STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

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N 000	Initial Comments On 07/26/2023, Surveyor conducted a probationary licensure survey and four complaint investigations at Eagles Rest at Pepin. Data collection continued through 08/10/2023. Four of 4 complaints were substantiated. Sixteen deficiencies were identified. Census: 30	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the Department within 3 working days after law enforcement personnel were called to the community based residential facility (CBRF). Findings include: On 03/07/2023 and 07/13/2023 the Department received complaints regarding police response to incidents at the facility.	N 164		

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

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N 164	Continued From page 1 On 07/26/2023 at 10:25 AM, Surveyor interviewed Administrator A and asked if law enforcement were ever called to the facility for assistance. Administrator A stated law enforcement had been on site for Resident 1 and Resident 3. Administrator A shared the following information: On 07/05/2023, Resident 1 had THC (marijuana) gummies and threatened to take them all. Resident 3 was looking up illegal content online and the facility's IP address was flagged. Law enforcement responded. No criminal charges were filed. Surveyor reviewed the above incidents for police intervention. On 07/26/2023 at approximately 3:45 PM, Surveyor asked if the facility reported the above incidents to the Department. Administrator A stated s/he was not aware of reporting requirements.	N 164		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the	N 165		

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N 165	Continued From page 2	N 165		

provider did not ensure a written report was sent to the Department within 3 working days for incidents resulting in injury requiring hospital admission or emergency room (ER) treatment of residents.

Findings include:

On 07/13/2023, the Department received a complaint regarding resident hospitalizations or ER treatment.

On 07/26/2023 at 10:15 AM, Surveyor interviewed Administrator A and asked if residents were sent to the hospital for admission or ER treatment for any incident or accident.

Administrator A shared the following information:

On 07/11/2023, Resident 1 was recently hospitalized due to lethargy after ingesting THC gummies. Resident 1 was reefusing medications and was treated in the hospital for high ammonia levels and had a blood clot in his/her hepatic duct. Resident 1 did not return to the facility.

On 06/27/2023, Resident 8 was sent to the emergency room where s/he was evaluated and admitted to the hospital after a fall.

Surveyor reviewed the above incidents requiring hospitalization and or ER treatment.

On 07/26/2023 at approximately 3:45 PM, Surveyor asked if the facility reported the above incidents to the Department. Administrator A stated s/he was not aware of reporting requirements.

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N 196	Continued From page 3	N 196		
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 licensee did not ensure the provider and its operation complied with all laws governing the facility. Findings include: The provider is licensed to care for 50 adults in the client groups advanced aged, developmentally disabled, terminally ill, irreversible dementia/Alzheimer's and physically disabled. The provider was issued a probationary license on 12/05/2022. The current survey was prompted by the probationary/standard survey to determine compliance, and 3 complaints. The Department received one additional complaint after the survey was initiated. Four of 4 complaints were substantiated and the following concerns were identified throughout the course of the survey: - The provider did not report to the department when law enforcement responded to incidents at the facility. - The provider did not report to the Department incidents resulting in hospitalization or emergency room treatment. - Staff did not receive required training.	N 196		

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N 196	Continued From page 4 - Residents were not screened for communicable disease, including tuberculosis (TB). - The provider did not provide an involuntary discharge notice in writing. - Residents did not receive medication in the dosage and intervals prescribed. - The provider did not conduct face-to-face interviews with residents prior to admission. - Individual service plans (ISP) were not developed within 30 days. - ISPs were not developed with the resident or resident's legal guardian. - Medications were not stored securely. - Resident health concerns were not monitored. - Resident records were not secured from unauthorized use or access. - Resident rooms were not clean and comfortable. - Toxic substances were not stored securely. - Out of state background checks were not completed. On 07/26/2023 at approximately 4:00 PM, Surveyor interviewed Owner J and asked who owned the license. Owner J stated they adjusted the percentages of the shareholders listed under the corporation and Owner J informed Surveyor that s/he took over in June 2023. Owner J stated s/he did not have a lot of history on how to operate an assisted living facility but wanted to "do right" by the employees and residents. On 08/03/2023 at approximately 8:00 AM, Surveyor interviewed Owner J about who was to be listed as the Licensee contact. Owner J stated Administrator A had the most experience and would be operating the facility. Owner J further stated s/he had hired a consultant and was committed to making changes to address the issues identified throughout the course of the	N 196		

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N 196	Continued From page 5 survey. Cross Reference N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury N0243 DHS 83.21(1)-(3) All Employee Training N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0382 DHS 83.35(1)(b) Sources Used For Assessment Information N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0431 DHS 83.38(1)(g) Health Monitoring N0479 DHS 83.42(2) Resident Records Safeguarded N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0499 DHS 83.45(3) Toxic Substances Z0012 Wis. Stat. §50.065(2)(bm) Out Of State Background Checks	N 196		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified	N 243		

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N 243	Continued From page 6 under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by:	N 243		

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N 243	Continued From page 7	N 243		

Based on record review and interview, the provider did not ensure 3 of 4 employees reviewed obtained all training as required within 90 days after starting employment.

