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PRAIRIE RIDGE ASSISTED LIVING	212 EAST INDUSTRIAL DR BEAVER DAM, WI 53916

(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 12/03/2024, with information obtained through 12/04/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and complaint investigation at Prairie Ridge Assisted Living, a community-based residential facility (CBRF) located in Beaver Dam, WI. As a result of the survey, 4 deficiencies were identified. Three deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) 4JNG12, dated 07/26/2024. The complaint was substantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 27	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall	N 239		

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

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successfully complete training in first aid and procedures to alleviate choking.
Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that Caregiver J obtained all department approved training as required.

Caregiver J did not have training in fire safety or first aid and choking within 90 days after starting employment.

This is a repeat deficiency. See Statement of Deficiency (SOD) 4JNG12, dated 07/26/2024.

Findings include:

On 12/03/2024, Surveyor conducted a review of 2 employees to verify compliance with department-approved training requirements. Surveyor requested all training records for Caregiver J from Care Coordinator C.

Fire Safety

The record for Caregiver J, hired 06/04/2024, did not contain evidence of training or evidence of meeting an exemption for fire safety.

At approximately 1:05 p.m., Surveyor interviewed

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N 239	Continued From page 2 Care Coordinator C and Nurse K. Care Coordinator C confirmed the provider did not have evidence that Caregiver J completed or met an exemption for fire safety training. Care Coordinator C confirmed awareness that Caregiver J had not yet completed fire safety training but reported that s/he was scheduled to complete it on 12/13/2024. Care Coordinator C reported that Caregiver J was a part-time caregiver who attended college and so s/he had difficulties getting him/her scheduled for the course. First Aid and Choking The record for Caregiver J, hired 06/04/2024, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. At approximately 1:05 p.m., Surveyor interviewed Care Coordinator C and Nurse K. Care Coordinator C confirmed the provider did not have evidence that Caregiver J completed or met an exemption for first aid and choking training. Care Coordinator C confirmed awareness that Caregiver J had not yet completed first aid and choking training but reported that s/he was scheduled to complete it on 12/12/2024. Care Coordinator C reported that Caregiver J was a part-time caregiver who attended college and so s/he had difficulties getting him/her scheduled for the course.	N 239		
N 318	83.29(3)(a) Refunds returned within 30 days of discharge The CBRF shall return all refunds due a resident under the terms of the admission agreement within 30 days after the date of discharge.	N 318		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not return the refund due to the legal representative of Resident 8, Person M, within 30 days after the date of Resident 8's discharge.

Resident 8's signed admission agreement allowed for partial charges to apply based on both his/her room being filled within the same month of it having being vacated and him/her having to move based on needing a level of services the provider was not able to provide. On 05/28/2024, Resident 8 was hospitalized for several days and subsequently discharged to a skilled nursing facility. Written communications from Person M to the provider on 06/06/2024, 07/19/2024, and 11/11/2024 also identified that the provider had not been able to meet Resident 8's care needs. Additionally, Resident 8's vacated room was filled by another resident who moved in on 06/18/2024. Despite both of these occurrences, Person M did not receive the partial refund to which s/he was entitled for June 2024. Despite 2 written refund requests from Person M, there was no evidence the provider investigated the matter until cued by Surveyor on 12/04/2024 (approximately 5 months after Resident 8 was discharged and his/her room vacated).

Findings include:

On 12/03/2024, Surveyor conducted a complaint investigation into concerns of residents/legal representatives not receiving refunds they were owed.

On 12/03/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider

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on 02/16/2024 where s/he resided until 05/28/2024 when s/he was hospitalized and subsequently moved to a skilled nursing facility. Resident 8's facesheet identified Person M as his/her activated power of attorney for healthcare and finances. Resident 8's observation notes from 05/31/2024 (3 days after s/he had already been hospitalized) through 11/15/2024 detailed the following:

- 05/31/2024 (1:45 p.m.): "Resident [family member] came to pick up clothes for resident for [his/her] week stay at the hospital."

- 06/06/2024 (2:45 p.m.): "Resident [power of attorney (POA)] gave a 30-day notice resident will not be returning to the facility, due to a change in condition in [his/her] health."

- 06/10/2024 (2:45 p.m.): "Family was here today taking most of [his/her] stuff out of resident room."

- 06/12/2024 (9:41 a.m.): "[Resident 8] was discharged from the system." Under a "Discharge Reason" section of the entry, the following was documented: "Moved to Skilled Nursing Facility."

