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	0017918	A. BUILDING: _____ B. WING _____	C 05/30/2024

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APPLE CREEK PLACE III	5117 N CHERRYVALE AVENUE APPLETON, WI 54913

(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 05/29/2024, with information gathered through 05/30/2024, Surveyors conducted 4 complaint investigations at Apple Creek Place III in Appleton. Three of 4 complaints were substantiated. One of 4 complaints was unsubstantiated. As a result of the survey, 3 deficiencies were identified. One deficiency was a repeat violation. See Statement of Deficiency (SOD) P4Z913, dated 03/21/2024. Census: 11	N 000		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.	N 406		

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

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This Rule is not met as evidenced by:
Based on observation, staff interview and record review the provider did not establish an effective procedure for the proper destruction and disposal of unused, discontinued, or outdated medications.

Per staff interview, a large white garbage bag located on the medication room floor contained empty resident medication unit dose packages waiting to be taken to the dumpster. Upon further inspection by the Surveyor, one of the unit dose packages contained 2 Oxybutin pills.

Findings Include:

On 03/18/2024, the department received a complaint related to medication administration and storage.

A facility policy titled, "Drug Buster Drug Disposal System" with an effective date of 5/2020 states, "...2. Place unused medications (tablets, capsules, liquids, suppositories, creams, and narcotic) into the bottle of Drug Buster. 3. Invert the bottle and swish the bottle twice. 4. After two (2) hours or when the bottle is full, discard the bottle with the regular trash..."

On 05/29/2024, Surveyors conducted an onsite visit to the facility. At approximately 9:00 AM, Surveyor observed a large white garbage bag located on the medication room floor. Medication Passer C indicated to Surveyor the bag contained empty resident medication unit dose packages waiting to be taken to the dumpster as it was "cycle fill" day at the facility. Medication Passer C stated s/he just got done removing the top of

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N 406	Continued From page 2 each of the unit dose packages so there would be no identifying information on the packages and they could be placed in the garbage. At approximately 11:00 AM, Surveyor reviewed the medication cart. Surveyor noticed the large white garbage bag was still located on the floor of the medication room. Surveyor asked Medication Passer C if s/he could review the contents of the bag. Medication Passer C assisted Surveyor in looking in the bag. Surveyor found a unit dose package containing 2 white pills. Medication Passer C stated s/he could not tell what medication it was or who the medication belonged to as s/he had removed any identifying information from the package. Upon further investigation, Medication Passer C and Surveyor identified the 2 pills to be Oxybutin. At approximately 11:30AM, Surveyor interviewed Medication Passer C who verified s/he did not see the pills when removing the medication unit dose packages from the medication cart. Medication Passer C stated, "I should have seen them and destroyed them."	N 406		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the	N 415		

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resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, at the time of administering medications, staff members did not document in the resident record the name, dosage, date and time of the medication taken for 5 of 5 (Residents 1, 2, 3, 4, and 6) residents reviewed.

Resident 1's May 2024 Medication Administration Record (MAR) contained 1 day where staff did not document whether Resident 1 refused/received medications. Resident 1's MAR contained 2 duplicate orders of Lorazepam where staff signed out 4 doses twice as being administered to Resident 1.

Resident 2's May 2024 MAR contained 2 days where staff did not document if Resident 2 refused/received medications.

Resident 3's May 2024 MAR contained 2 days where staff did not document if Resident 3 refused/received medications.

Resident 4's April 2024 MAR contained 7 days where staff did not document if Resident 4 refused/received medications. Additionally, Resident 4's May 2024 MAR contained 7 days where staff did not document if Resident 4 refused/received medications.

Resident 6's April 2024 MAR contained 17 AM doses, 1 AM patch application, and 30 PM doses where staff did not document whether Resident 6

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refused or received medications or treatment. Resident 6's May 2024 MAR contained 1 AM dose and 9 PM doses where staff did not document whether Resident 6 refused or received medications.

Findings Include:

On 03/18/2024, the department received a complaint related to medication administration.