Findings include:

The facility is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 50 residents. The facility is licensed to serve residents within one the following client groups: advanced aged, irreversible dementia/Alzheimer's, developmentally disabled, physically disabled, and terminally ill.

At approximately 1:00 PM on 07/26/2023, Surveyor reviewed employment files of four employees. The following information was not found in 3 of 4 employee records:

Caregiver F's hire date was 07/06/2022. Caregiver F did not have evidence of completing recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment in his/her file. Also missing from the file was evidence of completing client group training within 90 days of starting employment.

Caregiver G's start date was 12/19/2022. Caregiver G did not have evidence of completing recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment in his/her employment file. Also missing from the file was evidence of completing client group training within 90 days of starting employment.

Caregiver H's start date was 02/16/2023. Caregiver H did not have evidence of completing

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N 243	Continued From page 8 recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment in his/her employment file. Also missing from the file was evidence of completing client groups within 90 days of starting employment. At approximately 2:30 PM, Surveyor asked Administrator A if there was any information in the employee files regarding client group and challenging behaviors. Administrator A stated s/he would look. At approximately 4:00 PM, Surveyor asked Administrator A if any information was found in the employee files for the three employees reviewed who did not have all required training within 90 days of their hire date. Administrator A stated no training was conducted for the three employees reviewed by the Surveyor, for client groups or challenging behaviors. Caregivers F, G and H did not have an exemption for the trainings.	N 243		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.	N 302		

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N 302	Continued From page 9	N 302		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 6 was screened for clinically apparent communicable disease, including tuberculosis (TB), and document the results of the screening within 90 days before or 7 days after admission.

Findings include:

On 07/28/2023, the Department received a self-report from the facility regarding resident wound care.

Resident 6 had an admission date of 03/31/2023.

On 08/01/2023, Surveyor requested Resident 6's record from Administrator A. The record did not contain documentation to show Resident 6 was screened for communicable disease, including TB. Surveyor asked if Resident 6 had a screening or TB results available for review.

On 08/02/2023 at approximately 9:50 AM, Administrator A stated Resident 1 did not receive a screening or TB test and stated Resident 6 refused 3 times.

Cross Reference
N0431 DHS 83.38(1)(g) Health Monitoring

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N 328	Continued From page 10	N 328		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's involuntary discharge was in writing to the resident or resident's legal representative when the provider discharged the resident after s/he was escorted out of the facility with law enforcement and hospitalized. Findings include:	N 328		

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N 328	Continued From page 11 On 03/07/2023, the Department received a complaint regarding a resident discharge. On 07/26/2023 at 10:30 AM, Surveyor interviewed Administrator A and asked if Resident 2 was discharged from the facility. Administrator A stated Resident 2 was discharged after s/he got aggressive in the facility and was escorted to the hospital by law enforcement where they found drugs and alcohol in his/her system. Surveyor asked Administrator A if Resident 2 was issued a discharge notice in writing. Administrator A stated a discharge notice was issued after Resident 2 was taken away and hospitalized. On 07/26/2023, Surveyor requested to review Resident 2's record, including the individual service plan (ISP), any staff charting notes related to behaviors and incident reports. Resident 2 had an admission date of 02/09/2023. Resident 2's record did not contain an ISP or completed pre-admission assessment, and no staff charting was available for review. On 07/27/2023 at approximately 12:00 PM, Administrator A emailed Surveyor and stated s/he did not have an ISP or staff charting notes available for Resident 2 to show there was an allowable reason for discharge. On 07/27/2023 at 11:47 AM, Administrator A provided Surveyor with the documentation regarding Resident 2's discharge. The documentation did not include a discharge notice in writing. The documentation included a statement from Nurse Practitioner (NP) I who was previously employed at the time of the incident. The statement read, in part, "...During the discussion with [Guardian J] I spoke to the fact	N 328		

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N 328	Continued From page 12	N 328		

that we cannot have [Resident 2] in our home with this behavior as we have staff and residents scared due to [his/her] words and actions today. [Guardian J] stated [s/he] understands and if we come to that decision we should issue an immediate notice due to safety and [s/he] knows we have done our best, but understands needing to keep in mind the safety of all." The statement was signed by NP I, dated 03/02/2023.

A document attached to the statement was a self-report of the incident that occurred on 02/28/2023. The report read, "Resident to staff altercation. [Hospital name] did lab draws and assessment and resident was positive for drugs and alcohol. Local hospital & county authorities sent resident to higher acuity hospital."