- 11/15/2024 (10:00 a.m., approximately 5 months after Resident 8 was discharged from the provider): "Recv'd another letter from [Person M] asking for June rent back because [Resident 8] was moved out. I explained to [family member], [name], that we recv'd a 30 day on June 6th and that meant [s/he] would pay us through July 6th as per the contract. [S/he] understands and said that [Person M] is moving into [facility name] with [Resident 8] because [s/he]'s not doing well. We won't have to worry about it anymore." Surveyor observed that this entry was made by Admissions

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N 318	Continued From page 5 Coordinator B. At approximately 9:35 a.m., Surveyor interviewed Care Coordinator C regarding Resident 8's discharge. Care Coordinator C confirmed that Resident 8 had lived with the provider for a couple months until s/he was hospitalized, and then from the hospital s/he was placed in a skilled nursing facility for a higher level of care. Care Coordinator C confirmed the provider received letters from Person M regarding a refund s/he felt s/he was owed. Care Coordinator C reported that since s/he didn't have anything to do with the finances/accounting for the provider s/he passed these letters onto Admissions Coordinator B. Care Coordinator C then provided the letters to Surveyor. In reviewing the information provided, Surveyor observed the following: - Document dated 06/06/2024 and signed by Person M detailing that Resident 8 "will terminate [his/her] tenancy as a resident effective immediately. Your facility cannot provide the type of care needed as directed by [his/her] physician." - Letter dated 07/19/2024, signed by Person M, which documented, "I am writing this letter in regards to...[Resident 8]. As I am the Power of Attorney (POA) for [his/her] affairs. I am requesting refund of [his/her] monthly fee for the month of June. [S/he] was unable to be placed under your care as [his/her] medical needs increased to a licensed nursing home for the month of June. "As you did receive a 30-day notice regarding termination of residents [sic] for [Resident 8] on June 6, 2024 based on medical needs. I	N 318		

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understand that the agreement I signed spells out the terms under the agreement on Page 4 Section (G) that I should receive a pro-rated refund based on the day of vacating the apartment, which was on June 10, 2024 plus 7 days after...At your earliest convenience please review the request and process the refund. Please send me the refund to my residents [sic] that is list [sic] on the admissions paperwork."

- Letter dated 11/11/2024, signed by Person M, which documented, "I am writing this letter following up on response from you regarding my letter dated July 19, 2024. Regarding...[Resident 8] residency terminating at the end of May. As of this date, I have not received payment or response to my letter regarding my request for reimbursement of funds that are owed based on signed agreement. As I am the Power of Attorney (POA) for [his/her] affairs. I am requesting refund of [his/her] monthly fee for the month of June. [S/he] was unable to be placed under your care as [his/her] medical needs increased to a licensed nursing home for the month of June..."

Surveyor reviewed Resident 8's admission agreement, which was signed by Person M and dated 02/14/2024. Surveyor observed that Resident 8's fees were listed as $196.72 per day or $6,000 per month for a 30-day month. Surveyor observed the following 2 sections that detailed refund information:

- Section E (page 3): "Written Notice: A 30 day written advance notice is required of residents who voluntarily leave the facility. If a written notice is not provided, the resident/responsible party will be responsible for all charges incurred until the end of the month the unit was vacated. If the unit is filled within the month of vacating, a prorated

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refund will be given from the date the room is filled [emphasis added]."

- Section G (page 4, as referenced from Person M's 07/19/2024 letter detailed above): "Termination by Resident: Resident/responsible party may terminate this agreement upon thirty (30) day written notice to company management. The agreement terminates at the end of the notice period. If your move is need based and the company cannot provide the type of care needed or this is due to death, you and/ or your responsible party will be responsible for monthly fee for seven (7) days AFTER you have vacated the apartment and all of the belongings have been removed [emphasis added]."

At approximately 1:05 p.m., Surveyor interviewed Care Coordinator C regarding Resident 8's discharge situation. In reviewing the timeline of Resident 8's discharge, Care Coordinator C confirmed that the letter Person M provided on 06/06/2024 was the first notice s/he had received regarding Resident 8's intention to discharge (as corroborated by the observation note entry and Person M's letter of the same date). Care Coordinator C reported that s/he believed Resident 8's room was fully vacated by his/her family members on either 06/10/2024 or 06/11/2024 but that s/he didn't know which of the 2 dates for sure. Care Coordinator C reported s/he had no notes or documentation to indicate what day specifically Resident 8's room was vacated. Care Coordinator C reported s/he was unsure if Resident 8's room was filled within the month of June (the month Resident 8 vacated, which would have related to a prorated refund amount owed in accordance with Section E of his/her signed admission agreement). Care Coordinator C reported s/he had limited

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involvement with the business aspect of the provider and that Admissions Coordinator B would know more.

