STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017129	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILLSVILLE RETIREMENT COMMUNITY	1211 LLOYD ST NEILLSVILLE, WI 54456

(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
U 000	INITIAL COMMENTS On 02/15/2024, Surveyor conducted a complaint investigation at Neillsville Retirement Community. Data collection continued through 03/06/2024 Two of the 3 complaints were substantiated. Three deficiencies were identified. Two of the 4 deficiencies were repeat violations. See Statement of Deficiency (SOD) 4JCP11, dated 12/09/2019. Census: 22	U 000		
U 171	89.26(4) ANNUAL REVIEW A tenant's capabilities, needs and preferences identified in the comprehensive assessment shall be reviewed at least annually to determine whether there have been changes that would nescessitate a change in the service or risk agreement. The review may be initiated by the facility, the county department designated under sub. (3)(c)2., or at the request of or on the behalf of the tenant. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Tenant 1's assessed capabilities and needs were reviewed to determine whether there had been changes that would necessitate an update to the service or risk agreement. This is a repeat deficiency. See Statement of Deficiency (SOD) 4JCP11, dated 12/09/2019.	U 171		

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

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U 171	Continued From page 1 Findings include: DHS 89.26(2)(a-k) read, " CONTENTS. The comprehensive assessment shall identify and evaluate the following factors relating to the person's need and preference for services: (a) Physical health. (b) Physical and functional limitations and capacities. (c) Medications and ability to self-administer medications. (d) Nutritional status and needs. (e) Mental and emotional health. (f) Behavior patterns. (g) Social and leisure needs and preferences. (h) Strengths, abilities and capacity for self-care. (i) Situations or conditions which could put the tenant at risk of harm or injury. (j) Type, amount and timing of services desired by the tenant. (k) Frequency of monitoring which the resident's condition requires." On 01/22/204 and 02/02/2024, the Department received complaints regarding tenant care. On 02/15/2024 at 9:31 AM, Surveyor interviewed Director A. Director A stated Tenant 1 had rapid onset dementia and escalated behaviors in the last 2 months. Director A stated Tenant 1 had tried to break into Director A's office and the confidential shred bin. Tenant 1 had been going into other resident's rooms and taking items and money. Multiple pills had been found in the garbage can of Tenant 1's room and there were concerns Tenant 1 was self-medicating. Tenant 1 would state intent to self-harm and scream and call residents names/expletives. When Tenant 1 would not get his/her way, s/he would call staff expletives and speak down to them. Tenant 1 was	U 171		

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manipulative and would state s/he did not remember doing things such as going into other resident's rooms. Tenant 1 also had paranoia, where s/he thought staff and Director A were stealing items from his/her room and/or giving items away. Tenant 1 was sent to the clinic multiple times to be evaluated for behaviors and cognitive changes. Meetings were held with the care team where Tenant 1 would deny any of the changes and incidents that occurred. Director A stated Tenant 1 had been seeing a psychiatrist regularly and they were currently trying to get his/her power of attorney activated, or a guardianship, due to Tenant 1 not making the best choices for him/herself. Director A stated Tenant 1 would be moving out of the facility by the end of the week due to the risk for self-harm and harm to other residents.

On 02/15/2024 at 10:02 AM, Surveyor reviewed Tenant 1's record. S/he was admitted on 03/27/2019 and is his/her own decision maker.

The service agreement, dated 03/27/2019 and signed by Tenant 1, did not identify behavior risks or cognitive changes.

A managed care organization (MCO) member report, dated 04/04/2023, indicated Tenant 1 had a behavioral health and wellness plan that read, "As long as [Tenant 1] attends counseling and sees [his/her] psychiatrist on a regular basis (every 3 months) [s/he] will be able to keep [his/her] mental health under control."

A total plan of resident care, dated 05/11/2023, indicated under the category "mental attitude," that Tenant 1 was orientated, alert, moody, and agitated.

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Tenant 1's last comprehensive assessment was completed on 05/11/2023. The assessment indicated Tenant 1 was alert and orientated but did not address behavioral or cognitive changes.

Tenant 1's last negotiated risk agreement, dated 05/11/2023, did not address behavioral or cognitive changes.

The record included documentation of the following incidents between October 2023 through February 2024:

12/04/2023 at 2:00 PM - "Staff is to keep an eye on [Tenant 1] as [s/he] has been going into other residents [sic] rooms for snacks. If this occurs; document it, notify [Director A]. And remind [Tenant 1] [s/he] shouldn't be in the other residents [sic] room without their consent."

