

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER St Paul Elder Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 316 East 14th Street Kaukauna, WI 54130	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff interview and record review, the facility did not ensure an allegation of misappropriation was reported to the State Agency (SA) for 1 resident (R) (R3) of 2 sampled residents.</p> <p>On 8/8/24, R3 alleged Certified Nursing Assistant (CNA)-C took R3's Fentanyl patch. The allegation of misappropriation was not reported to the SA.</p> <p>Findings include:</p> <p>The facility's Resident Protection and Prevention and Investigation of Abuse, Neglect, Misappropriation, Exploitation, Caregiver Misconduct, and Injuries of Unknown Source policy, revised 10/2022, states all associates are to immediately report any incident of misconduct, which includes abuse, neglect . misappropriation of a client's property. Misappropriation is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent. The Nursing Home Administrator (NHA) should submit the initial report to the Division of Quality Assurance (DQA) Office of Caregiver Quality (OCQ) within 24 hours, as well as the local police in the event that a potential crime occurred.</p> <p>On 9/26/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including prostate cancer, anxiety, depression, and hypertension. R3's most recent Minimum Data Set (MDS) assessment, dated 8/2/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R3 had moderate cognitive impairment. R3 passed away at the facility with Hospice services on 9/9/24.</p> <p>On 9/26/24 at 10:01 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E regarding an allegation that R3 had a missing Fentanyl patch. LPN-E verified there was a time in August when R3's Fentanyl patch was missing. LPN-E stated LPN-E reported the missing patch to LPN-E's supervisor immediately.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER St Paul Elder Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 316 East 14th Street Kaukauna, WI 54130	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24, Surveyor reviewed the facility's investigation for the allegation of misappropriation. The investigation indicated NHA-A was notified by Nurse Manager (NM)-F around midnight on 8/9/24 that R3's Fentanyl patch was missing. The patch was verified to be in place by two staff between the PM and night (NOC) shifts. Around midnight, Registered Nurse (RN)-G went to verify R3's patch placement and noticed the patch was missing. RN-G immediately reported the missing patch to NM-F. NM-F and RN-G went to R3's room to verify the patch was missing. When asked about the patch, R3 stated, She took it off. The one I've never seen before. NM-F then notified NHA-A. NM-F gathered all staff on the unit and brought them into R3's room to see if R3 recognized any of them as the staff who took R3's Fentanyl patch. RN-G recalled that CNA-C had been on the unit for a period of time despite being assigned to a different wing. NM-F brought CNA-C into R3's room to see if R3 recognized CNA-C. R3 stated, I am sorry, I don't recall. NM-F left the room to find RN-G and CNA-C returned to CNA-C's unit. NM-F and RN-G returned to R3's room and noticed the Fentanyl patch was back on R3's chest and was sticking out of R3's gown. R3 stated CNA-C was the one who took the patch off and then put it back on. NM-F verified with R3 that CNA-C was the staff who took R3's Fentanyl patch off and then put it back on and R3 agreed.</p> <p>NM-F updated NHA-A about the suspicion that CNA-C took R3's Fentanyl patch and then returned it. NHA-A and NM-F asked CNA-C about the allegation and CNA-C denied it. CNA-C confirmed CNA-C had gone to R3's unit to help with linens. CNA-C was suspended pending further investigation and told CNA-C needed to submit to a drug test. CNA-C left the facility and resigned on 8/9/24.</p> <p>The local police department was notified of the allegation and a case number was assigned. NHA-A facilitated interviews with staff and residents, reviewed all residents for narcotic medications/patches, and provided education to staff on misappropriation and verifying patch placement.</p> <p>On 9/26/24 at 10:45 AM, Surveyor interviewed NHA-A and Director of Nursing (DON)-B regarding R3's missing Fentanyl patch. NHA-A verified the allegation was not reported to the SA (DQA) because the patch was returned the same evening.</p>		