On 12/04/2024, at approximately 11:02 a.m., Surveyor interviewed Admissions Coordinator B. Admissions Coordinator B confirmed that Resident 8 was already gone from the provider when Person M gave staff a 30-day notice of his/her discharge. Surveyor reviewed Resident 8's admission agreement with Admissions Coordinator B and asked about the clause in Section E that detailed a prorated refund being owed if a resident's room was filled in the month they vacated. Admissions Coordinator B replied that s/he "didn't think about that" and would have to check his/her laptop to see if another resident had moved into Resident 8's room. Admissions Coordinator B reported s/he would call Surveyor back.

At approximately 11:35 a.m., Surveyor interviewed Admissions Coordinator B again. Admissions Coordinator B reported that another resident had moved into Resident 8's vacated room on 06/18/2024, and stated, "We owe [Person M] from the 18th up." Admissions Coordinator B reported that upon Resident 8's discharge s/he sent a paper to the provider's corporate office indicating that Resident 8 had to pay until the end of June. Admissions Coordinator B reported that the fact that Resident 8's vacated room was filled by another resident in June was missed by him/her. Surveyor then reviewed Section G of Resident 8's admission agreement with Admissions Coordinator B and reported that it seemed based on Resident 8's discharge observation note and Person M's letters that Resident 8's discharge to a facility providing a higher level of care that the "need-based" move

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criteria outlined in the section was met. Admissions Coordinator B replied, "You're right, it does sound like that." When asked when Resident 8's room was vacated (in accordance with the criteria outlined in Section G), Admissions Coordinator B reported that Care Coordinator C is supposed to let him/her know when everything is out of a resident's room but s/he was not informed of the potential 06/10/2024 or 06/11/2024 move-out date that Care Coordinator C had reported to Surveyor the previous day. Admissions Coordinator B reported that s/he submitted a move-out sheet for Resident 8 on 06/12/2024 and so s/he must have gotten a phone call that Resident 8's items were out by that day. Admissions Coordinator B confirmed s/he had no records or documentation to indicate if Resident 8's room was vacated on 06/10/2024, 06/11/2024, or 06/12/2024. Admissions Coordinator B reported that s/he didn't have anything to do with the accounting/finances aspect of the provider and so wasn't sure if or when refunds for residents were issued. Admissions Coordinator B reported that the accounting/finances was handled by the "corporate office" which s/he identified as a company with which the provider contracted to handle finances/accounting information. Admissions Coordinator B reported s/he was unable to give Surveyor contact information for this company because their staff would not talk with any outside entities. Admissions Coordinator B reported that s/he sent Person M's letters regarding his/her refund request to a representative from this contracting company but did not think they had any follow up communication with Person M. When Surveyor reported that it seemed like Person M was entitled to a partial refund based on Section G of his/her admission agreement (detailed above),

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N 318	Continued From page 10 Admissions Coordinator B replied that that "sounds right." Admissions Coordinator B reported s/he would count 06/10/2024 as the day Resident 8's room was vacated and thus would count 06/17/2024 as the seventh day and in turn refund the remainer of June after that. Admissions Coordinator B reported s/he would work to get the refund issued.	N 318		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update the individual service plan (ISP) for 1 of 3 residents reviewed when there were changes in his/her needs, abilities, and physical or mental condition. There was no information regarding Resident 7's aggressive behaviors, bed rail use, as well as his/her resistance to cares in his/her ISP.	N 389		

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This is a repeat deficiency. See Statement of Deficiency (SOD) 4JNG12, dated 07/26/2024.

Findings include:

On 12/03/2024, at approximately 10:15 a.m., Surveyor toured the environment. Surveyor observed Resident 7's bed, which had bilateral quarter rails in the up position.

At approximately 10:18 a.m., Surveyor interviewed Caregiver L. Caregiver L identified Resident 7 has someone who was known to demonstrate both verbally and physically aggressive behaviors, including yelling at and hitting staff. Caregiver L reported that these behaviors were exacerbated with Resident 7's sundowning.

