STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood of Sauk Prairie	245 Sycamore St Sauk City, WI 53583

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45695 Based on observation, interview, and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 1 resident (R3) observed during screening. R3 was observed to have her medications left at the bedside. This is evidenced by: The facility's policy titled Addendum: Self Administration of Medications, undated, states in part, . Policy: Prior to allowing a resident to administer medications without direct supervision by licensed nursing staff, the resident's ability to do so will be assessed and doctor's order will be obtained . 2. Physician will be updated with resident's desire to administer medications without direct staff supervision, following set up of the medications by nursing. If physician is in agreement with the assessment made by staff and is okay with the resident taking medications without direct supervision, an order shall be obtained . R3 was admitted to the facility on [DATE] with diagnoses that include acquired absence of right leg below knee, major depressive disorder (a severe and persistent low mood, profound sadness, or a sense of despair), type 2 diabetes mellitus with hyperglycemia (characterized by high levels of sugar in the blood), chronic diastolic congestive heart failure (the heart has trouble supplying the body's organs and tissues with oxygen-rich blood they need and the hallmarks are shortness of breath with exertion or when lying down; swelling in the legs, ankles, or abdomen, unexplained fatigue, or a bulging jugular vein), acute embolism (a condition that results from a blood clot) and thrombosis of deep veins of left upper extremity, end stage renal disease (a medical condition in which the kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis), dependence on renal dialysis, unspecified dementia, acute kidney failure, acute respiratory failure with hypoxia, hallucinations (an experience involving the apparent perception of something not present). R3's most recent Minimum Data Set (MDS) dated [DATE] states that R3 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R3 is cognitively intact. R3's medical record does not contain a Self-Administration Assessment. R3's current plan of care does not indicate that R3 is to self-administer any medications. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Maplewood of Sauk Prairie		STREET ADDRESS, CITY, STATE, ZIP CODE 245 Sycamore St Sauk City, WI 53583	

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's physician orders do not indicate a Self-Administration order. On 6/20/24 at 9:08 AM, Surveyor observed R3's morning medication on her bedside table in a medication cup. Surveyor asked R3 if that was her medication, she indicated that they it was and that they normally leave it there. R3 further indicated that she normally takes her medication after breakfast, and that breakfast was later today. Surveyor asked R3 how many medications were in the cup, she indicated she thought there were 14 medications. On 6/20/24 at 9:15 AM, Surveyor observed R3 being taken to the shower room by staff and the morning medication was left on R3's bedside table in the medication cup. On 6/20/24 at 9:21 AM, Surveyor interviewed LPN D (Licensed Practical Nurse). Surveyor walked with LPN D and obtained R3's medication cup with her medications and returned to the medication cart. Surveyor asked LPN D if R3 had a self-administration order, she indicated she did not see an order and she normally leaves her medication at R3's bedside. LPN D further indicated that she should have not left R3's medications at her bedside. Surveyor and LPN D verified each medication consisting of Sentry senior multivitamin 1 tablet, Creon DR 36000 units 2 capsules, Vitamin D 1000 International Unit (IU) 2 capsules, amlodipine 10 mg 1 tablet, fluoxetine 20mg 1 tablet, pantoprazole 40mg 1 tablet, loperamide 2mg 1 capsule, carvedilol 12.5mg tablet, potassium extended release 10 milliequivalent 2 capsules, bumetanide 2mg 1 capsule, and aspirin enteric coated 325mg 1 capsule (14 tablets/capsules total). LPN D then placed the medication in a paper envelope and labeled with R3's name and date and reported she would administer them after R3 was finished with her shower. On 6/20/24 at 10:12 AM, Surveyor interviewed R3 and asked if she had taken her medication and she indicated she did. On 6/20/24 at 2:06 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if medications should be left in a resident's room unattended, she indicated no, and that the resident should have a self-administration order. Surveyor asked DON B if R3 has a self-administration order, she indicated R3 did not have a self-administration and that R3 should have had an order to self-administer her medications.