On 05/29/2024, Surveyor conducted an onsite visit to the facility. A sample of resident records were requested, including the resident records of Resident 1, 2, 3, 4, and 6. Surveyor reviewed Resident 1, 2, and 3's MAR for May 2024 and Resident 4 and Resident 6's MARs for April and May 2024. Review of the MARs showed days where medication administration was not documented as indicated by no medication passer's initials on specific dates.

RESIDENT 1: Missing Documentation on MARs:

Divalproex sprinkle 124 mcg 4 take 4 capsules every 8 hours
-6 AM dose on 05/17/2024

Duplicate Documentation on MARs:
Lorazepam 1 mg Take 1 tablet three times daily
-8 AM dose on 05/20/2024
-4 PM dose on 05/18/2024, 05/19/2024, 05/20/2024

On 05/30/2024 at approximately 11:30 AM, Surveyors interviewed Director of Nursing (DON) B who stated Lorazepam was listed in Resident 1's MAR twice. Surveyor inquired whether Resident 1 got 2 doses of Lorazepam on days where the order was listed in the MAR twice and

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N 415	Continued From page 5 DON B said s/he did not know, but did not think so. DON B said there was more than 1 card of Lorazepam as there was more than 1 order. Surveyor noted in Resident 1's MAR Resident 1 had an as needed (PRN) Lorazepam 1 mg order. RESIDENT 2: Missing Documentation on MARs: Gabapentin 100mg (milligrams) take 1 capsule twice daily -8PM dose on 05/04/2024 and 05/05/2024 RESIDENT 3: Missing Documentation on MARs: Calmoseptine ointment 113gm (grams) apply to coccyx twice daily -7PM dose on 05/04/2024 and 05/05/2024 RESIDENT 4: Missing Documentation on MARs: Breo Ellipta 100/25 INH inhale 1 puff into the lungs once daily -9AM dose on 04/04/2024 Bumetanide 0.5mg 1 tablet in the morning -9AM dose on 04/04/2024 Calcium/D3 600mg/10mcg (micrograms) 1 tablet twice daily -9AM dose on 04/04/2024 -6PM dose on 04/03/2024 Carvedilol 3.125mg 1 tablet once daily in the evening -6PM dose on 04/03/2024 Carvedilol 6.25mg 1 tablet once daily in the morning -9AM dose on 04/04/2024	N 415		

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N 415	Continued From page 6 Donepezil 10mg 1 tablet once daily at bedtime -6PM dose on 04/03/2024 Fluticason 50mcg nasal spray instill 2 sprays in each nostril once a day -9AM dose on 04/04/2024 Ipratropium/albuterol 0.5/3mg/3ml (milliliters) use one vial per nebulizer 3 times daily -9AM dose on 04/04/2024 -2PM dose on 04/18/2024 -6PM dose on 04/03/2024 Lantanoprost instill one drop in both eyes once daily at bedtime -6PM dose on 04/03/2024 Melatonin 5mg 1 tablet once daily at bedtime -6PM dose on 04/03/2024 Memantine 10mg 1 tablet daily -9AM dose on 04/04/2024 Sertraline 50mg 1 tablet once daily -9AM dose on 04/04/2024 Timolol instill one drop into both eyes twice daily -9AM dose on 04/04/2024 -6PM dose on 04/03/2024 Vitamin D3 1 tablet once daily -9AM dose on 04/04/2024 Levothyroxine 100mcg 1 tablet once daily 30 minutes before breakfast -6AM dose on 04/20/2024, 04/26/2024, 04/28/2024, 04/29/2024, 05/09/2024, 05/15/2024, 05/17/2024, 05/23/2024, 05/24/2024, 05/26/2024 and 05/027/2024 -7AM dose on 04/04/2024	N 415		