12/06/2023 at 2:00 PM - "[Tenant 1] was trying to go in the pantry this morning [sic] when asked about it [s/he] denied it. [S/he] has been told [s/he] is not allowed in the pantry or other residents [sic] rooms."

12/06/2023 at 4:40 PM - "[Tenant 1] stopped me in the hallway to tell me that [s/he's] not going to play Bingo anymore."

12/07/2023 at 9:00 AM - "[Tenant 1's] behaviors have been out of control."

12/08/2023 at 5:00 PM - Tenant 1 had an unwitnessed fall with no serious injury.

12/16/2023 at 1:45 PM - "A resident came up to me and said [s/he] had seen [Tenant 1] take snacks out of the kitchen around 6:45 AM, [sic] the resident went up to [Tenant 1] and told

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[him/her] [s/he] couldn't do that. Witness said [Tenant 1] just walked away. I was asked to address [Tenant 1] about the snacks by my lead RA (resident assistant). [Tenant 1] lied to my face and said [s/he] put them back, when in fact did not. [Tenant 1] then went on saying that [s/he] was going to refuse any and all meals because [s/he] is sick of this place and the people that live and work here."

12/16/2023 - Tenant 1 had an unwitnessed fall with no injury.

12/18/2023 at 6:30 PM - "As I was passing [Tenant 1] [his/her] 5pm [sic] meds [sic], [s/he] told me that [s/he] was going to hurt [him/herself] on purpose so the ambulance can come get [him/her]. [S/he] said [s/he] was going to tell the ambulance and hospital staff that [s/he] is not safe here at [the provider] just so [s/he] didn't have to come back. [Tenant 1] said [s/he] wasn't sure if [s/he] is going to do this yet. At this time [Tenant 1] proceeded to say that [s/he] was going to do this and wanted to do this to [him/herself] because the [expletive] is working on 12/19/23. [Tenant 1] said [s/he's] referring to another employee when said the [expletive]."

12/27/2023 at 5:00 PM - "[Tenant 1] refused supper again."

12/28/2023 - "When we got a donation of pads and other supplies, [Director A] took two packs of pads down to [Tenant 1] to see if [s/he] would like them. [Tenant 1] told [Director A] that [s/he] had enough and didn't need them. At about 7:00 PM [Tenant 1] paged and said [s/he] needed pads now."

12/30/2023 at 12:00 PM - "[Tenant 1] refused

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breakfast and lunch when asked if [s/he's] eating."

1/20/2023 - "[Tenant 1] was down at the kitchen demaning [sic] for a tray at 7:00 AM when breakfast is not sevred [sic] until 8AM [sic] then [s/he] come [sic] back at 7:35 wanting [his/her] tray [sic] [S/He] said it's not ready yet so [s/he] went back to [his/her] room. Then [s/he] came back at 7:55 pounding on the side kitchen door for a good 8 to 10 mins (minutes)."

1/20/2024 at 12:00 PM - "As I went to pass [Tenant 1] [his/her] 12pm [sic] meds [sic] [his/her] door was locked. I knocked twice and heard no response. I then unlocked [his/her] door and proceeded in [his/her] room. As I went to give/hand [Tenant 1] [his/her] meds [sic], [s/he] forcefully snatched the cup from my hand and the cup went on the floor. [Tenant 1] then shrugged [his/her] shoulders and said 'Oh well!.'"

1/25/2024 at 3:00 PM - Director A spoke to Tenant 1 about meal trays and it was agreed with his/her care team that Tenant 1 would walk down and pick up his/her tray at meal times and walk the tray back to the kitchen. If s/he had a tray delivered to his/her room, then there would be a service charge. "[Director A] also told [Tenant 1] that [s/he] does not want to hear that [Tenant 1] is pounding on the kitchen doors demanding [his/her] food or that [s/he] is yelling at staff because [s/he] is not getting what [s/he] wants."

02/01/2024 - "[Tenant 1] also was sitting in [a resident's] old room and I asked [him/her] what [s/he] was doing and [s/he] said just looking [sic] then I told [him/her] [s/he] can't be in here [sic] then [s/he] walked out and I locked the door."

