STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019672	A. BUILDING: _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH POINT RESIDENCE GERMANTOWN SOUTH	W150 N11127 FOND DU LAC AVE GERMANTOWN, WI 53022

(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 08/07/2024, Surveyors conducted an onsite visit to investigate one complaint. On 08/14/2024, a second complaint was received and Surveyors returned onsite 08/19/2024 to investigate the complaint and a self-report. On 09/25/2014, the Department received a third complaint and returned onsite 10/07/2024 to investigate. Additional information was received through 10/08/2024. Three (3) of 3 complaints were substantiated. Eleven (11) deficiencies were identified which included 2 repeat deficiencies. Census 42	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not investigate injuries of unknown source. Between 09/13/2024 and 10/07/2024 Resident 1 sustained 3 different injuries to include a bruise on his/her thigh, a bump/scrape on his/her forehead and a bruise on his/her upper left torso. Resident 1 had diagnoses to include dementia and was unable to explain the sources of the injury. Administrator C did not ensure 3 of 3 injuries were investigated.	N 161		

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

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N 161	Continued From page 1 Findings include: Surveyor reviewed Resident 1's complete facility record on 10/07/2024. Surveyor also received and reviewed hospice records on 10/08/2024. Surveyor noted the following: Resident 1 was admitted to the facility on 05/28/2024 and to hospice on 09/14/2024. The hospice admission narrative read in part, "...admitting to hospice care with a terminal diagnoses of Pick Disease (type of frontotemporal dementia)...[unable] to speak in complete sentences and is found with increased aggression requiring behavior np (nurse practitioner) to be involved...no longer able to safely walk independently...alert and oriented to self only. Patient is unable to make needs known or engage in consistent, meaningful conversation due to garbled, nonsensical speech pattern...Patient is dependent on facility staff for bathing, dressing, grooming and toileting at this time." INJURY 1: Hospice visit notes: 09/17/2024 - "Large bruise to right thigh. Purple in color. Unknown origin...is unable to communicate how the bruise occurred...ambulates independently..." 10/04/2024 - "Large healing bruise to right medial thigh..." On 10/08/2024 at 3:14 PM, Surveyor interviewed Family X. S/he recalled on 09/16/2024, s/he visited Resident 1 and provided toileting assistance. S/he observed a dark purple bruise approximately 4" in diameter on the front of Resident 1's right thigh. Family X said s/he last	N 161		

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N 161	Continued From page 2 observed Resident 1's thigh on 09/12/2024 when s/he assisted Resident 1 with a shower and the injury was not present. Family X said s/he reported the bruise to Administrator C on 09/16 who did not know how it occurred but implied it may have been sustained while Resident 1 was intrusively wandering in other resident rooms on 09/13. Family X sent Surveyor a photo of the bruise and it was consistent with his/her description of a circular dark purple bruise at least 4" in diameter. Surveyor interviewed Administrator C on 10/07/2024 at 2:48 PM. S/he recalled Family X showing him/her a bruise on Resident 1's right thigh during September. Surveyor asked how the injury was sustained and s/he replied, "No idea. We just assumed it was from [him/her] walking into railings and just walking around." Administrator C said the injury also could have been sustained while crawling on the ground, which is something Resident 1 is prone to do. Administrator C said s/he did not conduct or document an investigation into the injury of unknown origin and was unfamiliar with the regulatory requirement to do so. S/he also confirmed Resident 1 would have been unable to explain the source due to the progression of his/her dementia. During the interview, Surveyor requested and reviewed the providers policy binder. The binder contained a policy for response to injuries of unknown origin and mirrored the regulatory requirement. Administrator C confirmed Surveyor's review of the policy. INJURY 2: Facility incident report:	N 161		