A summary of the incident was attached to the self-report and stated Resident 2 was approached by the administrator after a visit with family and Administrator A informed him/her s/he was no longer allowed to smoke after trying to smoke inside. Resident 2 became agitated and started to slam doors, threw items, and punched walls. Police were called to assist.

The provider stated Resident 2 was discharged for safety concerns but did not retain documentation in the resident's record to show there was an imminent risk of serious harm to the health or safety of the resident, other residents or employees, as no documentation was available for review to show a pattern or existence of behaviors prior to his/her discharge from the facility.

Resident 2's record did not contain evidence s/he had a history of behaviors and did not identify Resident 2 had a history of smoking in

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N 328	Continued From page 13 inappropriate areas. The facility discharged the resident after s/he was taken to the hospital by law enforcement and was not allowed to return to the facility.	N 328		
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 Resident 1 received medication in the dosage and at intervals prescribed by a practitioner. Findings include: On 07/24/2023, the Department received a complaint related to medications. On 07/26/2023, Surveyor requested Resident 1's record. Resident 1 had an admission date of 04/17/2023. Resident 1 was hospitalized on 06/30/2023 for hepatic encephalopathy and discharged back to the facility on 07/02/2023. Resident 1 was hospitalized again on 07/11/2023 and was treated for high ammonia levels and a blood clot in his/her hepatic duct. Resident 1 did not return to the facility.	N 352		

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N 352	Continued From page 14 Surveyor reviewed the medication administration record (MAR) for June and July. Staff charted Resident 1 did not get the following medications on the following dates due to "med out" and not available at the facility: -Ferosul 325mg Tablet: 06/01/2023-06/08/2023, 06/11/2023-07/11/2023. -Folic Acid 1 mg Tablet: 06/05/2023, 06/12/2023-06/26/2023 and 06/28/2023. -Furosemide 20mg Tab: 06/01/2023- 06/24/2023. -High Potency Multivitamin Tab: 06/01-06/04, 06/06-06/08, 06/11-06/13, 06/15-06/27, 06/29-07/07, 07/10-07/11. -Lidocaine 5% (700mg) PAT: 06/01-06/08, 06/13, 06/15, 06/16, 06/19-06/22, 06/24, 06/26-06/30; Resident 1 did not receive any Lidocaine for the month of June according to the MAR. Dates not identified were left blank or staff charted "Resident refused." -Xifaxan 550mg Tablet (dx Infection): 06/01-06/08, 06/12-06/13, 06/15-07/11. On 07/26/2023 at approximately 11:45 AM, Surveyor interviewed Administrator A and Registered Nurse (RN) D and asked why multiple medications were not available in the facility. Administrator A and RN D stated multiple other residents did not have medications available as a result of issues with the pharmacy. Administrator A and RN D confirmed Resident 1 did not receive medications due to the ongoing issue. Administrator A and RN D informed Surveyor the decision was made to switch pharmacy services to a different provider on 08/01/2023. Surveyor reviewed Resident 1's observation notes provided by Administrator A. The observation notes read:	N 352		

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N 352	Continued From page 15 07/05/2023: The following medications were added: Ibuprophen 400mg q6h prn, lactulose changed to 30ml daily, MVI daily, Tramadol 25mg q6h/prn x 3 days for pain. Surveyor reviewed the July MAR for medication updates documented in the observation notes. Tramadol was not listed on the MAR and did not indicate Resident 1 received the medication. On 08/10/2023, Surveyor interviewed Director of Staff (DS) B (in Administrator A's absence) and asked why the order for Tramadol was not listed on the MAR. DS B stated, "[S/he] returned on a Sunday and that was a weekend holiday so we did not have a nurse available to approve the order through the pharmacy system to get the order filled on time for the pharmacy to fill it." DS B further stated, "We didn't have a nurse available that weekend to process the order. The prescription was only good for 3 days so by the time the nurse was available to confirm the order, it was past the 3 day mark the ER (emergency room) had prescribed the medication for." Surveyor asked DS B if Resident 1 complained of pain after his/her discharge back to the facility. DS B stated, "[Resident 1] always had pain and was prescribed other pain medication like Gabapentin so I can't say for sure if s/he requested the medication or not." Charting documentation was not available to show Resident 1's pain was monitored. Resident 1 did not receive several medications in the dosage and at intervals prescribed by his/her practitioner as they were not available in the facility to administer.	N 352		

