STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013379	A. BUILDING: _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE RICHLAND CENTER MEMORY CARE	240 N ORANGE STREET RICHLAND CENTER, WI 53581

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 08/21/2024, with information gathered through 09/04/2024, the Bureau of Assisted Living, Southern Regional Office conducted two complaint investigations at Our House Richland Center Memory Care located at 240 N Orange Street in Richland Center, Wi. Two citations of noncompliance were issued. Both complaints were substantiated. Census: 19	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 was in transition from being prescribed Seroquel (a psychotropic medication) to being prescribed risperidone (a psychotropic medication) for 10 days for dementia related agitation. Resident 1's practitioner's order, dated 05/14/2024, included a direction for the facility to update the practitioner on Resident 1's "agitation/issues" within approximately seven days after Resident 1 received the first dose of risperidone. Resident 1 received the first dose of	N 352		

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

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N 352	Continued From page 1	N 352		

risperidone on 05/17/2024, after the order was processed. The facility did not communicate with Resident 1's practitioner, as ordered, to provide an update on approximately the seventh day, 05/23/2024, or any time before Resident 1's risperidone supply ran out on the tenth day, 05/26/2024. The facility sent a fax to Resident 1's practitioner after office hours asking about Resident 1's risperidone order on Saturday, 05/25/2024. Resident 1's behaviors including striking others, fecal smearing, urinating in inappropriate areas of the facility, and resistance with personal cares increased during this medication transition and erroneous omission.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) 7VRV11, issued 011/09/2018.

The findings include:

On 07/16/2024 and 07/30/2024, the department received allegations of medications not being administered to residents as prescribed.

On 08/21/2024 at 9:44 A.M., Surveyor observed Resident 1 in bed with his/her eyes closed and Resident 1's Legal Representative E seated in a chair near Resident 1's bed. Resident 1 discussed a concern with Resident 1 not receiving prescribed risperidone for approximately 3 days near the end of May 2024 and Resident 1's agitated behavior worsened during this timeframe. Legal Representative E told Surveyor the facility was responsible for administering Resident 1's medications, as prescribed. Legal Representative E told Surveyor the facility did not follow Resident 1's primary practitioner's order related to risperidone and the medication ran out the day before Memorial Day.

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N 352	Continued From page 2 Legal Representative E said Resident 1's risperidone was not re-started until later that week. Legal Representative E told Surveyor Resident 1 was more calm and his/her aggressive behavior decreased after the risperidone was re-started. Legal Representative E told Surveyor Resident 1 continued to receive risperidone twice daily, as ordered. On 08/21/2024 at approximately 11:41 A.M., Surveyor conducted an interview with Resident 1's managed-care organization Case Manager F and Resident 1's managed-care Nurse Case Manager G. Nurse Case Manager G told Surveyor s/he conducted a visit at the facility on 05/17/2024 and reviewed a new order for Resident 1 including risperidone. Nurse Case Manager G said Resident 1 was in transition from being prescribed Seroquel (a psychotropic medication) to being prescribed risperidone for 10 days. Nurse Case Manager G said Resident 1's practitioner included a direction within the order for the facility to update the practitioner on Resident 1's behavior issues on the seventh day after Resident 1 received the first dose of risperidone. Nurse Case Manager G told Surveyor s/he spoke to Administrator A about this order and told Administrator A to make sure and get in touch with Resident 1's practitioner, as ordered, on the seventh day of Resident 1 receiving prescribed risperidone and before the Memorial Day holiday weekend. Nurse Case Manager G said the facility staff did not communicate with Resident 1's practitioner, as ordered, on the seventh day or any time before Resident 1's risperidone supply ran out on the tenth day, 05/26/2024. Nurse Case Manager G told Surveyor the facility told him/her a fax was sent to Resident 1's practitioner asking about Resident 1's risperidone, but it was sent after	N 352		

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office hours. Nurse Case Manager G told Surveyor Resident 1's behaviors including striking others, fecal smearing, urinating in inappropriate areas of the facility, and resistance with personal cares increased as result of this medication omission or error.