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N 161	Continued From page 3 09/23/2024: "I had just come in don't really know what happened I seen a bump on [his/her] head has a scratch but I walked into it so I don't really know many details as much but I did mention it to see if anyone knew anything...I don't know really all I heard was on wheelchair!" Hospice visit note: 09/21/2024 at 3:47 PM : " ...Resident laying on bedroom floor upon arrival. Writer greeted [him/her] and sat on the floor next to [him/her]. Staff very adamant that Resident had not fallen but 'laid on the floor and refused to get up.' ..." During the aforementioned interview and email correspondence with Family X, s/he also said s/he observed the 09/23 bump and abrasion and sent a photo. Surveyor observed a pronounced bump approximately 1" in diameter and there was an abrasion in the center of the bump. During the aforementioned interview with Administrator C, s/he confirmed the 09/23 bruise was reported to him/her. Administrator C said s/he informed caregivers to "do an incident report as you found it. I asked the staff that worked prior. They said [s/he] was crawling around the room all weekend but nobody said anything about a bump." Administrator C did not state s/he documented the conversations with staff or describe any other efforts to investigate the potential source of the injury. INJURY 3: On 10/07/2024 at 12:46 PM, Family X informed Surveyor on Saturday 10/05/2024, s/he found a bruise on Resident 5's rib cage area and there "was not an incident report filled out about it and again, no one knows where it came from."	N 161		

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N 161	Continued From page 4 Surveyor observation: On 10/07/2024 at 1:44 PM, Caregiver O lifted Resident 1's shirt and Surveyor observed a circular bruise, 2-3 inches in diameter on his/her left side rib cage area. The bruise had a yellow edge and was lighter in the center. Caregiver O said s/he was previously unaware of the bruise or how it occurred. Resident 1's record did not contain an incident report or other documentation of this injury. During the aforementioned interview with Administrator C, Surveyor asked if s/he was aware of the current bruise Resident 1 had on his/her left side torso. Administrator C said s/he was not and no investigation into the source of the injury was completed. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	N 161		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.	N 214		

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N 214	Continued From page 5	N 214		

This Rule is not met as evidenced by:
Based on record review and interview, Administrator C did not supervise the daily operations of the facility to ensure residents received necessary care and services.

Findings include:

Surveyor reviewed Department records. Administrator C was the designated administrator effective 04/23/2024.

On 08/07/2024, Surveyors conducted an onsite visit to investigate 1 complaint. At 2:05 PM and 4:09 PM, Surveyor interviewed Executive Director A. S/he explained Administrator C was his/her supervisor, but s/he would not be present at the facility due to a pre-arranged medical appointment for a family member. At the conclusion of the facility visit, Surveyors communicated areas of concerns including (but not limited to) the following:

Right of Residents: Receive Medication - Resident 2's pain medication was not available
Written Order for Medication, Supplements - no medication orders were maintained in the resident records
Medication Administration - caregivers were administering crushed medications to Resident 1 that were contraindicated for crushing and systems were not in place to ensure residents were scheduled to receive medications at the times ordered by the prescriber
Care - caregivers were not providing Resident 1 with necessary shower assistance and residents were experiencing long wait times, in part due to lack of available pagers for staff.

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N 214	Continued From page 6 Executive Director A acknowledged the concerns and explained the facility went through multiple leadership and process transitions dating back to March 2024. During that time, s/he was promoted from assistant director of marketing to the Executive Director role and Administrator C promoted from Executive Director to Administrator. Executive Director A said there was "change after change" and s/he was unable to effectively implement the changes. Executive Director A also stated, "I wasn't fully trained, I was just thrown in." On 08/19/2024, Surveyors returned for a second visit, after receiving a complaint regarding the circumstances of a fall with injury sustained by Resident 3 in July 2024. Surveyors interviewed Executive Director A and Administrator C at 11:12 AM and 1:25 PM, and asked about management roles/responsibilities and Resident 3's care needs. Administrator C said this is one of 3 facilities s/he manages. Although s/he is in the building weekly, Executive Director A provides daily oversight and deferred to Executive Director A for details of Resident 3's care needs and circumstances of the fall. During the 08/19/2024 return visit, Surveyors identified new concerns to include deficiencies with individual service plans (ISPs.) Surveyors also determined concerns persisted that were first identified during the 08/07 visit. Examples include: Right of Residents: Receive Medication - Resident 5's psychotropic medication was not available and s/he experienced an increase in behaviors Written Order for Medication, Supplements - no medication orders were maintained in the resident records	N 214		