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N 382	Continued From page 16	N 382		
N 382	83.35(1)(b) Sources used for assessment information. Information gathering. The CBRF shall base the assessment on the current diagnostic, medical and social history obtained from the person ' s health care providers, case manager and other service providers. Other service providers may include a psychiatrist, psychologist, licensed therapist, counselor, occupational therapist, physical therapist, pharmacist or registered nurse. The administrator or designee shall hold a face-to-face interview with the person and the person ' s legal representative, if any, and family members, as appropriate, to determine what the person views as his or her needs, abilities, interests, and expectations. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a pre-admission assessment was completed face-to-face with the person and the person's legal representative, if any, and family members, as appropriate, to determine what the person views as his or her needs, abilities, interests, and expectations. Findings include: On 03/07/2023, 07/13/2023 and 08/01/2023, the Department received complaints regarding resident care. On 07/26/2023, Surveyor requested to review resident records from Administrator A. RECORD REVIEW Resident 1 had an admission date of 04/17/2023.	N 382		

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N 382	Continued From page 17 The record did not contain a pre-admission assessment. Resident 2 had an admission date of 02/09/2023. The record contained a pre-admission assessment form but several areas were left blank, did not contain a signature of reviewer, and did not have a date. Resident 3 had an admission date of 02/14/2023. The record did not contain a pre-admission assessment. Resident 5 had an admission date of 04/05/2023. The record did not contain a pre-admission assessment. Resident 6 had an admission date of 03/31/2023. The record did not contain a pre-admission assessment. INTERVIEW On 07/26/2023 at approximately 2:20 PM, Surveyor asked Administrator A if pre-admission assessments were conducted prior to admission. Administrator A confirmed they did not complete a pre-admission assessment face-to-face for any of the residents prior to admission and relied on the paperwork received from the resident's managed care organization.	N 382		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan	N 386		

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N 386	Continued From page 18 for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a comprehensive individual service plan (ISP) was completed within 30 days after admission and based on the assessment when comprehensive ISPs were not completed by the facility. Findings include: On 07/26/2023, Surveyor requested a sample of resident records from Administrator A. Surveyor reviewed the following records: Resident 1 had an admission date of 04/17/2023. The record did not contain an ISP. Resident 2 had an admission date of 02/09/2023. The record did not contain an ISP. Resident 3 had an admission date of 02/14/2023. The record contained a document Administrator A stated was the ISP. The ISP was not signed and did not contain a date. Resident 5 had an admission date of 04/05/2023. The record did not contain an ISP.	N 386		

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N 386	Continued From page 19 Resident 6 had an admission date of 03/31/2023. On 08/02/2023, Administrator A provided Surveyor with an ISP, dated 08/01/2023. Administrator A stated the ISP was initially completed on 07/12/2023. The ISP was not completed within 30 days of admission. On 07/26/2023 at approximately 3:45 PM, Surveyor interviewed Administrator A and asked if ISPs were completed within 30 days of admission. Administrator A stated they used the managed care organization (MCO) "Member Centered Care Plan" and would use that information to create an ISP. Administrator A confirmed that Resident 1, Resident 2, Resident 3, Resident 5, and Resident 6 did not have comprehensive ISPs completed within 30 days of admission. Cross Reference N0387 DHS 83. Service Plan Development: Parties Involved	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its	N 387		

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N 387	Continued From page 20 approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) when ISPs were not available or did not contain the resident or the resident's legal representatives' signatures acknowledging their involvement in, understanding of, and agreement with, the plan. Findings include: RECORD REVIEW On 07/26/2023, Surveyor requested a sample of resident records from Administrator A. Surveyor reviewed the following records: Resident 3 had an admission date of 02/14/2023. The record contained a document Administrator A stated was the ISP. The ISP was not signed and did not contain a date. Resident 6 had an admission date of 03/31/2023. On 08/02/2023, Administrator A provided Surveyor with an ISP, dated 08/01/2023. Administrator A stated the ISP was initially completed on 07/12/2023. The ISP was not completed within 30 days of admission and was not comprehensive to Resident 6's needs. The ISP was not signed and did not contain a date.	N 387		

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N 387	Continued From page 21 INTERVIEW On 07/26/2023 at approximately 3:45 PM, Surveyor interviewed Administrator A and asked if ISPs were completed with the resident or resident's legal representative. Administrator A stated the resident's managed care organization (MCO) was responsible for reviewing and obtaining signatures on the MCO's "Member Centered Care Plan." Administrator A confirmed the provider did not review or develop an ISP with Resident 3 and Resident 6, or with their legal guardians, as required. Cross Reference N0386 DHS 83. Comprehensive Individualized Care Plan	N 387		
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 all medicine cabinets were locked and stored properly. Findings include: The facility is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 50 residents. The facility is licensed to serve residents within one the following client groups: advanced aged, irreversible dementia/Alzheimer's, developmentally disabled,	N 419		

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physically disabled and terminally ill.

On 07/26/2023 at approximately 11:40 AM, Surveyor conducted a medication administration observation with Medication Passer C. During the observations, Surveyor noticed the medication cart could not be easily moved by Medication Passer C. Surveyor tried to open one of the locked doors of the medication cabinet and was able to open the medication drawer by wiggling the door even though it was locked. Surveyor also noted that the locked box which contained controlled substances could be completely removed from the medication cabinet even though the top of the controlled substances door was locked.