On 08/21/2024 at 1:45 P.M., Surveyor conducted an interview with Caregiver H including Resident 1's behavior. Caregiver H told Surveyor Resident 1 exhibited agitation following his/her admission to the facility in April 2024. Caregiver H told Surveyor Resident 1 would become agitated and resist personal cares, including incontinence care, Resident 1 would grab caregiver's private parts during cares, Resident 1 would strike out and hit other residents and caregivers, Resident 1 would take food off of other resident's plates during meals, Resident 1 would smear feces if caregivers were not immediately aware Resident 1 had a bowel movement, Resident 1 would wander into other resident's rooms, and would urinate in inappropriate areas throughout the facility. Caregiver H said Resident 1 would jiggle the doorknob to Resident 2's room and Resident 2 would respond to Resident 1 in annoyance which would cause a resident-to-resident altercation. Caregiver H said Resident 1 would yell in the faces of other residents and caregivers. Caregiver H told Surveyor Resident 1's behaviors decreased, and Resident 1 became "more cooperative" with personal cares and interactions after Resident 1's psychotropic medications were changed.

On 08/21/2024 at 2:24 P.M., Surveyor conducted an interview with Administrator A and reviewed Resident 1's record, as provided by Administrator A. Resident 1 was admitted to the facility on 04/01/2024 with diagnoses including

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frontotemporal neurocognitive disorder, dementia, attention-deficit hyperactivity disorder, and major depressive disorder.
Administrator A told Surveyor s/he issued an involuntary discharge notice for Resident 1 to Legal Representative E on 05/30/2024 in response to Resident 1's escalating behaviors. Administrator A told Surveyor the notice had not been rescinded and Resident 1 remained at the facility.
On 08/21/2024 at 5:29 P.M., Assistant Administrator B sent an email to Surveyor including, "This is the requested medication information pertaining to the risperidone order for [Resident 1]." The email included a copy of a fax sent from Former Assistant Administrator C to Resident 1's practitioner dated 05/08/2024. The fax included, "We [the facility staff] are seeing an increase in agitation with [Resident 1] since the increase of [his/her] quetiapine [Seroquel]. [Resident 1] did hit another resident with a pillow this morning. [Legal Representative E] stopped by and suggested a switch to risperidone, as it worked for [Resident 1] in the past." The fax included a response and written order from Resident 1's practitioner dated 05/14/2024. Resident 1's practitioner's order included, "1. Risperidone 0.5 mg [milligrams] po [by mouth] BID [twice a day] x [times/for] 10 days. 2. Discontinue quetiapine [Seroquel] on day after [underlined] risperidone started. 3. Update on agitation/issues in [approximately] 7 days." Resident 1's May 2024 medication administration record [MAR] included Resident 1's risperidone 0.5 mg was started on Friday, 05/17/2024 at 5:00 P.M., 3 days after the order was received. Resident 1 continued to receive a twice daily dose of risperidone 0.5 mg twice daily until ten days later on Sunday, 05/26/2024, as documented within the MAR. Resident 1's May

