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	0010589	A. BUILDING: _____ B. WING _____	R 12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE GARDENS	900 O'KEEFFE AVE SUN PRAIRIE, WI 53590

(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 12/27/2023, with information obtained through 12/29/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Prairie Gardens, a community-based residential facility (CBRF) located in Sun Prairie, WI. As a result of the survey, 5 deficiencies were identified. Five deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) XR2711, dated 08/02/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 41	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 4 received all prescribed medications in the dosages as prescribed by a practitioner. Resident 4 received the incorrect dosage of sliding scale insulin on 3 occasions from 12/01/2023 - 12/27/2023.	N 352		

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

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N 352	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) XR2711, dated 08/02/2023. Findings include: On 12/27/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 01/03/2022 with diagnoses including type II diabetes mellitus. Resident 4's prescriptions included insulin aspart 100 unit/mL with instructions to inject separate baseline dosages at breakfast, lunch, and dinner, in addition to the following sliding scale: <151 = 0 units; 151-200 = 2 units; 201-250 = 4 units; 251-300= 6 units; >300 = 8 units. Surveyor reviewed Resident 4's medication administration record (MAR) from 12/01/2023 - 12/27/2023, and observed the following 3 occasions in which Resident 4 was documented as receiving the incorrect sliding scale insulin dosage: - 12/17/2023 (supper): Blood sugar documented as 298 (within parameters for 6 units of sliding scale insulin), 0 units documented as administered - 12/20/2023 (lunch): Blood sugar documented as 254 (within parameters for 6 units of sliding scale insulin), 2 units documented as administered - 12/24/2023 (breakfast): Blood sugar documented as 148 (within parameters for 0 units of sliding scale insulin), 4 units documented as administered At approximately 1:15 p.m., Surveyor interviewed Administrator A and Resident Manager F. Both	N 352		

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N 352	Continued From page 2 reported that they were unaware of the errors. After reviewing the errors, Resident Manager F reported that each one was made by a different staff member. Both reported that they would follow up with staff and would be looking into ways to mitigate insulin administration errors for the future.	N 352		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that medicine cabinets were locked. This is a repeat deficiency. See Statement of Deficiency (SOD) XR2711, dated 08/02/2023. Findings include: On 12/27/2023, at approximately 10:27 a.m., Surveyor observed the kitchenette in the back of the dining area. One set of upper cabinets in the kitchenette contained 39 different resident medications (see Photo 57). The cabinets were not fitted with a lock or any other way to secure the medications inside. The medications observed included: - 1 container of "Fiber Powder Psyllium Husk" (see Photos 1 and 2). The back of the container had a pharmacy label indicating that the bottle was prescribed to someone, but the label was partially ripped off the container. - 1 bottle of polyvinyl alcohol 1.4% lubricating eye	N 419		

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N 419	Continued From page 3	N 419		

drops with a pharmacy label indicating that it was prescribed to Resident 9 (see Photos 3 and 4)
- 1 container of polyethylene glycol 3350 powder with a pharmacy label indicating that it was prescribed to Resident 23 (see Photos 5 and 6)
- 1 container of "Daily Fiber 100% Natural Psyllium Husk" (see Photo 7)
- 1 container of fiber powder with a pharmacy label indicating that it was prescribed to Resident 16 (see Photos 8 and 9)
- 1 bottle of Adult Tussin 200 mg/10mL oral solution with a pharmacy label indicating that it was prescribed to Resident 6 (see Photos 10 and 11)
- 2 albuterol sulfate inhalers with pharmacy labels indicating that they were prescribed to Resident 6 (see Photos 12, 13, 14, 32, and 33)
- 1 bottle of Robitussin cough syrup with the name of Resident 16 handwritten on the box containing the bottle (see Photo 15)
- 1 tube of muscle rub cream with a pharmacy label indicating that it was prescribed to Resident 4 (see Photos 16 and 17)
- 1 baggie containing acetaminophen 650 mg tablets (for rectal insertion) with a pharmacy label indicating that they were prescribed to Resident 9 (see Photo 18)
- 1 tube of ketoconazole 2% cream with a pharmacy label indicating that it was prescribed to Resident 10 (see Photo 19)
- 2 tubes of hydrocortisone 2.5% cream with pharmacy labels indicating that they were prescribed to Resident 24 (see Photos 20, 21, 24, and 25)
- 3 tubes of ketoconazole 2% cream with pharmacy labels indicating that they were prescribed to Resident 8 (see Photos 22, 23, 30, 31, 37, and 38)
- 1 tube of hydrocortisone 2.5% cream with a pharmacy label indicating that it was prescribed to