At approximately 12:00 PM, Surveyor interviewed Medication Passer C. Surveyor discussed the concerns regarding the medication cart not being easy to move, not actually being locked, and that the controlled substances box could be completely removed from the medication cart. Medication Passer C stated the medication cart was hard to steer due to the wheels not turning properly on the cart. S/he also stated the doors could be wiggled and sometimes, even when locked, the doors could be pulled open. Medication Passer C also confirmed the locked box for the controlled substances could be completely removed from the medication cabinet. Medication Passer C stated the medication cart concerns were like that since s/he started. Medication Passer C was hired on 05/25/2023.

During the exit conference at approximately 3:45 PM, Surveyors discussed the above concerns with the medication cart. Registered Nurse D stated s/he was aware of the concerns with the medication cart and new medication carts would

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N 419	Continued From page 23 be provided by the new pharmacy the provider was changing to. Surveys stated the medication cart concerns should have been addressed immediately upon the provider finding out about the concerns and that the concerns were known since May of 2023, per interview with Medication Passer C.	N 419		
N 431	83.38(1)(g) Health monitoring. 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 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.	N 431		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 6's health was monitored.

Findings include:

The provider is licensed to care for 50 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, terminally ill, developmentally disabled and physically disabled.

On 08/01/2023, the Department received a complaint related to care and treatment.

Resident 6 had an admission date of 03/31/2023, with the following diagnoses: Acquired absence of right leg below the knee, history of falling, hyperlipidemia, unspecified, long term (current) use of anticoagulants, major depressive disorder, recurrent, mild, restless leg syndrome, type 2 diabetes mellitus with diabetic neuropathy, unspecified, type 2 diabetes mellitus with diabetic chronic kidney disease, vitamin D deficiency, unspecified.

RECORD REVIEW

On 08/01/2023, Surveyor requested Resident 6's record from Administrator A.

The face sheet provided by Administrator A indicated Resident 6 had a guardian.

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Administrator A confirmed Resident 6 had a guardian and provided the guardian's name.

The individual service plan (ISP) was dated 08/01/2023. Administrator A informed Surveyor the date reflected on the ISP was the date s/he retrieved the ISP from the electronic record system and the ISP was initially created on 07/12/2023.

The ISP did not address current skin concerns or open areas and did not identify interventions or alternative approaches for staff if/when resident refused services. The ISP was not dated, was not signed by any party, and the following areas were left blank:

-Allergies
-Medications
-Advance Directives
-Nursing Procedures
-Supervision
-Capacity for Self-Care
-Capacity of Self Direction

Surveyor reviewed documentation related to orders and notifications for Resident 6's wound care:

07/24/23 9:15 AM: Late entry from 07/23/23: Received phone call at home re: resident's leg. Resident leg's inspected and writer consulted on call for Dr. Order received to transfer to hospital. Transferred to ambulance gurney with mechanical lift and assist of three. ER- updated verbally on medical condition. Report given to ambulance staff and necessary paperwork sent with. Administrator updated as well.

07/23/23 5:30 PM: resident paged, [sic] writer

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went to assist. Resident complained of flys [sic] crawling on leg, [sic] and asked that the blanket be put over [his/her] foot. When writer moved the blanket to fix it, writer noticed a magget [sic] fall onto the floor. Writer told resident that [s/he] had to go get the other staff to assist [him/her]. Which [sic] then [s/he] called the nurse who came in.

07/23/23 10:30 AM: Right leg is hurting [him/her] and [s/he] would like a RN to look at this on Monday.

07/13/23 7:15 AM: Received fax back from PCP (personal care physician) regarding referral sent for wound care. Triage denied PCP request, d/t resident being on palliative care and declining skin cheks [sic]/ disinterest in treatment for [his/her] wounds. They are willing to met [sic] [his/her] needs when [s/he] is there for monthly cath (catheter) changes. They recommend weekly wound care in the clinic.

07/12/23 7:30 AM: MD was faxed for wound care. New orders as follows: Wound care consult place [sic]. Clotrimazole BID to groin & absorbent towel BID. DME supplies sent to [pharmacy name] pharmacy. Increase 70/30 insulin to 40u BID. Please transfer pt with hoyer [sic] lift.

07/07/23 6:45 AM: Late entry from 7/6/2023: Summoned to room by aide. Has new open area on the top of [his/her] left foot. Offered a MD visit or phone call and [s/he] declined. Discussed risks up to and including death or loss of limb due to [his/her] choices. "I don't care, I wanted to go 4-5 years ago." Discussed Hospice care again which was declined by resident.

06/27/23 3:45 PM: Left a message with [physician name]'s nurse to follow up as no paperwork was

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received following MD appointment last Friday 6/23/2023.