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U 171	Continued From page 6 02/02/2024 at 11:00 AM - "This morning [Tenant 1] told me that [s/he] was in an old room because [s/he] believes that [Director A] did take [his/her] chair to [his/her] house that's [sic] why it ain't [sic] here. [S/he] also called an employee a [expletive] and said [s/he] was useless just like the rest of use that work here." 02/04/2024 at 1:00 AM - "[Tenant 1] was out looking through random cupboards. Stating [s/he] knows staff and [Director A] are hiding-stealing or throwing away [his/her] stuff such as a chair and some paper work. I told [him/her] that staff were not doing these things and that [s/he] can't just go through stuff that is not [his/hers]. [Tenant 1] walked away. A short time after that I noticed the sun room [sic] door open part way while doing room checks, so I walked over and there [Tenant 1] was standing by the grey [sic] bin with a tool kit trying to open to go through whats [sic] in there. I told [him/her] [s/he] could not be out there doing that. [Tenant 1] walked away and has been in [his/her] room sense [sic]." 02/04/2024 at 5:00 AM - "[Tenant 1] walked down to the office with a black box of tools. [S/he] asked if there was anyway [sic] of getting into [Director A's] office. I said no [sic] only [Director A] does. [S/he] then walked over to [Director A's] office trying to get in. I stopped [him/her] and told [him/her] that was absolutely not allowed. [Tenant 1] didn't say anything and walked back to [his/her] room." A physician visit form, dated 01/02/2024, indicated the provider wanted Tenant 1 evaluated for cognitive decline, not enjoying his/her days, concerns about frontotemporal dementia, not eating, and 2 recent falls. The physician's orders after the appointment included	U 171		

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neuropsychological testing for medical decision making and need for guardianship.

An email from MCO to Director A, dated 01/24/2024 at 11:19 AM, read, "The hospital did refer [Tenant 1] to [skilled nursing facility (SNF)], at [Tenant 1's] request. This nursing home denied the referral/admission, as [Tenant 1] is so high functioning. The hospital was going to be informing [Tenant 1] of this, today. (The hospital did refer to APS, at [Tenant 1's] request because [his/her] concerns regarding [his/her] safety.) I have not heard as to whether APS has done anything regarding the report that the hospital filed... [sic]

The hospital indicated that they believe [Tenant 1] will return to the ER (emergency room) shortly after discharge with similar concerns. [S/he] can certainly do that. It would be imperative to have your staff charting any concerns, in the even that [Tenant 1] were to further escalate, cause self-harm, and/or potentially blame or accuse staff of harming [him/her] in order to be moved out of the facility."

An email from Director A to an MCO, dated 01/24/2024 at 1:31 PM, read, in part,
"Diagnosis from Today:
Behavior concern
fear for personal safety
Major neurocognitive disorder
Encounter for assessment of decision-making capacity
Weakness or fatigue."

A physician visit form, dated 01/25/2024, indicated Tenant 1 was evaluated for symptoms of depression, paranoia, memory impairment, and assessment of neurocognitive level and

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decision making. The physician's orders only addressed some medication changes.

A 30-day discharge notice, dated 02/05/2024, indicated the provider could no longer provide the level of care that Tenant 1 required.

An email from Director A to Registered Nurse (RN) C from Tenant 1's MCO, dated 02/09/2024 at 4:11 AM, read, "One of my staff reported to me last night that while taking [Tenant 1's] garbage out, they had found a lot of identified pills, (80 in total). They were unsure of what they were so I had them put in a secure place until I came in this morning and could investigate further. They are Meclizine Hydrochloride. I am not sure where [s/he] obtained these as these are not a med [sic] [s/he] is prescribed."

An email from RN C to Director A, dated 02/09/2024 at 7:14 AM, read, "It's my understanding that [s/he] is experiencing a rapid decline type of dementia. Is there anything that can be put into place to help keep [him/her] safe while we get [his/her] placement squared away? [S/he's] a top priority for us at the moment."

An email from Director A to RN C, dated 02/09/2024 at 7:53 AM, read in part, "I know [s/he] has other meds [sic] in [his/her] room. [S/he] orders them from [grocery store and pharmacy]. Keeping with the residents' rights, we are not able to go through [his/her] stuff to confiscate medications in [his/her] room. There is absolutely no way [s/he] will give use permission to do that either since [s/he] is still [his/her] own person and hasn't been deemed incapacitated. My worry is [s/he] has stated in the past of self-harming behaviors. It was documented and emailed to [his/her] other case managers and

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also brought up to [his/her] dr. [sic] Nothing was ever done. I don't think legally there is a way around that. I know [Friend D] has stated in the past of finding pills on the floor and accused staff of not giving [his/her] meds [sic] correctly but this is evidence of [him/her] self medicating [sic], not poor medication management on my staff's end."