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N 352	Continued From page 5 2024 MAR included risperidone 0.5 mg was not administered to Resident 1 after 05/26/2024 related to the medication not being available for administration. Resident 1's May 2024 MAR's documentation dated 05/28/2024 included "Script [prescription was only written for 10 days, awaiting pcp's [primary care practitioner's] direction." Resident 1's progress notes included the following documentation of Resident 1's behavior during May 2024; * 05/06/2024 at 9:58 A.M. included, "[Former Caregiver I] and [Caregiver J] walked out of the med [medication] room to see [Resident 1] hit [Resident 2] with a pillow." * 05/13/2024 at 5:19 A.M. included, "[Resident 1] was found in [Resident 3's] room laying on [his/her] bed." Resident 1's May 2024 MAR included documentation Resident 1 received his/her first dose of risperidone 0.5 mg on Friday, 05/17/2024 at 5:00 P.M. Resident 1's progress notes included the following documentation of Resident 1's continued behavior during May 2024; * 05/17/2024 (Friday) at 5:53 A.M. included, "[Resident 1] had a medium bowel movement. [Caregiver K] and other [caregiver] tried to get [Resident 1] changed. [Resident 1] got angry and started yelling and swinging. [Caregiver K] told [Resident 1] that we [caregivers] had to get [him/her] cleaned up. [Resident 1] did not think so. [Resident 1] kept telling us no. [Resident 1] kept grabbing at [his/her] Depends [incontinence product] and pulling it up. [Caregiver K] gave [him/her] a little bit to cool off. [Resident 1] kept yelling and said [s/he] just wanted to go to bed." * 05/17/2024 at 9:26 A.M. included, "[Caregiver L] was assisting another resident with toileting when [Caregiver M] and [Caregiver H] were trying	N 352		

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N 352	Continued From page 6 to assist [Resident 1] with changing and cleaning up from a bm [bowel movement] accident. [Caregiver L] went into assist other [caregiver] as [s/he] was getting upset. [Caregiver L], [Caregiver H], and [Caregiver M] were trying to have [Resident 1] independently change [his/her] pants, shirt, and Depends due to having fecal matter on all three items. [Resident 1] then told [caregiver] [s/he] had to use the bathroom so [Caregiver L] had [Resident 1] in bathroom and tried to have [Resident 1] sit on the toilet. [Caregiver L] then had [Caregiver M] leave due to [Resident 1] getting combative and upset with [Caregiver M]. [Caregiver M] did go get [Administrator A] to assist [Caregiver L] and [Caregiver H] when assisting [Resident 1] with wiping [his/her] fecal matter off [his/her] bottom. [Resident 1] became combative with all three staff members. [Resident 1] punched, pinched, pulled hair, yelled, and threatened all three staff members several times. [Resident 1] became very aggressive and combative when trying to clean [him/her] up and change [his/her] clothing. [Resident 1] seemed to calm down after [s/he] was dressed. About 20 minutes later [s/he] had another BM and took it out of [his/her] Depends and placed it over the counter in the kitchen. [Resident 1] was also going around the build [building] placeing [sic] fecal matter in odd place[s] throughout the building and throughout the day." * 05/17/2024 at 10:27 A.M. included, "[Caregiver M] was walking towards [Resident 1] when [Caregiver M] noticed [Resident 1] urinating on the hallway floor and the wall." * 05/17/2024 at 5:42 P.M., included, "[Former Assistant Administrator C] was walking down the front hall with [Former Caregiver N] when [Former Assistant Administrator C] heard a commotion coming from the hallway by the med room.	N 352		

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N 352	Continued From page 7 [Former Assistant Administrator C] and [Former Caregiver N] quickly diverted to the commotion and found a group of [caregivers] attempting to wash a mess from [Resident 1's] face, while [Resident 1] was swinging [his/her] fists around, in a windmill-like fashion." The documentation included, "[Resident 1] began to become combative against [Caregiver L] and [Former Assistant Administrator C], but we [caregivers] were both able to deflect the blows. [Former Assistant Administrator C] instructed [Caregiver L] to leave, and we were both able to leave, although leaving a mess on the resident's face. While exiting, [Former Assistant Administrator C] tossed an empty box for [sic] gloves into the trash can. [Resident 1] screamed, "Why would you do that?" as [Former Assistant Administrator C] exited the room. [Resident 1] then rushed out the door swinging [his/her] fists at [Former Assistant Administrator C]." * 05/18/2024 at 9:30 P.M. included, "[Resident 1] was walking hallways at beginning of shift. [Resident 1] would get agitated at someone talking near [him/her], walking to [sic] close, accidentally touching [him/her] and start yelling, swearing, attempting to his them, or bite them. [Resident 1] does this every second shift [evening] all night. [Resident 1] is very combative when needing [to be] changed, punching, pushing, biting, swearing, yelling, kicking, spitting." Based on review of Resident 1's record, as received by Administrator A, there was no evidence the facility contacted Resident 1's practitioner with an update of Resident 1's agitation or behavior on or about 05/23/2024, within the seventh day after Resident 1's first dose of risperidone, nor any day prior to the holiday weekend. Resident 1's progress notes included the	N 352		