06/27/23 11:45 AM: Resident has open area on RLE. Area was draining clear drainage. Dressing applied to area. Also, groin area is red [sic] and staff instructed to apply corn starch.

06/19/23 1:30 PM: T-97.9. Lower left extremity pink on anterior/posterior side. Aide reports elevated BG level. Faxed to MD, resident c/o "leg throbbing." Slightly warm.

06/14/23 2:30 PM: RA reported a greenish discharge coming out of the residents [groin]. Scant amount of tan/light brown discharge on pull-up. No redness. Denied any pain. Resident has an upcoming appointment on 6/16 with primary MD and will have MD address. Will continue to monitor until appointment.

06/07/23 4:15 PM: Left message to ask MD to address fax that was sent initially on 06/05/2023.

06/07/23 8:15 AM: Updated [MCO] on continued declines of cares, etc as previously charted.

06/06/23 1:45 PM: RA called resident to room as s/he declined to have [his/her] left leg treatments completed. Provided education on potential negative outcomes to [his/her] choices. "I don't care, I don't want it done." Left leg left OTA per [his/her] choice. Have not heard response from MD re: meds and refusals from yesterday's fax update. Refaxed [sic] information to primary MD.

06/05/23 5:00 PM [Resident family member] updated on continued refusals of most medical interventions and previously charted conversations with resident and MD.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 28 06/05/23 2:30 PM: Primary MD updated via fax of refusals of medications, dressing changes, TB test, cares, hospice cares, interventions for low blood sugars as well as previously charted interventions. [Resident 6] continues to decline these things. Left message to return call to facility. 06/01/23 7:15 AM: Late Entry from 05/31/2023: Writer and LPN (licensed practical nurse) met with resident to discuss continued refusals of care, medications, dressing changes, repositioning, meals, blood glucose interventions. [Resident 6] states [s/he] has ongoing pain which [s/he] describes as "pins and needles" in [his/her] hands, arms, and legs. Provided education that [s/he] currently has medications available to [him/her] and that nurses are willing to discuss further/alternative interventions with [his/her] MD. Though [s/he] was able to verbalize [his/her] understanding that [s/he] is aware of [his/her] current interventions and that alternatives could be sought to make [him/her] more comfortable, [s/he] declined all of this. Discussed [his/her] mood, [S/he] was offered to see a psychiatrist, psychologist, counselor, antidepressant therapy, discussion with [his/her] primary MD for [his/her] mood. [S/he] declined all of it. Discussed potential for a different wc, both electric and manual. [S/he] declined all offers. Discussed the continued refusals of [his/her] care, medications and other interventions and how this would continue to affect [his/her] health, both currently and in the future. "I don't care, I was ready to go 4-5 years ago." [S/he] was able to articulate adequately the potential negative outcomes to [his/her] choices, up to and including death. Hospice care was offered and declined. Benefits to hospice care were given. Continued to refuse. [S/he] did agree	N 431		

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N 431	Continued From page 29 to have all other medications discontinued except for the following medications: Insulin, laxative and vitamin. Will update medical provider of the above conversation upon return to work. 05/12/23 12:45 PM: Wound care completed on left lower mid shin and left heel. Provided education as to pressure relief, verbalized understanding but states [s/he] will be non-compliant. Was incontinent of stool, cleansed and barrier cream applied. Repetitive health and non-health complaints verbalized, and behavior not easily redirected. Peri area skin cleansed and dried with light dusting of cornstarch applied. Staff to continue with light dusting of cornstarch after peri-care completed. Cath care completed with patient. 03/31/23 Nursing note: Admission assessment completed. Resident is mostly uncooperative at this time. Alert, confused as to time, place and situation. Is aware of self. Able to answer questions regarding health, answers verify with current medical history... RBK amputation many years ago, uses a prosthesis, states [s/he] just got a new one and it's working good. Left legs intact with 3 ulcerations. One on inner left foot just lateral to left great toe. 1cm wide x 2 cm length dark dry scab, surrounding skin pale, blanches, no signs of infection. Left lower leg 2 open wounds top measuring 3cm wide x 4cm length, lower wound measures 2cmx3.5cm length. Both these wounds open and moist with clear serous drainage. Denies pain in any of these areas. Surrounding skin has obvious coloration of having previous wounds non healed. Resident had staff remove dressing and refusing it to be dressed at this time. Also refusing TB test & temperature checks. Will revisit for these items.	N 431		