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Resident 8 (see Photos 26 and 27)
- 1 tube of fluocinoide 0.05% ointment with a pharmacy label indicating that it was prescribed to Resident 11 (see Photos 28 and 29)
- 1 bottle of Nystatin 100,000 units/gram powder with a pharmacy label indicating that it was prescribed to Resident 15 (see Photo 34)
- 1 container of betamethasone dipropionate 0.05% lotion with a pharmacy label indicating that it was prescribed to Resident 13 (see Photos 35 and 36)
- 1 box of lidocaine patches with a pharmacy label indicating that they were prescribed to Resident 14 (see Photos 39 and 40)
- 1 bottle of "advanced antacid" solution with a pharmacy label indicating that it was prescribed to Resident 4 (see Photo 41 and 42)
- 2 containers of polyethylene glycol 3350 with pharmacy labels indicating that they were prescribed to Resident 13 (see Photos 43, 44, 53, and 54)
- 1 bottle of milk of magnesia solution with a pharmacy label indicating that it was prescribed to Resident 18 (see Photo 45)
- 1 bottle of cough syrup with the room number of Resident 12 handwritten on the box containing the bottle (see Photo 46)
- 1 bottle of milk of magnesia solution with a pharmacy label indicating that it was prescribed to Resident 5 (see Photo 47)
- 1 bottle of Mucinex
- 1 bottle of "Cold & Flu" syrup with the room number of Resident 25 handwritten on the bottle (see Photos 49 and 50)
- 1 bottle of Geri-Lanta with a pharmacy label indicating that it was prescribed to Resident 21 (see Photo 51)
- 1 container of MiraLAX
- 1 bottle of milk of magnesia solution with a pharmacy label indicating that it was prescribed to

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N 419	Continued From page 5 Resident 9 (see Photo 55) - 1 bottle of milk of magnesia solution with a pharmacy label indicating that it was prescribed to Resident 23 (see Photo 56) - 4 boxes of lidocaine patches, with a pharmacy label indicating that they were prescribed to Resident 26 (see Photos 58 and 59) - 2 tubes of hydrocortisone 1% cream with the name and room number of Resident 13 handwritten on each tube (see Photo 60 and 73) - 1 box of lidocaine patches with a pharmacy label indicating that they were prescribed to Resident 7 (see Photos 61 and 62) - 1 bottle of olopatadine hydrochloride ophthalmic 0.1% solution with a pharmacy label indicating that it was prescribed to Resident 11 (see Photos 63 and 64) - 1 bottle of polyethylene glycol 400 0.4% solution (eye drops) with a pharmacy label indicating that it was prescribed to Resident 4 (see Photos 65 and 66) - 1 container of petrolatum 42% hydrating ointment with a pharmacy label indicating that it was prescribed to Resident 25 (see Photos 67 and 68) - 1 bottle of polyethylene glycol 400 0.4% solution (eye drops) with a pharmacy label indicating that it was prescribed to Resident 11 (see Photos 69 and 70) - 1 bottle of polyethylene glycol 400 0.4% solution (eye drops) with a pharmacy label indicating that it was prescribed to Resident 27 (see Photos 71 and 72) - 1 bag of Halls cough drops (see Photo 74) - 1 tube of muscle rub cream with a pharmacy label indicating that it was prescribed to Resident 6 (see Photos 75 and 76) At approximately 10:30 a.m., Surveyor interviewed Resident Manager F. Resident	N 419		