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N 415	Continued From page 7 RESIDENT 6: Missing Documentation on MARs: Acetaminophen 500 mg caplet 2 tablets by mouth three times daily -8 AM dose on 04/04/2024 -8 PM dose on 04/03/2024, 04/19/2024, 04/28/2024, and 05/20/2024 Xarelto 15 mg tab 1 tablet every evening -8 PM dose on 04/03/2024, 04/19/2024, 04/28/2024, and 05/20/2024 Metformin 100 mg tab 1 tablet twice daily -8 AM dose on 04/04/2024 Metoprolol Tart 50 mg 3 tablets (150 mg) twice daily -8 AM dose on 04/04/2024 and 05/12/2024 -8 PM dose on 04/03/2024, 04/13/2024, 04/19/2024, 04/28/2024, and 05/20/2024 Primidone 50 mg 1 tablet once daily -8 AM dose on 04/04/2024 Sertraline 100 mg 1 tablet daily -8 AM dose on 04/04/2024 Tamsulosin 0.4 mg 1 capsule daily at bedtime -8 PM dose on 04/03/2024 Vitamin B12 500 mcg 1 tablet daily -8 AM dose on 04/04/2024 Melatonin 3 mg 1 tablet daily at bedtime -8 PM dose on 04/03/2024, 04/13/2024, 04/19/2024, 04/28/2024, and 05/20/2024 Levetiracetam 750 mg 1 tablet twice daily -8 AM dose on 04/18/2024	N 415		

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N 415	Continued From page 8 -8 PM dose on 04/03/2024 Jardiance 10 mg 1 tablet daily -8 AM dose 04/04/2024 Isosorbide Din 10 mg 1 tablet daily -8 AM dose on 04/04/2024 Gabapentin 100 mg 1 capsule twice daily -8 AM dose on 04/03/2024 and 04/19/2024 -8 PM dose on 04/28/2024 Furosemide 20 mg 1- tablet twice daily -8 AM on 04/04/2024 Ferrous Sulfate 325 mg 1 tablet in the morning -8 AM dose on 04/04/2024 Carbamazepine ER 200 mg 1 capsule daily -8 PM dose on 04/03/2024, 04/19/2024, and 05/20/2024 Carbamazpine ER 100 mg 1 capsule daily -8 AM dose on 04/04/2024 Buspirone 10 mg 2 tablets twice daily -8 AM dose on 04/04/2024 -8 PM dose on 04/03/2024, 04/19/2024, 04/28/2024, and 05/20/2024 Atorvastatin 40 mg 1 tablet at bedtime -8 PM dose on 04/03/2024, 04/19/2024, 04/28/2024, and 05/20/2024 Apipiprazole 10 mg 1 tablet daily -8 AM dose on 04/04/2024 Tamsulosin 0.4 mg 1 capsule at bedtime -8 PM dose on 04/03/2024, 04/19/2024, 04/28/2024, and 05/20/2024	N 415		

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N 415	Continued From page 9 Vitamin D3 1000IU (25 mcg) 2 capsules daily -8 AM dose on 04/04/2024 Trazodone 50 mg 1/2 tablet at bedtime -8 PM dose on 04/19/2024, 04/28/2024, and 05/20/2024 Rivastagmine 4.6 mg/24 hour apply patch topically daily -8 AM patch application on 04/17/2024 On 05/30/2024 at approximately 11:30AM, Surveyor interviewed Regional Nurse D. Regional Nurse D confirmed the April and May MAR's did not contain initials on the referenced dates.	N 415		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and	N 431		

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N 431	Continued From page 10 fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor Resident 5 and Resident 6's health. The provider did not observe Resident 5's food and fluid intake consistently and did not report significant deviations from normal food intake patterns to his/her physician. The provider did not document communication with Resident 6's physician and hospice providers, and record changes of health in Resident 6's records. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023. Findings include: The provider is licensed to provide services for up to 22 residents who may be terminally ill, of advanced age, and/or have Alzheimer's/dementia. On 04/22/2024 and 05/20/2024, the department received complaint information alleging resident health was not being monitored.	N 431		