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N 431	Continued From page 30 No other charting documentation was available for review prior to 05/12/2023. The facility switched to an electronic record system in May 2023. Documentation provided did not indicate Resident 6 had an appointment between 7/13/2023 and 07/23/2023. Shower/Skin Audits identified the following concerns: -07/17/2023: 2 blisters on the right foot. -07/10/2023: New sore on resident's left lower leg Shower/skin audits were not available for review prior to 06/29/2023. Surveyor reviewed the care history provided by Administrator A, dated 06/01/2023-current: The care provided history showed resident refusals of care were documented on the following dates and times: -07/23/23 -07/22/23 -07/15/23 -07/08/23 -07/07/23 -06/29/23 -06/28/23 -06/23/23 -06/16/23 -06/05/23 Care refused was documented as "yes" or "no" and did not specify the type of care refused. Refusal documentation was not available for review prior to 06/05/2023.	N 431		

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N 431	Continued From page 31 Surveyor reviewed orders for Resident 6: 06/27/2023- Nursing Order for Lotromin to groin/area BID (twice daily) until healed. dressing [sic] applied to LLE (lower left extremity). The document was signed by LPN K. 05/03/2023- Xeroform on Adaptic + dressing to L (left) lower leg wound followed by ACE wrap from toes to knee every other day. Podus boot L foot at all times. F/u (follow-up) 2 weeks. 04/07/2023- Assessment/Plan: 1. Pressure Injury (ulcer) Of Left Heel Stage 2: Patient also seen by doctor for assistance with wound care for [his/her] calcaneous [sic] ulcer today. Please see notes for wound care instructions. [S/he] was started on Levaquin. Left foot x-ray was also ordered. 2. Stasis Dermatitis Lower Extremity Left. Continue to care with Petroleum gauze and Kerlix changing 3 times per week. 3. Swelling: Leg Left: I ordered left lower ultrasound to rule out DVT due to tenderness and swelling which [s/he] states are new. [S/he] should elevate [his/her] leg. [S/he] will be non-weightbearing to the left foot due to [his/her] ulcer as well. 9. Amputation Leg Below Knee Status Post Right: Right BKA in 2007 due to nonhealing ulcer. [S/he] is wearing a prosthetic. 03/29/2023- Wound dressings: "[Resident 6] has 1 wound on LLE. Dressing change 3 times weekly using 1 vaseline [sic] gauze and 1 kerlix roll with tape. Medication Administration Record (MAR) reviewed:	N 431		

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N 431	Continued From page 32 1. Resident had an order for Clotrimazole 1% topical cream: Apply topically to affected groin area twice daily until resolved. The order started on 06/29/2023 and continued until Resident 6 was hospitalized on 07/23/2023. The MAR showed Resident 6 refused treatments on the following dates: -06/28/2023 -06/29/2023 -07/07/2023 -07/11/2023 (med out) -07/14/2023 No updates were available for review regarding the status of Resident 6's groin, initially charted by staff on 06/14/2023. Resident 6's MAR for May, June and July 2023 did not include any wound care orders to show when dressing changes were scheduled or attempted. INTERVIEW On 08/01/2023, Surveyor emailed Administrator A a list of questions regarding Resident 6's care related to wound care. On 08/02/20283 at 9:51 AM, Administrator A replied via email and stated facility nursing staff last looked at Resident 6's legs on 07/21/2023, two days prior to him/her being hospitalized for maggots in the wound, requiring an amputation to the lower left leg. No documentation was available for the nurse assessment completed on 07/21/2023. Administrator A stated wound care was not completed consistently as s/he refused cares. Administrator A further stated that Resident 6 did not have open wounds upon admission	N 431		

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N 431	Continued From page 33	N 431		

(admission note charted states s/he had 3 ulcerations). Administrator A confirmed Resident 6 was admitted with an amputation of the lower right leg.

On 08/01/2023, Surveyor discussed staff charting, dated 06/14/2023, that identified discharge coming from Resident 6's groin and asked Administrator A for physician visit notes for the appointment scheduled 06/16/2023. Administrator A stated the appointment had been re-scheduled to 06/23/2023. No documentation was provided to show the area was being monitored for approximately 9 days after the appointment was re-scheduled.

SUMMARY

Resident 6 consistently refused cares and was admitted with open wounds and an amputation below the knee of the right leg, on 03/31/2023. The provider did not maintain documentation to show when wound care was attempted and did not provide assessments of the wound to show the wounds were being monitored leading up to the fly larvae infestation. Administrator A stated s/he received an update from the hospital that Resident 6's left lower leg was amputated.

Resident 6 was noted to have discharge coming from his/her groin on 06/14/2023. An order for cream was obtained to apply twice daily until resolved. No documentation was available to show what the status of the issue was or that the area was monitored to determine if the treatment prescribed was appropriate.