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N 419	Continued From page 6 Manager F reported that s/he had intended to clear the medications out of the closet but had recently been not working due to illness. At approximately 1:15 p.m., Surveyor interviewed Administrator A and Resident Manager F. Administrator A reported that after the last survey s/he had attempted to follow up with a service to outfit the cabinets for locks, but had never heard back from them. Both acknowledged Surveyor's concern of resident medications being stored in an area that was unlocked and accessible to anyone entering the facility.	N 419		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the environment was safe and clean. This is a repeat deficiency. See Statement of Deficiency (SOD) XR2711, dated 08/02/2023. Findings include: On 12/27/2023, Surveyor toured the facility and observed the following: - At approximately 10:41 a.m., Surveyor observed	N 481		

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N 481	Continued From page 7	N 481		

a cabinet under the sink in the dining area kitchenette that contained multiple debris resembling rodent feces on the cabinet floor (see Photos 77, 78, and 79)

- At approximately 10:47 a.m., Surveyor observed another kitchenette in the dining area that appeared to contain games and objects for resident activities. In this kitchenette area, a double light switch was missing it's cover plate (see Photo 85) and an outlet was missing its cover plate (see Photo 86).

- At approximately 10:49 a.m., Surveyor observed a cabinet under the sink in a separate dining area kitchenette (closest to the kitchen) that contained debris resembling rodent feces on the cabinet floor (see Photo 89).

- At approximately 11:28 a.m., Surveyor observed the stove in the kitchen, which was covered in crumbs, crusted food debris, and grease stains (see Photo 90). Surveyor discussed the stove concern with Cook G, who was also in the kitchen. Cook G agreed with Surveyor that the stove should be cleaned.

- At approximately 12:20 p.m., Surveyor observed a red lighted exit sign outside the stairwell near the main floor activity room. The sign was lighted, but was missing its "EXIT" cover plate (see Photo 91). At approximately 12:37 p.m., Surveyor observed the exit sign with Administrator A. Administrator A reported s/he was unaware of the missing cover plate and thought maybe one of his/her maintenance staff was working with it. Administrator A reported s/he wasn't sure where the cover plate would be.

- At approximately 12:21 p.m., Surveyor observed

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N 481	Continued From page 8 a scuff in the hallway wall near Resident 18's room (see Photo 92). The scuff appeared to measure approximately 2" x 10" and in one section, appeared to extend into the drywall. At approximately 1:15 p.m., Surveyor discussed the above areas of concern with Administrator A and Resident Manager F. Administrator A reported that s/he also had observed the mouse droppings in the kitchen sink cabinets. Administrator A reported that after the last survey the cabinets had been cleaned out and that s/he had contracted a service for mouse baiting. Administrator A reported that the droppings observed during today's survey must have been from more recent mouse activity. Regarding the missing light switch and outlet plates, Administrator A reported that the dining area was painted approximately 1 month ago and so the plates were likely removed during that time. Administrator A reported that the re-installation of the plates must have been missed. Regarding the kitchen stove, Administrator A reported that it was power washed after the last survey, but agreed that it did not appear clean during today's survey. Regarding the hallway scuff, Administrator A reported s/he was aware of the scuffed area which was due to a past resident who scuffed the wall with his/her electric wheelchair. Administrator A reported that s/he had staff who would address the area in the coming weeks.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.	N 499		

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N 499	Continued From page 9	N 499		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that all cleaning compounds, polishes, and insecticides were stored in secure areas.

This is a repeat deficiency. See Statement of Deficiency (SOD) XR2711, dated 08/02/2023.

Findings include:

The provider is licensed to serve up to 47 residents in the client groups of advanced aged and physically disabled.