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Medication Administration - caregivers continued to administer crushed medications to Resident 1 that were contraindicated for crushing and systems were not implemented to ensure residents were scheduled to receive medications at the times ordered by the prescriber
Care - Resident 1 was still not receiving necessary assistance with showers, pagers were not available to all caregivers and residents continued to experience long wait times

As a result of the 2 aforementioned complaint investigations, both complaints were substantiated and a total of 7 deficiencies were identified (not including this deficiency.) The deficiencies were reviewed with Administrator C during an interview on 08/26/2024 beginning at 1:00 PM. During the interview. S/he confirmed medication management systems had not been resolved between the 2 visits to ensure medications orders were in the record and medications were scheduled for the correct times. S/he also stated s/he was responsible for ISP (individual service plan) updates.

On 10/07/2024, Surveyors returned for a third visit, after receiving a complaint alleging concerns with behavior management services for Resident 5. During an interview at 8:51 AM, Administrator C said they separated employment with Executive Director A on 09/09/2024 after discovering s/he was not effectively managing oversight of the facility. Administrator C said since Executive Director A left, s/he had been more involved in the day to day oversight and operations of the facility.

During the course of the 10/07 complaint investigation, Surveyors identified ongoing concerns with ISP updates specific to Resident 5's behavior management needs and new

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N 214	Continued From page 8 concerns with Administrator C's response to injuries of unknown origin sustained by Resident 5 between 09/13/2024 and 10/07/2024. As a result, 3 additional deficiencies were identified (not including this deficiency.) On 10/08/2024 at 3:14 PM, Surveyor interviewed Resident 5's family member (Family X.) Family X described Administrator C as kind but expressed disappointment their frequent communication had not been "productive" and said ultimately Resident 5's needs were not met. Cross Reference: N0161 DHS 83.12(3)(a) Investigate Injuries of Unknown Source N0352 DHS 83.32(3)(h) Right of Residents: Receive Medication N0391 DHS 83.35 (3)(f) Staff Access to Assessment And ISP N0389 DHS 83.35(3)(d) Service Plan Updated Annually Or On Changes N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0400 DHS 83.37 (1)(a) Written Order for Medication, Supplements N0415 DHS 83.37 (2)(d) Documentation of Medication Administration N0432 DHS 83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management Y3244 Chapter 50.09(1)(l) Care	N 214		
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	N 352		

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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 and interview, the provider did not ensure all residents received all prescribed medications in the dosage and at intervals prescribed by the practitioner.

During July and August 2024, Resident 2 did not receive all doses of scheduled acetaminophen for pain.

During August 2024, Resident 5 did not receive prescribed risperidone used to treat anxiety and behaviors.

Findings include:

The Department received a complaint about medication administration.

RESIDENT 2:

On 08/07/2024 at 7:49 AM, Surveyors conducted an interview with Resident 2. Resident 2 told Surveyors s/he was "in pain." Resident 2 explained s/he has chronic lower back pain and s/he receives scheduled Tylenol (acetaminophen) to manage it. Resident 2 said it is "sometimes a little hit or miss" whether s/he receives the right medications at the right times and it "depends who is working."

On 08/15/2024 at 8:43 AM, Pharmacy Client Relations (PCR) J sent Surveyors an email containing signed, current medication orders for Resident 2. Surveyors noted the following:

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N 352	Continued From page 10 --Acetaminophen - 650 mg tablet, take one tablet by mouth every 6 hours for pain. Order date: 05/09/2024 Surveyors received and reviewed Resident 2's medication administration records (MARs) for July and August 2024 (received on 08/07/2024 from Executive Director (ED) A. --Acetaminophen: scheduled 4 times/day at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. JULY 2024: 30 of 31 days, one or more of the 4 daily doses were not documented as administered. 76 of 124 total doses were not documented as administered; charting for 38 doses were left blank, 32 doses were charted as held and 6 doses were charted as refused. Of the 32 doses charted as "held," reasons were documented on the following dates: 07/03 12:20 PM waiting on refill 07/05 12:23 PM not taken at this time 07/05 05:55 PM not taken anymore needs refills 07/08 12:17 PM needs new order 07/09 01:43 PM doesn't take at this time 07/12 06:10 PM not in cart 07/13 12:25 PM does not take 07/13 05:57 PM does not take 07/14 05:07 PM not taken at this time 07/14 11:17 PM not in med cart 07/15 01:49 PM reordered (author: ED A) 07/16 12:10 PM on order 07/18 02:21 PM does not take at this time 07/20 06:53 AM not scheduled med anymore 07/21 11:51 AM don't have 07/22 09:45 AM n.a. [sic] 07/22 01:12 PM n/a 07/23 08:42 AM n/a	N 352		

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07/23 08:44 AM n/a
07/23 03:41 PM n/a
07/23 03:47 PM n/a
07/27 02:08 PM n/a
07/28 01:09 PM n/a
07/30 11:00 AM not in cart (author: ED A)
07/30 11:07 AM not in cart (author: ED A)
07/30 11:10 AM not in cart (author: ED A)

Surveyors noted on 07/17/2024, the 12:00 PM and 6:00 PM scheduled doses of acetaminophen were charted as not administered. The same day, a PRN (as needed) dose of acetaminophen was administered at 8:40 PM with an associated pain level of 9 out of 10. On 07/19/2024, charting for the 06:00 PM dose was left blank and on the same day at 8:56 PM, a PRN dose was administered with an associated pain level of 9 out of 10.

Surveyors also noted an entry in the MAR notes on 07/22 at 5:12 PM (after missing 2 doses of scheduled acetaminophen) that read, "resident reported to staff that [s/he] is feeling to stiff to sit up for long period as well as having burning sensation in [his/her] legs]. staff offered prn..." [sic - all]

August MAR (08/01-08/07)

5 of 6 days one or more of the 4 daily doses were not documented as administered.
8 of 27 doses were not documented as administered; charting all 8 doses were left blank.

Surveyors reviewed Resident 2's MARs with ED A on 08/07/2024 at 2:43 PM and again on 08/19/2024 at 11:12 AM. ED A acknowledged Surveyor's review of the MARs and did not offer an explanation as to why Resident 3 was not

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receiving scheduled acetaminophen.

RESIDENT 5:

On 08/19/2024 at 8:20 AM, Surveyors observed Caregiver D administering medications for Resident 5. Caregiver D said, "[His/her] risperidone is not in the cart. Lately this place has issues not getting medications correct. It's been out of the cart since (at least) last night. [S/he] is supposed to get it two times/day...no one has checked the re-order button in PCC (Point Click Care - electronic record keeping system). Surveyors observed Caregiver D click the re-order tab. [Resident 5] has a lot of behavior issues, [s/he] gets violent in the nighttime. The last few days I heard [s/he] went downhill in behaviors. It's documented in [PCC]." Surveyors observed Caregiver D offer Resident 5 the other medications. Resident 5 told Caregiver D s/he hasn't been sleeping much.

Surveyors interviewed Caregiver E on 08/19/2024 at 9:46 AM. S/he said it was not uncommon for medications to be unavailable and added, "Today there were 3-4 residents where PCC is prompting to administer a medication that is not here...Not too long ago one of my co-workers made an entire list of medications that were missing...and gave it to management." At 10:31 AM, Caregiver E showed Surveyors documentation in PCC for Resident 5. Surveyors reviewed 3 notes regarding Resident 5's behaviors:

08/14 at 5:50 AM: "...[Resident 5] really needs some type of medication that will clam [him/her] down when its not time it hard to get [him/her] to do anything [s/he] uses profanity all around the other residents. Two of the residents are complaining about [him/her] and [his/her]