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N 431	Continued From page 11 On 05/29/2024, Surveyors conducted a complaint investigation. RESIDENT 5: On 05/29/2024, Surveyor reviewed Resident 5's record and noted s/he was admitted to the facility on 10/28/2022 with diagnoses of vascular dementia, insomnia, anxiety disorder, aphasia, and cerebral infarction. Resident 5 had an activated Power of Attorney for Health Care (POAHC) and his/her primary language was not English. INDIVIDUAL SERVICE PLAN (ISP) Surveyor reviewed Resident 5's most recent ISP with print date 05/29/2024, and noted Resident 5 required "24-hour supervision ...needs total assistance ...cannot make needs known." "CONSUMPTION MONITORING ...Daily @ Breakfast, Lunch, Dinner." "DIET - GENERAL ... Resident is on a general diet." "EATING - MONITOR AND CUE ...Monitor and cue when eating. Provide mighty shakes during all meals ...Resident requires staff monitoring and/or reminders and cues to complete eating tasks. Resident does have a history of not eating meal or eating small amounts. Resident is on might shakes to help promote nutrition ...Resident's Desired Goals & Outcomes: To maintain adequate food/nutrition intake ...Staff to monitor and cue resident to eat all meals. Update RCC [Resident Care Coordinator] of any changes or concerns." "MEALS - COMMUNITY PREPARES ... Resident requires community to prepare meals 3x [times] daily ...To have nutritious meals that resident enjoys ... Staff to prepare and serve meal 3x	N 431		

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daily."
"MONTHLY - WEIGHTS ...Obtain weight monthly. Update RCC or Nurse of >5 lbs [pounds] in month ...Schedule: Every month on the days 1 @ 7:00 AM."

TREATMENT ADMINISTRATION RECORD (TAR)
Surveyor reviewed Resident 5's February and March 2024 TAR and noted "CONSUMPTION MONITORING" and staff documented Resident 5 missed at least one meal on 02/04/2024, 02/18, 02/20, 02/21, 03/19, and 03/21 (6 days missing at least one meal). Staff documented Resident 5 did not eat any food on 02/08, 02/10, 03/09, 03/20, and 03/24 (5 days missing all meals).

Surveyor reviewed "Scheduled Care Notations" in the TAR and noted the following notations:
03/26/2024 3:30 PM "Resident refused [s/he] is not feeling well."
03/27/2024 9:34 AM "Resident pushed all drinks and food away from [him/her]. Acted as if [s/he] was going to vomit.
03/28/2024 7:40 PM "refused"
03/29/2024 1:10 PM "other" [no additional information documented]
03/30/2024 6:09 PM "refused"

Surveyor note: Within the consumption monitoring charting, multiple days and/or meals were left blank without documentation, so it was unknown Resident 5's consumption on these days/times: 17 days had blank documentation for all 3 meals, 17 days had blank documentation for 2 meals, and 6 days had blank documentation for 1 meal from February through March.

Surveyor noted on Resident 5's February, March, and April 2024 TAR "MONTHLY WEIGHT -

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Obtain weight monthly. Update RCC or Nurse of >5 [pounds] in month." Documentation was left blank for all three months. January 2024 TAR did not include an area to prompt staff to weigh or document Resident 5's weight.

VITAL HISTORY
Surveyor reviewed Resident 5's "Vital History" for 12/01/2023-04/30/2024 with one weight dated 03/20/2024 - 102.4 pounds documented by Administrator RN F. No previous weights were noted in Resident 5's record to compare.