On 12/27/2023, Surveyor toured the environment and observed the following:

- At approximately 10:42 a.m., Surveyor observed a cabinet under the sink in the dining area kitchenette that contained 1 bottle of CaviCide, which was labeled as a surface disinfectant cleaner (see Photo 80). In the lower cabinet to the right of the sink, Surveyor observed 1 can of stainless steel polish and 1 can of glass cleaner (see Photos 81, 82, 83, and 84). The cabinets that contained these compounds were unsecured and did not appear to have a mechanism to be secured.

- At approximately 10:49 a.m., Surveyor observed a cabinet under the sink in a separate dining area kitchenette (closest to the kitchen) that contained 1 bottle of In-Cide, which was labeled as a disinfectant (see Photo 88). The cabinet was unsecured and did not appear to have a mechanism to be secured.

- At approximately 12:25 p.m., Surveyor observed

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N 499	Continued From page 10 a closet in the downstairs activity room that contained 1 can of wasp and hornet killer (see Photos 93 and 94). The closet was unsecured and did not appear to have a mechanism to be secured. - At approximately 12:29 p.m., Surveyor observed a cabinet under the sink in the upstairs activity room kitchenette that contained 2 cans of PuriCit odor eliminator (see Photos 95 and 96). The cabinet was unsecured and did not appear to have a mechanism to be secured. At approximately 1:15 p.m., Surveyor interviewed Administrator A and Resident Manager F. Administrator A. Administrator A reported that s/he tries to stay on top of securing toxic substances with making signs for staff to follow and educating staff. Administrator A reported that after the last survey, staff seemed to do better with securing toxic substances and cleaning compounds, however, approximately over the last month s/he has noticed them backsliding.	N 499		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under	Z 010		

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Z 010	Continued From page 11 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that every reasonable effort was made to contact the clerk of courts and obtain the criminal complaint for 2 of 2 employees charged with crimes that warranted this information. This is a repeat deficiency. See Statement of Deficiency (SOD) XR2711, dated 08/02/2023. Findings include: On 12/27/2023, Surveyor conducted a review of 3 employees to verify compliance with background check requirements. Surveyor requested the background checks for Caregivers C and H from Resident Manager F.	Z 010		

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Example 1 - Caregiver C

The Department of Justice (DOJ) background check for Caregiver C, hired on 10/11/2021, was completed on 10/18/2023 (7 days after hire.) The check showed that Caregiver C was charged twice with 947.01(1) Disorderly Conduct and once with 940.19(1) Battery. All three charges were issued on 02/09/2021. There was no additional information in Caregiver C's background check about the charges or the results of them.

Example 2 - Caregiver H

The background information disclosure (BID) for Caregiver H, hired 10/18/2023, was dated as completed in October (no date specified), and in the disclosure Caregiver H reported a charge or conviction with the note, "Battery/settled." The DOJ background check for Caregiver H was completed on 11/08/2023 (3 weeks after hire) and showed a felony charge of 940.19(2) Substantial Battery-Intend Bodily Harm. There was no additional information in Caregiver H's background check about the charge disposition.

On 12/27/2023, at approximately 1:15 p.m., Surveyor interviewed Administrator A and Resident Manager F. Both reported that they were unaware if attempts were made, potentially by Director of Nursing B, to contact the clerk of courts for further information about the charges for Caregivers C and H, but confirmed that neither of them had done so. Resident Manager F reported that s/he spoke with Caregiver H when s/he hired him/her and Caregiver H had requested to push back his/her work start date due to a court case s/he had. Resident Manager F reported that Caregiver H told him/her that court was settled and so s/he didn't obtain any

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Z 010	Continued From page 13 additional information about his/her felony battery charge. Both Administrator A and Resident Manager F reported they had no evidence of any attempts made to contact the clerk of courts and obtain the criminal complaints for the crimes Caregivers C and H were charged with.	Z 010		