At 10:22 AM, Surveyor interviewed Director A again. Director A stated Tenant 1 wanted all his/her meal trays in his/her room. Tenant 1 was independently ambulatory and could come down for meals or come to get his/her meal trays him/herself. Director A stated it was discussed with Tenant 1's care team that s/he could get and bring back his/her own meal trays. Surveyor asked Director A if Tenant 1 had been reassessed with all these changes. Director A stated an assessment was not done because "care-wise there had been no changes."

At 11:12 AM, Surveyor interviewed Caregiver B. Caregiver B stated Tenant 1 preferred certain staff to help him/her with cares. Tenant 1 also went through a period of refusing meals and certain medications, along with not coming out of his/her room to participate in activities for about 1 month.

At 11:30 AM, Surveyor interviewed Tenant 1. Tenant 1 stated staff were accusing him/her of going into other resident's rooms, so s/he was not leaving his/her room for meals or activities very often. Tenant 1 stated that occasionally s/he would refuse to have staff bathe him/her but had no concerns his/her needs were not being met. Tenant 1 stated s/he still felt unsafe but his/her new MCO was looking into getting him/her a guardianship in place before s/he left the facility.

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U 171	Continued From page 10 At approximately 12:00 PM, Surveyor interviewed Director A. Director A stated Tenant 1 changed MCOs recently to get transferred to a different facility. Director A stated that since then, Tenant 1's behaviors had calmed down a bit. Director A stated Tenant 1 had been refusing a new medication prescribed and was given a medication list from his/her physician recently to demonstrate what s/he was receiving for medications. Director A stated Tenant 1 had been seen coming from another resident's room and stole money from the resident. Director A stated adult protective services (APS) had not gotten involved or visited the facility. Director A stated Tenant 1 was a nurse by trade and knew how to work the healthcare system. Tenant 1 would be getting a psychological evaluation due to his/her actions and words not matching up. On 02/20/2024 at 4:59 PM, Surveyor asked Director A via email if a comprehensive assessment was done for Tenant 1 with recent behavioral and cognitive changes. On 02/23/2024 at 2:15 PM, Surveyor received a response via email from Director A which read, in part, "No, as [Tenant 1] physically has not had any changes. We do not have an in-depth assessment for mental health in place. [Tenant 1] does have a Neuropsychological elavaluation [sic] with [psychologist] on Monday 2/26 @ 12:30, to determine [his/her] mental status." On 02/20/2024 at 2:02 PM, Surveyor interviewed Case Manager (CM) E. CM E stated they were trying to figure out where to go with Tenant 1's case. Tenant 1 did have a neuropsychological consult appointment next week. CM E stated Tenant 1 had a diagnosis of dementia and would not remember certain behaviors. CM E stated	U 171		

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Tenant 1 also seemed paranoid. CM E stated Tenant 1 also had depression and suicidal ideation, and was recently seen for intent to self-harm.

On 02/20/2024 at 2:16 PM, Surveyor interviewed RN C. RN C stated Tenant 1 had a rapid decline in cognition due to dementia in the last 3.5 months. RN C stated Tenant 1 was aware s/he was having this decline and was agreeable to move along guardianship. RN C stated Tenant 1 had a history of mood disorder, major depression, and generalized anxiety. Tenant 1 also had both of his/her parents die from suicide.

On 02/20/2024 at 2:32 PM, Surveyor interviewed Friend D. Friend D stated s/he never thought Tenant 1 was suicidal but was depressed and his/her attitude had worsened. Friend D felt Tenant 1 needed more help.

On 02/29/2024 at 2:00 PM, Surveyor interviewed Director A. Director A stated s/he would do the annual assessments every June and if there was a physical change to a tenant that increased their care services. Director A stated the forms used were from the corporate company and did not have any assessments related to behavior or cognitive changes.