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HIGH POINT RESIDENCE GERMANTOWN SOUTH	W150 N11127 FOND DU LAC AVE GERMANTOWN, WI 53022

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behavior at night time very confused at night." [sic - all]
08/17 at 10:31 AM: "I do not see any morning medication for [Resident 5] and where is [his/her] Narc count sheet"
08/18 at 11:31 AM: "[Resident 5] is being very combative this morning [s/he] is being aggressive with staff and residents with using curse words. [S/he] was given all of [his/her] morning medication and and [s/he] is still not listening to staff when given directions. One of our [other] residents touched [Resident 5]'s leg and [Resident 5] hit [the other resident] with [his/her] news paper. [S/he] was asked to stop and for [him/her] to lay down if [s/he] is still tired. [S/he] has been walking around the building drowsy almost falling down, touching all the clean dishes that are set on table and using bad words thru out the building while guest are here. [S/he] is just so busy and [s/he] cant be still. [S/he] needs something that can add on to [his/her] behavior like [his/her] PRN every two as needed for [his/her] behavior and [his/her] medication were given on time Most of the residents want there door to be locked and they are not welling wanting to come out there room if [s/he] is out in the dining area." [sic - all]

On 08/19/2024 at 11:12 AM, Surveyors interviewed ED A and asked about the risperidone that was unavailable. S/he replied, "That was on [his/her] psych doctor (Nurse Practitioner I) . I was in communication...I did tell [Nurse Practitioner (NP) I] [Resident 5] needed refills... [s/he] saw [him/her] Thursday (08/15/2024) and one of [his/her] behaviors. So Friday (08/16/2024) I looked in the PCC in the (pharmacy) portal and I saw they were going to deliver the 16th...because [NP I] sent in refills." Surveyor asked ED A what transpired next as the medication was not

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available during the morning medication pass today (Monday.) S/he replied, "I would have to contact [the pharmacy]."

On 08/22/2024 at 11:11 AM, ED A provided Surveyors with portions of Resident 5's records to include his/her face sheet, individual service plan (ISP) and MARs. Resident 5's face sheet listed 2 diagnoses, anxiety disorder and hypertension. The ISP last updated 06/18/2024, described Resident 5 as forgetful, combative, prone to wandering and exhibiting "emotional or behaviors outbursts." It read, "Psych NP oversees medications." The ISP did not list any other diagnoses that would contribute to the behaviors.

Resident 5's August Mar (08/01-08/22) documented the following:
Risperidone .25 MG tablet start date 06/17/2024 - "Take 1 tablet by mouth every 12 hours. Discontinued 08/20/2024.
Risperidone .50 MG tablet start date 08/20/2024 - "Take 1 tablet by mouth 2 times a day

Between 08/01 - 08/22 the MAR documented the following dates when the medication was not administered. ED A did not provide Surveyors with the complete MAR to include reasons why medications weren't given.
08/01 AM
08/02 PM
08/05 PM
08/07 PM
08/08 AM
08/11 PM
08/17 PM
08/18 PM
08/19 AM & PM
08/20 AM

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N 352	Continued From page 15 Beginning with the PM dose on 08/20 the medication was administered as scheduled. 08/22/2024 11:11 AM, ED A provided documentation of communication between ED A and NP I to show his/her efforts to ensure Resident 5's medications were available: 07/08 - NP I to ED A "I escribed [sic] the med changes and the script under your door....I will be back 8/14 however call me if [Resident 5] is not improving in 2 weeks I can increase [his/her] med olanzapine I changed it to once/day." [sic - all] 08/13 - ED A to NP I "Can we please get a refill of Olanzapine..." [sic] 08/14 - NP I to ED A "I will be there early afternoon so I will do it then." EDA replied, "I may or may not be here when you come, but [Resident 5] also needs a refill on [his/her] Risperidone." [sic] 08/15 - ED A to NP I, "Were you able to come yesterday? [Resident 5] had an incident...was cursing at staff as well as throwing things. It took about an hour to get [him/her] to calm down. Staff could not figure out what triggered [him/her] or why [s/he] was so upset." 8:19 PM - NP I to ED A, "I can call today, left message on your phone last night. made changes for [Resident 5]...with Picks disease (type of frontal lobe dementia)...can be complicated...I escribed the med changes...call my cell if you need something more urgent for the future..." ED A noted for Surveyors, "More communication that was followed up by 2 phone calls." On 08/22/2024 at 11:31 AM, Surveyor sent an email to ED A and wrote at 12:02 PM, "I am interested in knowing the details of the 2 phone calls that occurred after 08/15/2024 at 8:19 PM, including dates/times of the calls and who you	N 352		

