p>04/16/2022, Resident was seen in the ER at West Allis Memorial Hospital. ER documents revealed Resident 21 was diagnosed with irritant contact</p>	N 431		

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N 431	<p>Continued From page 36</p> <p>dermatitis due to fecal incontinence. Resident 21's most recent fall risk dated 03/25/2022, indicated her/his fall risk score was 80. The fall risk assessment form indicated a score of 45 or higher placed the individual at a high risk for falls. Resident 21's Individualized Service Plan (ISP), dated 03/25/2022, identified Resident 21 required cueing for bathing and dressing. "Often smells of strong urine, refuses showers at times. Encourage resident to wash and change clothing. Check skin with bath/shower. Report any reddened/open areas to nurse." Resident 21 was independent with toileting, used adult incontinence products and required assistance with managing her/his suprapubic catheter. "Skin condition. Goal: Will notify caregivers of any skin conditions as they occur. Interventions: Report any skin issues to nursing." Resident 21's record did not include evidence of additional documentation related to her/his pressure wounds, post fall assessments, and post ER and hospital visits.</p> <p>On 06/02/2022, at approximately 11:40 AM, Surveyor interviewed Administrator A, DOW B, and ADOW C regarding health monitoring of 21's pressure wounds, post falls, and post ER and hospital visits. DOW B reported Resident 21 did not have open wounds when s/he arrived back to the facility after her/his hospital stay. Administrator A confirmed they should have put the assessment of post ER and hospital visits in the progress notes. Administrator A reported the leaking from the catheter was from the tubing and confirmed the assessment of the leaking was not documented. Administrator A reported the nurse would respond to the falls and assess the resident's health. As part of their quality improvement plan, they do look at the circumstances revolving around the fall and what</p>	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2022
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NAME OF PROVIDER OR SUPPLIER NOBLE SENIOR LIVING AT WEST ALLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 WEST GREENFIELD AVENUE WEST ALLIS, WI 53214
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N 431	Continued From page 37 they implemented to prevent further falls. Administrator A confirmed they did not document those strategies in the resident's record.	N 431		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure at least 1 fire drill was held annually that simulates the conditions during usual sleeping hours as well as quarterly drills with both employees and residents in 2021. Findings include: On 05/24/2022 at approximately 11:00 a.m., Surveyor reviewed safety records and identified the following: There was no documentation evidence fire drills	N 525		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2022
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N 525	<p>Continued From page 38</p> <p>were completed during 2021. There was no documentation evidence a nighttime simulated fire drill was conducted in 2021.</p> <p>On 05/25/2022 at approximately 11:00 a.m., Surveyor reviewed department documents regarding the facility. There was no evidence a waiver was submitted and approved for this requirement.</p> <p>On 05/24/2022 at approximately 11:35 a.m., Surveyor informed Administrator A of the above findings. Surveyor asked Administrator A who was responsible for conducting fire drills. Administrator A stated it was the maintenance director's responsibility to complete the fire drills. Administrator A stated those responsible for ensuring the drills were completed in 2021 were no longer employed. Administrator A stated, "I started in December 2021. I do not know if the drills were completed. I gave you everything I have." Administrator A stated, "We will make sure all drills are completed in the future."</p>	N 525		
N 526	<p>83.47(2)(e) Other evacuation drills.</p> <p>Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other evacuation drills were conducted at least semi-annually in 2021. In 2021, no other evacuation drills were conducted.</p> <p>Findings include:</p>	N 526		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2022
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N 526	<p>Continued From page 39</p> <p>On 05/24/2022 at approximately 11:00 a.m., Surveyor reviewed safety records and identified the following: There was no documentation evidence other evacuation drills were completed during 2021.</p> <p>On 05/25/2022 at approximately 11:00 a.m., Surveyor reviewed department documents regarding the facility. There was no evidence a waiver was submitted and approved for this requirement.</p> <p>On 05/24/2022, at approximately 11:35 a.m., Surveyor informed Administrator A of the above findings. Surveyor asked Administrator A who was responsible for conducting evacuation drills. Administrator A stated it was the maintenance director's responsibility to complete the evacuation drills. Administrator A stated those responsible for ensuring the drills were completed in 2021 were no longer employed. Administrator A stated, "I started in December 2021. I do not know if the drills were completed. I gave you everything I have." Administrator A stated, "We will make sure all drills are completed in the future."</p>	N 526		