On 12/03/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 05/11/2021 with diagnoses including polyneuropathy. Resident 7's observation notes, reviewed from 09/01/2024 - 12/03/2024, detailed the following entries related to Resident 7's behaviors, including refusals/resistance of cares:

- 09/03/2024 (12:15 a.m.): "...when staff went to move [him/her] [s/he] grab [sic] hold of staffs [sic] arm and pinched, [s/he] was also pushing staff away and not cooperating with staff at all."

- 09/24/2024 (12:15 a.m.): "staff went in to reposition resident and resident began swinging at staff with [his/her] fists. Resident didn't want staff to reposition [him/her]. staff was able to redirect resident with a conversation and was able to reposition resident."

- 09/25/2024 (4:15 a.m.): "Staff went to reposition

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resident, and resident was getting angry with staff and swinging [his/her] fists at staff. staff told resident we were trying to reposition [him/her] and started a conversation with resident was able to redirect resident to reposition resident."

- 10/29/2024 (4:00 a.m.): "Staff went to rotate and change resident, Resident was very uncooperative and not roll, [s/he] would push ageist [sic] the bed rail when staff tried to roll [him/her] to change [him/her], resident told staff to leave [him/her] alone or [s/he] would punch us, staff changed [him/her] and left [him/her] safe in bed."

- 10/29/2024 (9:15 a.m.): "staff went to go rotate resident. wash [him/her] up and change resident due to [overnight (NOC)] shift reporting that resident wasn't cooperating with them, resident was cooperating with staff, staff was able to rotate, wash up and change resident without any problem..."

- 10/30/2024 (2:45 a.m.): "resident was awake for check, refused to help turn, fists clenched."

- 11/02/2024 (6:00 p.m.) "Resident yelled throughout dinner. Resident was agitated and refused to explain what [s/he] needed. Resident refused to listen when staff tried to redirect [him/her]. While staff was attempting to try to get resident for bed. Resident tried to spit in the face of the staff and told them to shut up."

- 11/04/2024 (7:00 p.m.): "When staff was getting resident out of broda chair and ready for bed resident was not happy about anything that staff was doing. Resident stated to not touch [him/her] or [s/he] would punch staff. Staff tried to small talk to redirect resident so [s/he] wouldn't be so

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PRAIRIE RIDGE ASSISTED LIVING	212 EAST INDUSTRIAL DR BEAVER DAM, WI 53916

(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
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upset. Resident said do you want to be kicked in the head? Staff continued to get [him/her] ready for bed without incident."

- 11/05/2024 (12:30 p.m.): "Hospice nurse was here to see resident and nurse was updated on resident behaviors [s/he] has been having towards the staff at night, nurse was going to reach out to [medical doctor] and start [him/her] on quetiapine for behaviors."

- 11/13/2024 (6:30 p.m.): "staff went to put resident into bed and do [nighttime] cares, staff noticed that resident was full of [bowel movement]...resident started to get mean with staff, was yelling at staff, telling staff to shut up, and to shut their mouths, stated that [his/her] bottom hurt, and staff told resident that we understand, and that staff was trying to clean resident up, and wash up and make [his/her] bottom feel better, resident proceed to tell staff to shut up. staff got resident all cleaned up, and told resident that staff was going to give [him/her] a minute so [s/he] can clam [sic] down. after a while staff came back to finish resident [nighttime] cares, resident was not talking to staff while staff was doing cares, staff rolled resident over, and resident started to be aggressive, tried to slap the staff in the face, kept telling to shut up, and hitting staff. staff was unable to finish all [nighttime] cares due to resident aggressive about rolling over."

- 11/20/2024 (7:15 p.m.): "Staff was getting resident ready for bed and resident seemed to be very agitated. Resident was refusing cares and was trying to hit staff. Resident was trying to spit at staff and would not listen, Staff [sic] did get resident to calm down and to do cares."