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 1 of 3 residents reviewed for grievances (R1). The facility's Social Worker (SW) documented that R1's spouse had concerns with Activities of Daily Living (ADLs), fluid intake, soiled bed linens, and staffing; these concerns were not documented as grievances, investigated as grievances, or had a resolution provided to R1's spouse. Evidenced by: The facility's policy titled Grievance Policy and Procedure no date, states in part .Grievances can include things such as concerns about care and treatment provided or not provided, behavior of staff or other residents and any concerns related to the resident's stay in the facility .3. To file a grievance, the resident and/ or resident representative shall contact the facility grievance officer(s). The grievance can be filed orally, in writing, or by completing a Grievance Report Form. a. [facility name] grievance officers with be either social service representative .7. Grievance record keeping a. All grievance decisions will be documented to include the date that the grievance or grievance form was received, a summary statement of the grievance and a copy of the grievance form, steps taken to investigate the grievance, a summary of pertinent findings or conclusions regarding the concern, if the grievance was confirmed or not confirmed, any corrective action taken as a result of the grievance, and the date the written decision was issued. Example 1 R1 was admitted to the facility on [DATE] with diagnoses that include traumatic brain injury, epilepsy, major depressive disorder, and hyponatremia. R1's most recent Minimum Data Set (MDS) dated [DATE] indicates that R1 is barely/ never understood and that R1 is dependent on staff for all ADLs, transfers, and positioning/ transportation. On 4/10/24 at 3:09 PM, SW C documented, in part, the following note: Late entry from 4/8/24. Meeting with [R1's spouse], ombudsman, IDT (Interdisciplinary Team) including writer, DON (Director of Nursing), LTCM (Long Term Care Manager). [R1's spouse] requested ombudsman be present as she did not have any family/ friends who could attend with her/ wished for a neutral party to be present sharing she feels ganged up at meetings .[R1's spouse] shared ongoing concerns about R1's fluid intake, sodium levels, not getting his teeth brushed, wet linens .Encouraged [R1's spouse] to communicate her concerns with DON or point person. [R1's spouse] continuing to share her dissatisfaction . On 4/10/24 at 3:16 PM, SW C documented, in part, the following note: .Later in afternoon writer and DON met with [R1's spouse] . [R1's spouse] shared that her only concern about R1 this day is not having consistent wing staff .noting her dissatisfaction with agency staff . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/24/24 at 3:24 PM, SW C documented, in part, the following note: Writer and DON met with [R1's spouse] this day per her request as she shared her upset and disbelief that R1 was not placed in bed until 10:00 PM last night .Writer offered reassurance noting wing staff are well aware of [R1's spouse] ongoing concerns, therefor are hypersensitive to R1's needs .[R1's spouse] also noting she has observed R1 to be 'soaked' when she arrives, also noting that he did not eat last night as he did not know who was feeding him. Writer once again reiterated the importance of R1 and new staff needing time to get to know each other, thus R1 does need to work with new staff in order to build that rapport. Writer also reassured writer continues to check on R1 and his room throughout the days during the week to ensure R1 is receiving cares, and his room is clean and orderly. [R1's spouse] noting writer not here on weekends to do such. On 6/20/24 at 1:00 PM, Surveyor interviewed SW C, who is also the facility's grievance officer. Surveyor asked SW C what the process was for grievances, SW C stated that she encourages residents and family member to come to her or another member of leadership with hopes that they can address their concerns before it rises to a grievance. Surveyor asked SW C if a concern would be considered a grievance, SW C stated that it depends on the level and that a grievance is a repeated act. SW C reported to Surveyor that she has offered R1's spouse to fill out a grievance form. Surveyor asked SW C if R1's spouse expresses a concern, is she required to fill out a grievance form in order for her concerns to be addressed and is it the resident and/ or family member's responsibility to follow the facility's grievance policy, SW C stated that she would have to check with the Administrator. Surveyor asked SW C what concerns has R1's spouse reported, SW C stated she had concerns with hydration, oral intake, if R1's bed is not made, if R1 is not in bed at a certain time, range of motion, and ADLs. Surveyor asked SW C if these concerns were written up as grievances, SW C stated no. Surveyor asked if R1's spouse was provided with a written resolution, SW C stated no. On 6/20/24 at 1:59 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what her understanding of a grievance is, DON B stated that a grievance can be anything such as a concern or a lost item. Surveyor asked DON B if she would expect R1's spouse's concerns to be a grievance, DON B stated yes and no, yes but we don't write them down. She (R1's spouse) has repetitive concerns and brings up complaints from four years ago. It is important to know that SW C and DON B reported that the facility had zero grievances.