OBSERVATION NOTES
Surveyor reviewed Resident 5's observation notes dated 02/01/2024 through 05/29/2024 and noted the following related to food consumption:
02/04/2024 "[Resident 5] refused to eat dinner today but did an activity and was very happy."
02/08 "2/7/24 50% food was eaten, was sleeping more in the dining are instead of [his/her] room and trash was taken out [sic] 2/8/24 0% food eaten, refused to change into night cloths [sic] and was put into bed."
02/10 "Resident has been sleeping quite a bit. Write did ask if [s/he] was hungry and [s/he] declined both breakfast and lunch but did get up to get toileted."
02/18 "Refused dinner, was sleeping a lot in the dining area was moved to [his/her] room but kept coming back out to sleeping in the dining area, toileted, and put into bed."
02/20 "Slept most of the time in the dining are[a], refused to eat dinner, showered, changed into night [clothes] put into bed."
02/20 "Refused to eat dinner, sat at the table and slept majority of the time."
03/09 "Resident is not eating is very weak also is limping badly [sic]"
03/19 "Refused to eat dinner, toileted, sat in

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common are with residents watching tv."
03/20 "Resident has not been eating at any meals. Acts as if excited for food and then does not eat anything. Staff has tried to help [him/her] eat and [s/he] will hit us, then sleeps with arms folded at the table."
03/20 "Resident refused to eat dinner and preferred to sleep in common area, tried to encourage resident to eat but resident wanted nothing to do with food."
03/21 "Resident refused to eat dinner, folded arms and fell asleep at the dining table ..."
03/27 "Resident only took a few bites of [his/her] soup today but refused to eat anymore, pushed [his/her] drink away and when encouraged to try eating more [s/he] would point finger and say no."
03/27 "Resident pushed all drinks and food away from [him/her]. Acted as if [s/he] was going to vomit."

On 05/29/2024 at approximately 10:20 AM, Surveyor interviewed Medication Passer C who stated Resident 5 had a significant decline in eating. S/he said they offered protein shakes and multiple food options and consistencies, and Resident 5 would either refuse the meal and sit with his/her arms folded or sleep at the table. Medication Passer C said s/he notified Administrator RN F multiple times and nothing was done about it or followed up on. Surveyor inquired whether Resident 5's physician was notified and Medication Passer C stated s/he didn't believe so. Medication Passer C described Resident 5 as being small statured and petite individual who "could not afford to lose any more weight." Medication Passer C indicated Resident 5 could be more challenging to communicate with because s/he primarily spoke Spanish.

On 05/29/2024, Surveyor reviewed written

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information from Adult Protective Services/Crisis (APS) Worker E of an investigation conducted on Resident 5. Surveyor noted APS E identified harm to Resident 5 as s/he had gone multiple days without eating in February and March 2024. Resident 5's family had brought in soup when they learned of him/her not eating. Resident 5's physician was not notified by Administrator RN F to prescribe a special diet despite staff and Resident 5's POAHC reporting to Administrator RN F and documentation indicating that Resident 5 was not eating. APS E noted Administrator RN F requested a crush order for medication instead of diet changes or updates for Resident 5 which was not discussed with Resident 5's POAHC.

On 05/30/2024 at approximately 11:32 AM, Surveyors interviewed Regional Nurse D who acknowledged Resident 5's physician was not notified related to his/her change in eating pattern. Regional Nurse D stated s/he had been providing education to staff on tracking meals in percentages and the importance of monitoring resident intake in memory care, which this facility was identified to serve.

RESIDENT 6:

INTERVIEWS
On 05/29/2024 at approximately 9:00 AM, Surveyor interviewed Medication Passer C who stated Resident 6 was being administered morphine without a reason. Medication Passer C stated agency staff put in observation notes that Resident 6 needed morphine every hour, but it was not documented elsewhere or discussed with staff to provide morphine. Medication Passer C stated Resident 6 was up in his/her broda chair and not showing any symptoms listed for administering morphine. S/he said Resident 6

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was administered morphine around 2:00 AM the morning of Surveyors' visit.

At approximately 9:30 AM, Surveyor interviewed Director of Nursing (DON) B who stated s/he was not aware or why Resident 6 was administered morphine on the early morning of 1:00 AM. DON B stated staff were directed to call him/her before administering and when there was a change with resident condition. Surveyor inquired whether Resident 6 was actively passing and DON B said s/he did not think so. S/he said on the overnight of 05/25, Resident 6 was found unconscious and hospice evaluated Resident 6 and directed for Resident 6 to be administered lorazepam and morphine as Resident 6 was showing signs of decline. Surveyor inquired whether it was directed from hospice for Resident 6 to continue lorazepam and morphine and s/he said s/he did not know.