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N 389	Continued From page 14 - 11/23/2024 (5:30 a.m.): "staff went to get resident up and dressed for the day and [s/he] was very combative and would not allow staff to do cares. cleaned [him/her] up and left [him/her] in bed." An entry later that morning at 9:45 a.m. documented that the first shift staff got resident up and ready for the day "due to NOC shift not being able to." - 11/27/2024 (5:30 a.m.): "Went to change and rotate and give resident [his/her] meds. Was not having it.stiffened [sic] up, and lashed out, refused meds, will reapproach in 10 min." - 11/30/2024 (4:15 a.m.): "resident was very difficult when getting up, was cold and just didn't want to get up. Stiffened self up, was very difficult to get [him/her] dressed and ready for the day." Surveyor reviewed Resident 7's current ISP, dated 12/03/2024 and provided by Care Coordinator C. Under the "Skin Care" section, information about Resident 7 needing to be rotated in bed every 2 hours due to a buttocks skin wound as well as information regarding care for Resident 7's bilateral heel wounds was documented. There was no information about Resident 7's behaviors, including his/her physical and verbal aggression or his/her resistance to cares. There was no information about his/her bed rail use. At approximately 1:05 p.m., Surveyor interviewed Care Coordinator C and Nurse K. Both acknowledged Surveyor's concern of the missing information related to Resident 7's behaviors and bed rail use in his/her ISP and reported they were still actively working on updating residents' ISPs. Both confirmed that Resident 7 used the bed rails to assist with bed mobility.	N 389		

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N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISPs) for 3 of 3 residents included a rationale for use and a detailed description of the behaviors which indicated the need for administration of their as needed (PRN) psychotropic medication. There was no information in the ISPs of Residents 3 or 7 documenting the specific behaviors that warranted administration of their PRN lorazepam. There was no information in Resident 6's ISP	N 408		

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regarding the use of his/her lorazepam, as directed by his/her hospice team, for management of his/her difficulties breathing and/or breathing-related behaviors.

This is a repeat deficiency. See Statement of Deficiency (SOD) 4JNG12, dated 07/26/2024.

Findings include:

Example 1 - Resident 3

On 12/03/2024, at approximately 10:18 a.m., Surveyor observed the provider's medication carts with Caregiver L. Surveyor observed 2 cards of lorazepam 0.5 mg tablets with pharmacy labels indicating that both cards were prescribed to Resident 3. The labels indicated that the cards were dispensed on 04/19/2024 (30 tablets) and 09/13/2024 (30 tablets), respectively. The card dispensed on 04/19/2024 had 27 tablets punched out with 3 tablets remaining. The card dispensed on 09/13/2024 had 30 tablets present.

On 12/03/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 04/18/2024 with diagnoses including moderate dementia and anxiety disorder. Resident 3's prescriptions included lorazepam 0.5 mg tablets with instructions to, "Take 1 tablet by mouth every 8 hours as needed for anxiety or agitation..." Surveyor reviewed Resident 3's most recently reviewed ISP, signed on 07/18/2024, as well as his/her current ISP, dated 12/03/2024, both of which were provided by Care Coordinator C. Both documented that staff managed Resident 3's medications. Within both, the only information regarding his/her PRN lorazepam use was the following: "[Resident 3] takes behaviors and anxiety and agitation medication. takes quetiapine

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for behaviors, lorazepam for anxiety or agitation, and risperidone for behaviors..." Following this was a list of side effects of each medication. There was no evidence of a detailed description of the behaviors which indicated the need for Resident 3's PRN lorazepam use documented in either ISP.

At approximately 1:05 p.m., Surveyor interviewed Care Coordinator C and Nurse K. Both confirmed Surveyor's concern that there was no detailed description of the behaviors warranting the use of Resident 3's lorazepam documented in his/her ISP.

Example 2 - Resident 6

On 12/03/2024, at approximately 10:18 a.m., Surveyor observed the provider's medication carts with Caregiver L. Surveyor observed 1 card of lorazepam 0.5 mg tablets with a pharmacy label indicating that it was prescribed to Resident 6. The label indicated that the card was dispensed on 08/20/2024 (30 tablets). The card had 9 tablets punched out with 21 tablets remaining.

On 12/03/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/15/2021 with diagnoses including unspecified dementia and anxiety disorder. Resident 6's prescriptions included lorazepam 0.5 mg tablets, active as of 11/05/2024 with instructions to, "Take 1 tablet by mouth every 4 hours as needed for anxiety, insomnia, agitation." Of note, Resident 6 was also prescribed scheduled lorazepam 0.5 mg tablets to be taken twice daily for anxiety. Surveyor reviewed Resident 6's most recently reviewed ISP, signed on 09/13/2024, as well as his/her current ISP,

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dated 12/03/2024, both of which were provided by Care Coordinator C. Both documented that staff managed Resident 6's medications. The current ISP was the only ISP containing information regarding Resident 6's psychotropic medications, which documented the following: "[Resident 6] receives Citalopram for irritability associated with dementia, Donepezil for mental clarity, and Lorazepam for anxiety, agitation and insomnia. [Resident 6] has behaviors including restlessness, verbal aggression, yelling and restlessness. Provide non-medication interventions as resident accepts..." Surveyor observed that citalopram and donezepil were also scheduled psychotropic medications, in addition to scheduled lorazepam, that Resident 6 was prescribed.