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spoke with. Thank you." ED A replied at 12:02 PM, "First phone call Friday was with [NP I] and second one was Monday (8/19/2024) with [NP I] regarding [Resident 5's] medications and that [pharmacy] did not receive [his/her] Risperidone [sic] refill yet."

Surveyor noted this response was inconsistent with the information provided during Surveyor's interview with ED A on 08/19/2024 at 11:24 AM when s/he stated s/he did not do follow up on Friday 08/16 because the refill and anticipated delivery was in PCC. S/he also stated s/he had not done any other follow up on Monday 08/19 as of the time of the interview.

On 08/21/2024 at 8:34 AM, Surveyors sent an email to PCR J and inquired about prescribed risperidone. PCR J replied at 10:12 AM, "...facility was notified on 7/31/2024 that there was no refills and they would currently have medications through 8/16/2024. We received a escript on 8/19/2024 (attached). The medications was filled on the 20th and sent..." [sic - all] PCR J attached the signed order for risperidone, prescribed 08/19 at 4:39 PM (after Surveyors' interview with ED A on the same day.)

While reviewing Resident 5's MAR for the risperidone, Surveyors also noted concerns with other prescribed psychotropic medications, including olanzapine.

Olanzapine
10 mg tablet scheduled daily at bedtime for "behavior problem"
documented as administered 08/01-08/09; not administered 08/10 - 08/15
15 mg tablet was entered as a new prescription on the MAR, start date 08/16

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N 352	Continued From page 17 documented as not administered on 08/16 and 08/19 On 08/22/2024 at 4:16 PM, PCR J emailed Surveyors information about the olanzapine prescriptions: On 07/09/2024, the 10 mg dose was ordered and 30 doses were delivered to the facility on the same day. There was enough medication to last only until 08/07/2024. On 08/16/2024, "We sent (attached order) 15 doses of Olanzapine 15 mg ...1 dose for the night of the 16th and 14 doses for their (new 2 week) cycle which started on 08/17/2024." . Surveyors noted in the aforementioned email communication between ED A and NP I, ED A did not request a refill of the original dose of olanzapine until 08/13/2024, 5 days after the supply would have run out. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0433 DHS 83.38(1)(i) Behavior Management	N 352		
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	N 389		

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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 observation, record review and interview, the provider did not ensure Resident 5's individual service plan (ISP) was updated based on assessment to identify needs and interventions for fall prevention or aspiration risk.

Resident 5 was prescribed medications that increased his/her risk for falls, s/he experienced unwitnessed falls and a had a tendency to self-transfer to the ground and crawl. The ISP was not updated based on assessment to identify the fall risk or interventions to prevent falls.

Resident 5 experienced at least 2 incidents of aspiration (food or liquid entering the airway.) In response, on 09/24/2024 hospice ordered nectar thick liquids and mechanical soft food to prevent the risk of aspiration. Resident 5's ISP was not updated to identify the risk of aspiration or associated interventions.

Findings include:

On 08/07/2024 at 7:45 AM, 08/19/2024 at 8:30 AM and other times throughout the course of both days, Surveyors observed Resident 5 ambulate and wander throughout the facility. Surveyors attempted to engage in conversation with Resident 1 during both visits and observed s/he was confused, but verbal.

