STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017288	A. BUILDING: _____ B. WING _____	C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD AT MULBERRY	1281 W MAIN ST WHITEWATER, WI 53190

(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 01/02/2024, Surveyor conducted a self-report review at Glenwood at Mulberry. One deficiency was identified. Census: 19	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 3 of 3 residents received all prescribed medications in the dosage and intervals prescribed by the physician. Resident 1 did not receive his/her morning medications on 12/01/2023. Resident 2 did not receive his/her pain medications while on hospice. Resident 3 did not receive his/her psychotropic medication as prescribed for behaviors. Findings include: This facility can provide care up to 23 residents in the following client groups: irreversible dementia, Alzheimer's, advanced aged, terminally ill, and physically disabled.	N 352		

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

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N 352	Continued From page 1 On 12/08/2023, the Department received a self-report noting Caregiver C was observed throwing away resident medications. Example 1-Resident 1 On 01/02/2024, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted 10/07/2021 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. On 01/02/22024 at 10:32 AM, Surveyor interviewed Caregiver D regarding Resident 1's medications. Caregiver D stated s/he worked the morning shift on 12/02/2023 as the medication passer. Caregiver D stated when s/he opened the med cart's top drawer, s/he saw a small medication cup with crushed medications and 1 whole pill of Docusate, and the cup was labeled 113. Caregiver D stated Resident 1 lived in room 113. Caregiver D stated s/he called Nurse E to report finding the medication cup and suspected Resident 1 did not receive their AM medications for 12/01/2023. Caregiver D stated s/he worked as the medication passer on 11/30/2023 and did not see the medication cup with Resident 1's medications. Caregiver D stated Resident 1 only takes the Docusate 1x/day in the morning and s/he does not have a order to crush medications. Caregiver D stated Resident 1 receives Tramadol for pain during the AM medication pass as well. Caregiver D stated Caregiver C worked on 12/01/2023 as the medication passer. Caregiver D had been told by other staff Caregiver C will throw away resident medications. A review of Resident 1's December 2023 Medication Administration Record (MAR)	N 352		

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documented Resident 1 received his/her AM medications: (Acetaminophen 500 mg tablet, Aspirin 81 mg tablet, Docusate 100 mg tablet, Vitamin B-12 1000 MCG tablet, Tramadol 50 mg tablet, and Escitalopram 20 mg tablet) on 12/01/2023 administered by Caregiver C.

A review of the provider's staff schedule for 12/01/2023, AM shift (6am-2:30pm) documented Caregiver C as the medication passer.

On 01/02/2024 at 10:50 AM, Surveyor interviewed Nurse E. Nurse E confirmed s/he was contacted by Caregiver D about finding Resident 1's medications crushed in a medication cup. Nurse E stated Resident 1 does not have an order to crush medications and suspected Caregiver C did not administer Resident 1's medications on 12/01/2023.

Example 2-Resident 2

On 01/02/2023, Surveyor reviewed Resident 2's medical record. Resident 2 was admitted on 03/29/2023 with diagnosis including type 2 diabetes, chronic kidney disease, muscle weakness. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2 was on hospice and was actively entering end of life during November and December 2023. Resident 2 passed away on 12/15/2023.

Resident 2's physician orders included: Morphine Sulf 15 mg tablet, take ½ tablet (=7/5mg) by mouth 3x daily at 8am, 2pm, and 8pm directed for pain.

A review of the provider's investigation into Caregiver C throwing resident mediations in the

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garbage documented:
"[Caregiver F's] witness statement dated 12/06/2023 documented: November 11 during the beginning of my shift [Caregiver C] had all of short hall meds prepped for 2pms and wanted to leave early so [s/he] threw them in the trash and told us all to "keep your mouth shut about it. Nobody better say anything." She threw away all of short hall prepped 2pms including [Resident 1's] and [Resident 2's] with their narcotics for pain and continues to do so often.

[Caregiver F's] witness statement dated 12/06/2023 documented: ...There was another incident a few weeks ago (maybe the week of November 20th.) When I [Caregiver F] came into work. [Caregiver C] had [Resident 2's] pills sitting on the cart. We were waiting for the other 1st shifter to come in for shift report when [Caregiver C] said "I'm not giving [him/her] these" and threw [Resident 2's] meds in the garbage. [Caregiver C] then stated, "not going to lie, I be skipping [his/her] morphine every chance I get. I don't like how out of it [s/he] is. [S/he] sleeps all the time."

[Caregiver H's] witness statement dated 12/06/2023 documented: When coming in for second shift to get report there has been a few times when receiving report that I [Caregiver H] have witnessed [Caregiver C] throwing away [Resident 2's] Morphine. It was either crushed and mixed with apple sauce and getting thrown, or the pills alone were going right into the trash. [Caregiver C] has also expressed that [s/he] throws and skips [his/her] morphine anytime [s/he] can."

A review of Resident 2's progress notes dated 11/14/2023-12/15/2023 document Resident 2 refusing medications, refusing activities of daily

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living, showing signs of pain, restless, moving his/her arms all over the place, opening and shutting his/her mouth, moving his/her hands a lot, and entering final stage prior to passing on 12/15/2023.

A review of Resident 2's November 2023 MAR document as Resident 2 received his/her 2pm dose of Morphine on 11/11/2023, even though Caregiver C was observed throwing this medication into the garbage.

A review of the provider's staff schedule for 11/11/2023 documented Caregiver C as the medication passer for 8am and 2pm medications.

Example 3-Resident 3

On 01/02/2023 at 10:50 AM, Surveyor interviewed Nurse E. Nurse E stated on November 15th, s/he was doing the medication cycle check in, because the provider just had received the new month's resident medications. Nurse E stated at this time, s/he would also destroy any medications that were left over or not given. Nurse E stated when reviewing Resident 3's Haloperidol medication card, there was still 2 tabs left in the medication card. Nurse E stated November 8th's and 14th's 2pm dose was not given as prescribed. Nurse E stated Resident 3 needed these medications due to daily behaviors of wandering and yelling. Nurse E stated a staff meeting happened a few days later and s/he discussed the importance of giving residents their medications. Nurse E stated after looking over the staff schedules, Caregiver C worked November 8th.

On 01/02/2023, Surveyor reviewed Resident 3's medical record. Resident 3 was admitted on

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N 352	Continued From page 5 09/27/2022 with a diagnosis of dementia. Resident 3 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 3's physician orders included: Haloperidol 0.5 tabs, take 1 tablet by mouth two times daily (8am/2pm). A review of Resident 3's November 2023 MAR did not have staff's initial for Resident 3's 2pm Haloperidol on 11/08/2023 and 11/14/2023. A review of the provider's staff schedule for 11/08/2023 documented Caregiver C as the medication passer for 8am and 2pm medications. On 01/02/2023 at 12:51 PM, Surveyor interviewed Administrator A. Administrator A confirmed s/he was told by multiple staff that Caregiver C was throwing away resident medications. Administrator A stated Caregiver C thought Resident 2's Morphine made him/her too sleepy. Administrator A stated after investigating incidents, Caregiver C was terminated on 12/07/2023. Administrator A noted Caregiver C threatened many staff if they told on him/her and even threatened him/her during the termination. Administrator A acknowledged at the least Resident 1, Resident 2, and Resident 3 all missed medications.	N 352		