At approximately 9:35 AM, Surveyor interviewed Director A and Regional RN D who stated they were unaware Resident 6 was actively dying and whether Resident 6 had symptoms requiring morphine.

At approximately 11:00 AM, Surveyor interviewed Caregiver H who stated s/he administered Resident 6 morphine earlier that morning. S/he said Resident 6 was being combative during night changes, so Caregiver I told him/her to administer morphine, but s/he did not know why. Surveyor inquired whether Resident 6's hospice plan of care was communicated with him/her and s/he said no.

At approximately 8:47 AM, Surveyor interviewed Hospice RN G who said Resident 6 is visited daily to manage and ensure his/her medication regime

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was followed. Hospice RN G indicated Resident 6 was recently prescribed Seroquel for behaviors related to his/her dementia. S/he stated Resident 6 refused his/her medications frequently and the right approach in administration was important. S/he recalled Resident 6 also had a history of wandering into other resident rooms and combativeness with personal cares. Hospice RN G stated Resident 6 was on the hospice's "Muse" program which directed scheduled daily hospice visits with Resident 6. Hospice RN G said there was no contact with hospice about Resident 6 on the overnight into 05/29/2024.

At approximately 10:00 AM, Surveyor interviewed Hospice Marketing Director J who stated Resident 6 was on the St. Croix Hospice Muse Program which identified Resident 6 as receiving end of life care as of 05/25/2024. The Muse program was described as being an electronic monitoring system that included daily visits by hospice to monitor, assess and track patient's conditions during end of life. Surveyor inquired whether this was communicated with the provider and s/he said yes, notes were left daily and Hospice RN G had verbal communication with staff.
At approximately 8:55 AM, Surveyors went to Resident 6's room and observed Resident 6 to be in a wheelchair, hunched over at his/her trunk forward. Surveyor knelt down in front of Resident 6 and spoke to him/her. Resident 6 presented very lethargic, but lifted his/her head slightly to look at Surveyor. Resident 6 mumbled, but was unable to converse with Surveyors when spoken to.

RECORD REVIEW
On 05/29/2024, Surveyor reviewed Resident 6's record and noted s/he was admitted to the facility

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on 03/11/2024 with diagnoses of dementia, benign neoplasm of brain, and type 2 diabetes. S/he had an activated POAHC and was receiving hospice services. Resident 6 was identified to require assistance with all activities of daily living (ADL's).

INDIVIDUAL SERVICE PLAN (ISP)
Surveyor reviewed Resident 6's most recent ISP with print date 05/29/2024 and noted:
"MEDICATION MANAGEMENT - ASSIST ...Staff administer all medications. Resident prefers medications to be effective for diagnoses and to be administered safely according to physician orders."
"PSYCHOTROPIC MEDICATIONS - USING ...Appropriate use of medications will be maintained. Resident to show no adverse affects [sic] related to psychotropic medication use. Resident behaviors to be controlled as allowed by progression of disease process."
"DESTRUCTIVE/ABUSE - INDEPENDENT ... Displays no destructive/abusive behaviors."
"PAIN HISTORY & MANAGEMENT ... Resident has no c/o [complaint of] pain at this time."
"CHRONIC ILLNESSES - MONITOR/ASSIST ...Carry out and perform curing or treating of chronic illnesses ...Staff to monitor and report any exacerbations of chronic illnesses to appropriate supervisor ...Resident will have no exacerbations of chronic illnesses requiring hospitalization in the next 90 days."
Surveyor note: Resident 6's ISP did not identify Resident 6 having behaviors or a history of refusing medications, being on hospice services, and being on a program for end of life care.