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N 389	Continued From page 19 On 08/22/2024 at 11:11 AM, Administrator C provided Surveyors with portions of Resident 5's records to include his/her face sheet, email correspondence with psychiatric nurse practitioner (NP I) August 2024 medication administration records (MARs) and ISP. Resident 5 was admitted on 05/28/2024. S/he was under the age of 60. Resident 5's facility records listed two diagnoses of anxiety and hypertension, but email communication NP I noted Resident 5 also had a form of dementia. Resident 5's August MARs listed prescribed medications to include scheduled: olanzapine, risperidone, divalproex, quetiapine and lorazepam. Surveyor noted olanzapine, risperidone and quetiapine are classed as antipsychotic medications and have possible side effects of change in walking and balance (olanzapine), loss of balance control (risperidone) and dizziness and increased confusion (quetiapine). Divalproex which is classed as an anticonvulsant has side effects to include trouble walking and poor judgement. Lorazepam, which is a benzodiazepine, is noted to have side effects to include dizziness and unsteady walk. All the possible side effects of the above listed medications put Resident 5 at risk for falls. Surveyors returned to the facility on 10/07/2024, after receiving a complaint alleging concerns about the provider's response to falls and risk of aspiration. FALLS On 10/07/2024, Surveyors made the following observations: At 08:02 AM, Surveyors observed Resident 5 in a	N 389		

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high back wheelchair in the common area and s/he appeared to be sleeping. Between 08:02 AM and 08:45 AM three different caregivers tried to engaged Resident 1 but s/he was not responsive. Surveyors noted the change in condition was pronounced when compared to the August visits.
At 9:45 AM, Surveyor observed Resident 5 in his/her bedroom in his/her wheelchair unsupervised by staff. Resident 5 had shifted his/her bottom to the edge of the wheelchair and was holding on to the sides making rocking motions. It appeared as if s/he was attempting to stand. There was a blanket on the floor immediately in front of Resident 5's feet that presented a tripping hazard. Surveyor attempted to engage Resident 5 verbally, but s/he did not acknowledge Surveyor. Surveyor left the room in an effort to retrieve staff, but none were present in the common area or hallways. Surveyor returned to the room and Resident 5 remained in the same position still appearing as if s/he were about to stand. Surveyor again exited the room, saw Administrator C in the hallway and informed him/her Resident 5 needed assistance. Administrator C entered the room and told Surveyor this was normal for Resident 5 and sometimes s/he will even get down and crawl on the floor.
At 10:47 AM, Surveyor was in the hallway and observed Resident 5 on the floor on his/her knees by the couch in the common area, with Caregiver W. Administrator C and Caregiver O joined Surveyor to observe. Administrator C stated "Oh that's [Resident 5], [s/he] puts [himself/herself] on the floor and gets up". Caregiver O stated "we don't consider that a fall anymore".
At 11:30 AM, Surveyor observed Hospice RN Z sitting with Resident 5 on the couch in the common area. As Hospice RN Z stood up, Resident 5 scooted to the end of the couch.

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Hospice RN Z encouraged Resident 5 to "stay seated to stay safe" and told Surveyor s/he needed assistance looking for a caregiver to supervise Resident 5 as the visit was over and s/he was going to leave.

On 10/07/2024, Surveyors reviewed Resident 5's complete resident record and noted the following:

HOSPICE NOTES IN THE RESIDENT RECORD:
09/13/2024 - Admitted to hospice. Admission narrative, "...ambulating independently with shuffled gait. Family has noted that [Resident 5] now has to hold on to railings, and walls while walking. [Resident 5] is a high fall risk."
09/14/2024 - "...admitting to hospice care with a terminal diagnoses of Pick Disease (type of frontotemporal dementia.) Comorbidities include...chronic pain syndrome, osteoarthritis, dysphagia (difficulty swallowing)..."
09/14/2024 - "...(skilled nursing) visit...continue good supervision...meds increased...Risperidone 1 mg tab twice daily...Clonazepam 1 mg tab twice daily..." Surveyor noted clonzepam is a benzodiazapine and the risperidone dose doubled from the August prescription which was .5 mg twice daily.
09/23/2024 - "...was sleeping in wheelchair when RN arrived for routine visit...did not respond to tactile or visual stimuli."
09/25/2024 - "...was laying on floor when RN arrived for routine visit. Placed back in wheelchair...no injury from fall. Lethargic (with) minimal response...will order fall mat."