On 03/06/2024 at 11:30 AM, Surveyor received an email from Director of Operations (DOO) G that read in part, "Reassessments are done upon move in, after 30 days, any time that there is any type of change in condition, annually, and per resident or family request. I have attached the current on that our facilities use. On page 7 it does touch on cognitive ability and that is where with [Tenant 1's] decline, a reassessment should have been done immediately...And unfortunately,

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U 171	Continued From page 12 we realize these were not done by [Director A]." In the last 2 months, Tenant 1 experienced increased behaviors and decline in cognition. Tenant 1 had multiple incidents demonstrating these changes. The MCO was looking for alternative placement for Tenant 1 due to the provider no longer being able to meet his/her behavior and cognitive needs. Tenant 1 was also in the process of getting a guardian appointed. As of 02/15/2024, the provider had not completed an updated assessment and the last assessment on file was from prior to the change in condition. The provider did not have evidence they assessed Tenant 1's needs or implemented additional services to ensure his/her safety.	U 171		
U 200	89.28(2)(a)1. RISK AGREEMENT (2) CONTENT. A risk agreement shall identify and state all of the following: (a) Risk to tenants. 1. Any situation or condition which is or should be known to the facility which involves a course of action taken or desired to be taken by the tenant contrary to the practice or advise of the facility and which could put the tenant at risk of harm or injury. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a risk agreement was in place when Tenant 1 experienced behavior	U 200		

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U 200	Continued From page 13 changes and cognitive decline. Findings include: On 01/22/204 and 02/02/2024, the Department received complaints regarding tenant care. On 02/15/2024 at 10:02 AM, Surveyor reviewed Tenant 1's record. S/he was admitted on 03/27/2019 and is his/her own decision maker. The service agreement, dated 03/27/2019 and signed by Tenant 1, did not identify behavior risks or cognitive changes. Tenant 1's last comprehensive assessment was completed on 05/11/2023. The assessment indicated Tenant 1 was alert and orientated but did not address behavioral or cognitive changes. Tenant 1's last negotiated risk agreement, dated 05/11/2023, did not address behavioral or cognitive changes. The record included documentation of the following incidents between October 2023 through February 2024: 12/04/2023 at 2:00 PM - "Staff is to keep an eye on [Tenant 1] as [s/he] has been going into other residents [sic] rooms for snacks. If this occurs, document it, notify [Director A]. And remind [Tenant 1] [s/he] shouldn't be in the other residents [sic] room without their consent." 12/06/2023 at 2:00 PM - "[Tenant 1] was trying to go in the pantry this morning when asked about it [s/he] denied it. [S/he] has been told [s/he] is not allowed in the pantry or other residents [sic] rooms."	U 200		

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U 200	Continued From page 14 12/06/2023 at 4:40 PM - "[Tenant 1] stopped me in the hallway to tell me that [s/he's] not going to play Bingo anymore." 12/07/2023 at 9:00 AM - "[Tenant 1's] behaviors have been out of control." 12/08/2023 at 5:00 PM - Tenant 1 had an unwitnessed fall with no serious injury. 12/16/2023 at 1:45 PM - "A resident came up to me and said [s/he] had seen [Tenant 1] take snacks out of the kitchen around 6:45 AM, [sic] the resident went up to [Tenant 1] and told [him/her] [s/he] couldn't do that. Witness said [Tenant 1] just walked away. I was asked to address [Tenant 1] about the snacks by my lead RA (resident assistant). [Tenant 1] lied to my face and said [s/he] put them back, when in fact did not. [Tenant 1] then went on saying that [s/he] was going to refuse any and all meals because [s/he] is sick of this place and the people that live and work here." 12/16/2023 - Tenant 1 had an unwitnessed fall with no injury. 12/18/2023 at 6:30 PM - "As I was passing [Tenant 1] [his/her] 5pm [sic] meds [sic], [s/he] told me that [s/he] was going to hurt [him/herself] on purpose so the ambulance can come get [him/her]. [S/he] said [s/he] was going to tell the ambulance and hospital staff that [s/he] is not safe here at [the facility] just so [s/he] didn't have to come back. [Tenant 1] said [s/he] wasn't sure if [s/he] is going to do this yet. At this time [Tenant 1] proceeded to say that [s/he] was going to do this and wanted to do this to [him/herself] because the [expletive] is working on 12/19/23.	U 200		