MEDICATION ADMINISTRATION RECORD (MAR)
Surveyor reviewed Resident 6's May 2024 MAR

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and noted Morphine 20 mg/mL oral solution - "Take 0.25 ML by mouth every hour as needed for pain or shortness of breath."
Surveyor noted Resident 6 was administered morphine on:
05/20/2024 at 8:35 AM - reason administered not documented/ blank
05/22 at 8:36 AM - reason administered not documented/ blank
05/23 8:50 AM - reason administered not documented/ blank "Some Relief"
05/24 7:49 PM - reason administered not documented/ blank "Complete Relief"
05/24 3:00 PM - reason administered not documented/ blank "Some Relief"
05/25 1:31 AM - reason administered not documented/ blank "No Relief"
05/26 12:01 PM - reason administered not documented/ blank "Significant Relief"
05/26 1:35 AM - reason administered not documented/ blank
05/29 2:08 AM - reason administered not documented/ blank "Significant Relief"

OBSERVATION NOTES
Surveyor reviewed Resident 6's observation notes dated 02/01/2024 through 05/29/2024:
05/25/2024 4:15 AM "Upon arrival on shift at 3pm [Resident 6 was] found on toilet unconscious. Called hospice right away and they came out. Directions given was [s/he] is to be bed bound and PRN Morphine and Lorazepam to be given every hour. Upon relief staff arriving around 1 AM, [s/he] was starting to get combative and trying to get out of bed. PRN Lorazepam and Morphine was given. This was no help as [s/he] was pulling and pushing at staff reaching for [chest] and hair. Before [s/he] was given [his/her] next dose of Morphine ...Hospice was called and they came back out around 3:30 AM and did their

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checks and told staff to give PRN Morphine every hour even if [s/he] is sleeping and it states maxed reach, [sic] once the PRN Lorazepam comes in from the pharmacy to give both every hour together. Around 4 AM [s/he] calmed down and fell asleep. PRN Morphine is to [sic] given every hour."
Surveyor note: Resident 6's observation notes did not include any additional documentation about Resident 6 receiving Morphine or documentation of changes in condition. No observation notes were entered from 05/26/2024 through 05/29/2024 when Resident 6 reportedly had changes.

HOSPICE NOTES
Surveyor reviewed Resident 6's hospice notes titled "RESIDENTIAL COMMUNICATION FORM" completed by hospice staff that were located in a St Croix Hospice binder in the medication room with Resident 6's name on it. Surveyor noted:
05/25/2024 "Facility staff reported increased anxiety and aggression. Patient disoriented, laying in bed upon arrival. Patient does grab at staff's arm and have [sic] non-purposeful movement. Advised to utilize PRN [as needed] morphine every hour and last dose of PRN lorazepam with severe agitation. Write to follow up with pharmacy in AM [morning]. Patient resting comfortable at close of visit ..."
05/26 "Alert, disoriented x [times] 3. Tachycardic [high heart rate] ...1 episode of vomiting PRN ondansetron given. Increasing PRN lorazepam from 0.5 mg to 1 mg PRN. Breathing even and unlabored ...will continue daily RN and HHA [hospice caregiver] visits."
05/28 "very lethargic. Tachycardic (191/min) Did not get AM dose of metoprolol which is to help keep pulse within normal limits. Not anxious and no indications of pain. Very shaky which was

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N 431	Continued From page 21 better once [s/he] was dressed again. Will continue daily visits ..." 05/29 "Caregiver reports a failed attempt at med administration due to patient refusing. Staff will attempt again. Lethargic today. In part to med change. No indications of pain or discomfort just cold. No anxiety noted. Tachycardic.. pulse 131.. RN updated." On 05/30/2024 at approximately 11:30 AM, Surveyors interviewed DON B and Regional RN B who acknowledged Resident 6's record did not depict Resident 6's current health condition and need for monitoring. In summary, the provider did not document communication with Resident 6's hospice provider to record changes in Resident 6's care. Provider staff were unclear or unaware of Resident 6's current health status and direction from hospice leading to inconsistency in care, monitoring, and medication administration.	N 431		