Surveyor reviewed Resident 6's observation notes from 09/01/2024 through 12/03/2024 and observed the following entries related to Resident 6's PRN lorazepam use:

- Entries on 09/23/2024, 10/24/2024, 10/30/2024, and 11/10/2024 documenting that staff administered Resident 6 PRN lorazepam under the instruction of hospice on each occasion due to Resident 6 complaining of shortness of breath / difficulties breathing - three occasions of which - 10/24/2024 10/30/2024, and 11/10/2024, staff documented concerns of corresponding low oxygen saturation values.

- Entry by Resident 6's hospice nurse on 10/30/2024 (7:00 a.m.): "...Suspect that increased [shortness of breath] is likely [related to] heart and kidney failure. Utilize PRN lorazepam and oxycodone in addition to supplemental oxygen to manage dyspnea and anxiety."

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N 408	Continued From page 19 - Entries on 11/22/2024 (11:30 a.m.) documenting that staff administered Resident 6 PRN lorazepam due to Resident 6 complaining of "having a hard time breathing." - Entry on 11/24/2024 (3:15 a.m.) documenting that Resident 6 complained of having a hard time breathing and "be leave [sic] [s/he] was having a [sic] anxiety attack gave [him/her] a PRN..." A corresponding entry in Resident 6's MAR documented that the only PRN medication administered that day was one PRN lorazepam tablet. - Entry by Resident 6's hospice nurse on 11/25/2024 (12:15 a.m.): "Education provided to staff to utilize Lorazepam if patient is restless and trying to pull oxygen off..." - Entry on 11/28/2024 (3:15 p.m.) documenting that staff administered Resident 6 PRN lorazepam due to Resident 6 complaining of shortness of breath. Of note, Resident 6's active prescriptions included ipratropium/albuterol 0.5-3 mg/3mL solution, active as of 11/13/2024, with instructions to, "Inhale 3 mL by mouth four times a day as needed for shortness of breath or wheezing." From Resident 6's observation notes, staff documented administering Resident 6 his/her PRN inhaler on 11/22/2024 at 9:45 a.m. due to Resident 6 complaining of having difficulties breathing. Of note, Surveyor observed that this occurred approximately 2 hours prior to staff having administered a PRN lorazepam tablet to Resident 6 (as documented above). In reviewing Resident 6's current ISP again, Surveyor did not observe any information	N 408		

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regarding staff's general use of Resident 6's PRN lorazepam as directed by hospice on 10/30/2024 and 11/25/2024 for management of his/her difficulties breathing and/or breathing-related behaviors.

At approximately 1:05 p.m., Surveyor interviewed Care Coordinator C and Nurse K. Both confirmed that staff's administration of Resident 6's PRN lorazepam for specific breathing-related behaviors and difficulties was not documented in his/her ISP.

Example 3 - Resident 7

On 12/03/2024, at approximately 10:18 a.m., Surveyor observed the provider's medication carts with Caregiver L. Surveyor observed 1 card of lorazepam 0.5 mg tablets with a pharmacy label indicating that it was prescribed to Resident 7. The label indicated that the card was dispensed on 03/08/2024 (30 tablets). The card had 15 tablets punched out with 15 tablets remaining. While observing the medication cart, Surveyor interviewed Caregiver L. When asked about residents with behaviors, Caregiver L identified Resident 7 as the main resident s/he thought of who demonstrated verbally and physically aggressive behaviors that seemed to worsen with his/her daily sundowning.

On 12/03/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 05/11/2021. Resident 7's prescriptions included lorazepam 0.5 mg tablets with instructions to, "Take 1 tablet by mouth every 2 hours as needed for anxiety, agitation, or delirium." Surveyor reviewed Resident 7's most recently reviewed ISP, signed on 03/14/2024, as well as his/her current ISP, dated 12/03/2024,

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N 408	Continued From page 21 both of which were provided by Care Coordinator C. Both documented that staff managed Resident 7's medications. Neither contained information regarding Resident 7's PRN lorazepam or the specific behaviors that indicated the need for its use. At approximately 1:05 p.m., Surveyor interviewed Care Coordinator C and Nurse K. Both confirmed Surveyor's concern that there was no detailed description of the behaviors warranting the use of Resident 7's lorazepam documented in his/her ISP.	N 408		