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U 200	Continued From page 15 [Tenant 1] said [s/he's] referring to another employee when said the [expletive]." 12/27/2023 at 5:00 PM - "[Tenant 1] refused supper again." 12/28/2023 - "When we got a donation of pads and other supplies. [Director A] took two packs of pads down to [Tenant 1] to see if [s/he] would like them. [Tenant 1] told [Director A] that [s/he] had enough and didn't need them. At about 7:00 PM [Tenant 1] paged and said [s/he] needed pads now." 12/30/2023 at 12:00 PM - "[Tenant 1] refused breakfast and lunch when asked if [s/he's] eating." 1/20/2023 - "[Tenant 1] was down at the kitchen demaning [sic] for a tray at 7:00 AM when breakfast is not sevred [sic] until 8AM [sic] then [s/he] come [sic] back at 7:35 wanting [his/her] tray [s/he] said it's not ready yet so [s/he] went back to [his/her] room. Then [s/he] came back at 7:55 pounding on the side kitchen door for a good 8 to 10 mins [sic]." 1/20/2024 at 12:00 PM - "As I went to pass [Tenant 1] [his/her] 12pm [sic] meds (medications) [his/her] door was locked. I knocked twice and heard no response. I then unlocked [his/her] door and proceeded in [his/her] room. As I went to give/hand [Tenant 1] [his/her] meds, [s/he] forcefully snatched the cup from my hand and the cup went on the floor. [Tenant 1] then shrugged [his/her] shoulders and said 'Oh well!'" 1/25/2024 at 3:00 PM - Director A spoke to Tenant 1 about meal trays and it was agreed with	U 200		

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U 200	Continued From page 16	U 200		

his/her care team that Tenant 1 would walk down and pick up his/her tray at meal times and walk the tray back to the kitchen. If s/he had a tray delivered to his/her room, then there would be a service charge. "[Director A] also told [Tenant 1] that [s/he] does not want to hear that [Tenant 1] is pounding on the kitchen doors demanding [his/her] food or that [s/he] is yelling at staff because [s/he] is not getting what [s/he] wants."

02/01/2024 - "[Tenant 1] also was sitting in [a resident's] old room and I asked [him/her] what [s/he] was doing and [s/he] said just looking [sic] then I told [him/her] [s/he] can't be in here [sic] then [s/he] walked out and I locked the door."

02/02/2024 at 11:00 AM - "This morning [Tenant 1] told me that [s/he] was in an old room because [s/he] believes that [Director A] did take [his/her] chair to [his/her] house that's [sic] why it ain't [sic] here. [S/he] also called an employee a [expletive] and said [s/he] was useless just like the rest of us that work here."

02/04/2024 at 1:00 AM - "[Tenant 1] was out looking through random cupboards. Stating [s/he] knows staff and [Director A] are hiding-stealing or throwing away [his/her] stuff such as a chair and some paper work. I told [him/her] that staff were not doing these things and that [s/he] can't just go through stuff that is not [his/hers]. [Tenant 1] walked away. A short time after that I noticed the sun room [sic] door open part way while doing room checks, so I walked over and there [Tenant 1] was standing by the grey [sic] bin with a tool kit trying to open to go through whats [sic] in there. I told [him/her] [s/he] could not be out there doing that. [Tenant 1] walked away and has been in [his/her] room sense [sic]."

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U 200	Continued From page 17 02/04/2024 at 5:00 AM - "[Tenant 1] walked down to the office with a black box of tools. [S/he] asked if there was anyway [sic] of getting into [Director A's] office. I said no [sic] only [Director A] does. [S/he] then walked over to [Director A's] office trying to get in. I stopped [him/her] and told [him/her] that was absolutely not allowed. [Tenant 1] didn't say anything and walked back to [his/her] room." On 02/20/2024 at 4:59 PM, Surveyor asked Director A via email if a risk agreement was done for Tenant 1, given recent behavioral and cognitive changes. On 02/23/2024 at 2:15 PM, Surveyor received a response via email from Director A which read, in part, "No, we do not have a risk agreement for behavioral." On 02/29/2024 at 2:00 PM, Surveyor interviewed Director A. Director A stated the forms used were from the corporate office and did not have any risk agreements related to behavior or cognitive changes. On 03/06/2024 at 11:30 AM, Surveyor received an email from Director of Operations (DOO) G that read in part, "We have many risk agreements also, even blank ones that can be tailored specifically to individual residents based on their needs. And unfortunately, we realize these were not done by [Director A]." Tenant 1 did not have a risk agreement on file for situations or conditions that were known to the facility which put the tenant at risk of harm or injury, when Tenant 1 exhibited increased behaviors and decline in cognition.	U 200		