The provider charted observation notes that they followed up and notified Resident 6's physician of his/her refusals but did not have a complete

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N 431	Continued From page 34 record to show all physician communications, orders and visit summary notes. During the interview, the provider stated Resident 6's care was not able to be met due to his/her consistent refusals. Resident 6 had a guardian listed on his/her face sheet. Administrator A confirmed Resident 6 had a guardian. The provider did not initiate a discharge or arrange for alternative placement at any point during Resident 6's admission at the facility.	N 431		
N 479	83.42(2) Resident records safeguarded. The licensee shall ensure all resident records are adequately safeguarded against destruction, loss or unauthorized access or use. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were adequately safeguarded against unauthorized access or use when records were stored in the copy room that was left open and the door did not contain a lock. Findings include: On 07/27/2023 at approximately 10:00 AM, Surveyor observed the door to the copy room was open. The copy room was located in the main entryway across from the front desk, accessible to anyone entering or exiting the facility. On 07/27/2023 at approximately 12:35 PM, Director of Staff (DOS) B confirmed resident records were stored in the copy room and stated the room was not typically locked. Surveyor observed the door leading to the copy room and the doorknob did not contain a lock to securely store any of the records stored in the room.	N 479		

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N 479	Continued From page 35 On 07/27/2023 at approximately 3:45 PM, Surveyor discussed the above observation with Administrator A. Administrator A stated the records would be moved to the locked medication room.	N 479		
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 the environment was safe, clean, comfortable, and homelike for Resident 5. Findings include: The facility is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 50 residents. The facility is licensed to serve residents within one the following client groups: advanced aged, irreversible dementia/Alzheimer's, developmentally disabled, physically disabled and terminally ill. On 07/26/2023 at approximately 11:00 AM, Surveyors conducted an environmental tour of the facility and detected an odor in the hall near Resident 5's bedroom. Surveyors identified the odor as the strong smell of urine. The smell was worse outside Resident 5's bedroom door.	N 481		

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N 481	Continued From page 36 At approximately 11:30 AM, Surveyors were provided a tour of the facility conducted by Director of Staff (DOS) B. During that tour of the facility, Surveyors were able to enter Resident 5's bedroom with DOS B. Surveyors and DOS B observed the following: * the smell of urine was strong * a soiled brief was on the floor * there was a wet ring of urine on the bed * there was molding food on the counter * there appeared to be urine stains on the carpet * the floor in the bathroom was cluttered and soiled * there was spilled food on the carpet Surveyors asked DOS B if s/he could smell the strong odor of urine. DOS B said yes. Surveyors also asked DOS B to identify the bed was wet with what appeared to be urine. DOS B said yes. DOS B indicated that Resident 5 was independent and often refused personal care and housekeeping services. At approximately 3:45 PM, Surveyors discussed these concerns with DOS B and Administrator A. Both DOS B and Administrator A agreed Resident 5 needed to be re-assessed for a higher level of care. Summary The provider did not provide an environment that was safe, clean, comfortable, and homelike for Resident 5.	N 481		
N 499	83.45(3) Toxic substances.	N 499		

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N 499	Continued From page 37 Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were stored in a secure area when the storage closet was not locked. Findings include: On 07/27/2023 at approximately 11:30 PM, Surveyors toured the facility. The door labeled "chemical storage" was not locked. The following toxic substances were located in the unlocked room: *glass cleaner *bleach *liquid odor control *paint *bathroom disinfectant *deck wash *stain blaster *germicidal cleaner *multi surface cleaner * disinfectant On 07/27/2023 at 12:31 PM, Director of Staff (DOS) B confirmed the chemical storage closet was not secured. DOS B informed Surveyor that the closet should be locked. DOS B stated, "We have a key at the nurse's station and the housekeeper and [Administrator A] have one."	N 499		

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Z 012	Continued From page 38	Z 012		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an out of state (OOS) criminal history search (CHS) was completed for Caregiver H, who indicated he/she resided outside of Wisconsin in the 3 years preceding the date of his/her caregiver background check.	Z 012		

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Z 012	Continued From page 39 Findings include: The facility is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 50 residents. The facility is licensed to serve residents within one the following client groups: advanced aged, irreversible dementia/Alzheimer's, developmentally disabled, physically disabled and terminally ill. On 07/26/2023 at approximately 12:30 PM, Surveyor reviewed Caregiver H's employee file. Caregiver H's record included a hire date of 02/14/2023. Caregiver H's record included a background information disclosure (BID). The BID was checked to indicate Caregiver H had resided outside the state of Wisconsin. The BID indicated Caregiver H resided in Tennessee and Arkansas preceding the current background check conducted by the provider. There was no evidence in the file that an out of state background check was conducted for Caregiver H. At approximately 1:30 PM, Surveyor conducted an interview with Administrator A. Surveyor discussed with Administrator A that the BID for Caregiver H indicated s/he had lived out of state and the file did not contain an out of state background check. Administrator A stated s/he was aware Caregiver H had lived out of state. Administrator A stated s/he was not aware of the necessity of the out of state background check when the BID indicated an employee lived outside the state of Wisconsin.	Z 012		