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following documentation of Resident 1's continued behavior during May 2024;
* 05/24/2024 (Friday) at 9:22 P.M. included, "[Resident 1] was in hallways at beginning of shift. [Resident 1] walked around and randomly yelled, swore at and attempted to hit people. [Resident 1] did not listen to redirecting very well. [Resident 1] had numerous outbursts throughout the shift at random people for no reason."
* 05/25/2024 (Saturday) at 6:10 A.M. included, "Walked up behind [Resident 1] who stading [sic] by the dining room table, [Resident 1] was urinating on the dining room table."
* 05/25/2024 at 7:17 A.M. included, "[Resident 1] struck [Administrator A] twice this am [morning], while [Administrator A] was in with another resident assisting with ADLs [activities of daily living], [Resident 1] entered the room. While [Administrator A] was attempting to redirect [Resident 1] out of the room [Resident 1] struck [Administrator A] with a closed fist in the chest. While [Administrator A] was assisting [Resident 1] with [his/her] 7 a.m. [7:00 A.M.] medication, [Resident 1] got upset, yelled NO, and struck [Administrator A] with a closed fist in the arm."
A copy of a fax sent from Administrator A to Resident 1's practitioner dated Saturday, 05/25/2024 at 10:49 (no A.M. or P.M. indicated) included, "The risperidone script that we received was only for 10 days. Are you sending refills for it or something different?" The fax documentation did not include any information regarding Resident 1's behavior.
Resident 1's May 2024 MAR included documentation Resident 1 received his/her last available dose of risperidone 0.5 mg on Sunday, 05/26/2024 at 5:00 P.M.
Resident 1's progress notes included the following documentation of Resident 1's continued behavior during May 2024;

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N 352	Continued From page 9 * 05/26/2024 (Sunday) at 8:58 P.M. included, "[Former Caregiver O] saw [Resident 1] run up to [Resident 4] and start punching [him/her] in the face and shoulder." The documentation included, "[Former Caregiver O] moved [Resident 4] into the med room. [Caregiver P] and [Caregiver I] jumped in between the two residents. [Caregiver P] told [Resident 1] to "back up" and "go into the activity room." [Resident 1] responded by punching [Caregiver P] in the face. [Caregiver P] backed away after being hit while [Resident 1] continued to swing at [him/her]. [Caregiver P] walked away. [Former Caregiver I] went to shut the door to the med room to lock [self] inside. [Resident 1] started to hit the door and window over and over." * 05/27/2024 (Monday, Memorial Day) at 5:32 A.M. included, "After 10 pm [10:00 P.M.] rounds, [Resident 1] appeared to come out of [his/her] room and was wet. Staff tried [sic] one at a time to assist [Resident 1] with changing but [Resident 1] refused. [Resident 1] became aggressive with staff and started to yell. Both staff assisted with changing [Resident 1]. [Resident 1] appeared to be very unhappy and hit, kick, and bit both staff. [Resident 1] then wonder [sic] the hall and appeared to try to find ways out of the building and taking [his/her] own clothing off. Around 11:30 P.M. on-call [Administrator A] was notified off [sic] [Resident 1's] behavior. [Resident 1] was given PRN [as needed] lorazz [lorazepam, a psychotropic medication]. [Resident 1] appeared to wounder [sic] the hall for a few more hours before calming down and resting on the couch." * 05/28/2024 at 4:53 P.M. included, "[Caregiver Q] has witnessed [Resident 1] on 2 separate occasions follow another resident around the halls. While following the other [Resident 1] had swung and struck the resident both times. Both residents were separated [sic] by other	N 352		