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U 200	Continued From page 18 Cross Reference U0171 DHS 89.26(4) Annual Review	U 200		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Tenant 1 received prescribed medications in the dosage and at the intervals prescribed by the physician when Tenant 1 had a delay in administration of multiple medications and a duplicate entry in the medication administration record (MAR) led to staff charting error.	U 267		

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U 267	Continued From page 19 This is a repeat deficiency. See Statement of Deficiency (SOD) 4JCP11, dated 12/09/2019. Findings include: On 01/22/204 and 02/02/2024, the Department received complaints regarding residents not receiving the correct medications. On 02/15/2024, Surveyor requested Tenant 1's file, including the MAR, medication orders or changes, and face sheet, from Director A. Tenant 1 had an admission date of 03/27/2019. Surveyor reviewed the January 2024 and February 2024 MARs. The January 2024 MAR indicated the following medications were prescribed: 1. Amlodipine besylate 5 milligrams (mg) take 1 tablet by mouth in the morning 2. Donepezil Hcl 10 mg take 1 tablet and ½ tablet by mouth at bedtime 3. Risperidone 1 mg take ½ tablet by mouth at bedtime 4. Propranolol 20 mg take as directed with 3 different administration times listed throughout the day 5. Propranolol 20 mg 1 tablet twice daily for 1 week, then 1 tablet 3 times daily (duplicate entry from 01/25/2024 through 01/31/2024) 6. Iron 65 mg take 1 tablet by mouth daily (started 01/29/2024). The February 2024 MAR indicated the following medications were prescribed: 1. Amlodipine besylate 5 mg take 2 tablets by mouth in the morning 2. Donepezil Hcl 10 mg take 2 tablets by mouth at bedtime	U 267		

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3. Risperidone 1 mg take 1 tablet by mouth at bedtime
4. Propranolol 20 mg 1 tablet by mouth 3 times daily
5. Iron 65 mg take 1 tablet by mouth in the morning.

On 02/20/2024 at 4:59 PM, Surveyor requested via email from Director A, the most current orders for the medications listed above.

On 02/23/2024 at 2:15 PM, Surveyor received medication orders from Director A. The medication orders were as follows:
1. Amlodipine besylate 5 mg take 2 tablets by mouth daily - written date 01/24/2024
2. Donepezil 10 mg take 2 tablets by mouth daily at bedtime - written date 01/25/2024
3. Risperidone 1 mg take 1 tablet by mouth daily at bedtime - written 01/25/2024
4. Propranolol 20 mg take 1 tablet at bedtime for 1 week, then 1 tablet twice daily for 1 week, and 1 tablet 3 times daily - written 01/11/2024
5. Iron 65 mg take 1 tablet by mouth daily - written 01/26/2024.

A physician visit form, dated 01/02/2024, indicated Tenant 1's Donepezil was increased to 20 mg at bedtime.

A physician visit form, dated 01/25/2024, indicated Tenant 1's Risperidone was increased to 1 mg at bedtime, Donepezil was to continue at 20 mg at bedtime, and Amlodipine was to continue at 5 mg daily for high blood pressure.

On 02/29/2024 at 2:00 PM, Surveyor interviewed Director A. Director A stated the reason Amlodipine, Donepezil, and Risperidone was not administered until 02/01/2024 was due to the

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U 267	Continued From page 21 pharmacy not wanting to bubble pack the medications for only 4 days. The pharmacy waited until the start of February 2024 to package the medications, thus delaying the start of administration. Director A stated s/he was unsure why there was duplicate charting in the MAR for Propranolol. Director A stated Caregiver B, who was now terminated, was responsible for medication management. Director A stated there was a delay in Tenant 1's Iron supplement starting due to it being on back order. Director A stated s/he did not have any documentation to prove that this was the case due to it just being a phone conversation with the pharmacy. Tenant 1 received orders on 01/24/2024 for a dosage change to Amlodipine and on 01/25/2024 for a dosage change to Donepezil and Risperidone. The change in dosage for these medications did not start until 02/01/2024. Tenant 1 received an order for Propranolol on 01/11/2024. The medication had duplicate entries in the January 2024 MAR, which indicated staff had duplicate charting of the medication administration from 01/25/2024 through 01/31/2024. Tenant 1 received an order for Iron on 01/26/2024. The January 2024 MAR indicated this medication was not started until 01/29/2024, 3 days later.	U 267		