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N 352	Continued From page 10 [caregivers] to safety and attempt to deescalate the event happening at the moment." * 05/30/2024 at 3:45 P.M. included, "[Caregiver Q] saw [Resident 1] scold another resident standing by main door. Then [Resident 1] punched the other resident in the left side of chest with [his/her] right fist." * 05/30/2024 at 4:00 P.M. included, "[Resident 1] was following another resident around in the hallways. [Resident 1] then struck the other resident [s/he] was following." A copy of a fax sent from Resident 1's practitioner to the facility dated Wednesday, 05/29/2024 included, "Letter sent w/ [with] med changes 05/29/2024." The medication change order included, "Risperidone 1 mg tablet" to be administered "twice a day." On 09/04/2024 at 11:03 A.M., Surveyor conducted an interview with Administrator A. Administrator A told Surveyor s/he was aware of Resident 1's practitioner's order for risperidone 0.5 mg dated 05/14/2024 including a directive to update Resident 1's practitioner on Resident 1's agitation within approximately 7 days of Resident 1's first dose of the risperidone. Administrator A said s/he should have called Resident 1's practitioner right away when the order was received because of how it was written for 10 days, and it was going to "run out" over a holiday weekend. Administrator A said s/he did recall discussing this order with Resident 1's Nurse Case Manager G during his/her visit on 05/17/2024.	N 352		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats.,	N 358		

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each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.

This Rule is not met as evidenced by:
Based on observation and interview the provider did not safeguard residents from environmental hazards to which it is likely the residents will be exposed.

The facility's back patio utilized by residents, visitors, and caregivers included one concrete slab positioned 0.5 inch higher than surrounding slabs and there was a 0.75 inch gap between the higher concrete slab and the surrounding slabs. This difference in height and the gap width could pose a potential tripping hazard for ambulatory residents and a hinderance in the safe movement with the use of mobility devices.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) 7VRV11, issued 011/09/2018.

The findings include:

The facility may serve up to 21 ambulatory, semi-ambulatory, and/or non-ambulatory residents of advanced age and/or had diagnoses including irreversible dementia/Alzheimer's disease.

On 08/21/24 at 12:37 P.M., Surveyor observed the exit passageway leading from the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013379	A. BUILDING: _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE RICHLAND CENTER MEMORY CARE	240 N ORANGE STREET RICHLAND CENTER, WI 53581

(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 358	Continued From page 12 back sitting room to the facility's back courtyard including a patio with concrete slabs. Surveyor observed the passageway doors were propped open. Surveyor observed a large concrete slab placed directly in front of the exit door. Surveyor observed this concrete slab was higher in placement than the other surrounding concrete slabs. Caregiver D told Surveyor residents are free to ambulate and/or utilize a mobility device to access the patio/courtyard on their own. On 08/21/2024 at 12:42 P.M., Administrator A and Surveyor measured the height of the patio's concrete slab directly in front of the exit door leading from the facility compared to surrounding concrete slabs and the gap width between surrounding slabs. Surveyor observed a 0.5-inch height difference and a 0.75-inch gap between the higher concrete slab and the surrounding slabs. The height and gap width differences could pose a potential tripping hazard and could slow or hinder the safe navigation of a mobility device over the difference in surfaces. The wheels of walker, the point of a cane, and/or chair legs of nearby patio chairs could potentially get caught within the slab's gap width between surrounding slabs. Administrator A said s/he was not aware of the concrete slab's height and width difference and would contact maintenance staff to correct the issue. On 09/04/2024 at 11:03 A.M., Administrator A told Surveyor the patio concrete slab had not been fixed as of this date. Administrator A said maintenance staff were aware of the concrete slab issue and were trying to figure out how to fix it so all of the patio's concrete slabs were level.	N 358		