FACILITY INCIDENT REPORTS:
09/24/2024 9:00 AM - "Resident was laying on [his/her] left side upon entry looks as if [s/he] was trying to walk around and fell."
09/24/2024 3:30 PM - "I had just came don't really

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know what happened I seen a bump on [his/her] head has a scratch..."
09/29/2024 5:28 PM - "...was getting up out of [his/her] wheelchair walking and went to grab chairs and fall backwards." [sic]
09/30/2024 10:30 AM - "...was in common area and tried to get out of [his/her] wheelchair and dropped to [his/her] knees to try to crawl. Staff came over to help resident off the ground immediately and resident was able to help staff assist [him/her] off the ground."

HOSPICE NOTES - These notes were not in the resident record but provided to Surveyors from the hospice agency on 10/08/2024:
09/21/2024 at 3:47 PM : " ...Resident laying on bedroom floor upon arrival. Writer greeted [him/her] and sat on the floor next to [him/her]. Staff very adamant that Resident had not fallen but 'laid on the floor and refused to get up.' ..."
09/24/2021 at 7:52 PM : "PRN (as needed) visit for a fall, [Caregivers V and W] stated they were not told Resident had a fall today, CG (caregiver) from day shift stated Resident did not have a fall ..."
09/25/2024 at 9:42 AM : "Nurse entered Resident's room and found Resident on knees next to bed sleeping ...."
09/30/2024 at 1:51 PM : "[Caregiver O] & called to report Resident stood up from WC (wheelchair) then fell on buttocks ..."
10/01/2024 at 2:31 PM : "PRN visit for reported fall, Facility reports [s/he] didn't have a fall, that [s/he] gently put [him/herself] on the ground to lay down ..."

ISP: Surveyor reviewed Resident 5's ISPs provided 08/22/2024 by ED A and an updated version located in the record on 10/07/2024 and noted the following:

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N 389	Continued From page 23 Transfer Abilities: 06/18/2024 - Independent - no concerns. Updated 09/16/2024 - "staff to (assist with) walking. Offer walker or w/c (wheelchair.)" Assist of 1 staff for transfers. Adaptive Equipment: 06/18/2024 - None required. Updated (date not identified) - "staff to (assist with) walking due to unsteady gait." "Emotional Behavior" (undated note on back of ISP) - "...has been witnessed that resident will get out of w/c on [his/her] own and will crawl around on floor and then will get [him/herself] back up. These are not falls." The ISP did not document: Resident 5's risk of falls due to medications Resident 5's risk recent history of unwitnessed falls or interventions to prevent falls Potential risks associated with Resident 5's self-transferring to the ground and crawling or interventions to prevent and/or supervise the behavior to avoid injury Surveyor also noted the only assessment in the file was dated 06/04/2024. On 10/07/2024 at 2:48 PM, Surveyors interviewed Administrator C. S/he acknowledged Resident 5 had experienced unwitnessed falls. S/he said hospice had implemented the use of a fall mat and just today added bed/chair alarms. Administrator C confirmed the ISP did not contain information specific to the risk of falls, the recent unwitnessed falls or interventions to prevent falls. Administrator C said s/he added the note on the back of the ISP about self-transferring or crawling and agreed it did not include information about the risks of or interventions in response to self-transferring or crawling.	N 389		

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N 389	Continued From page 24 ASPIRATION RISK While reviewing the aforementioned records, Surveyor noted the following: From Resident 5's facility record: 09/23/24 hospice visit note: ""PRN visit for aspiration. Unable to tolerate anything by mouth tonight...heavy mucus in throat and mouth. Plan: start: nectar thick liquids mechanical soft diet..." Surveyor note: "What is a mechanical soft diet? This diet is designed for people who have trouble chewing and swallowing. Chopped, ground and pureed foods are included in this diet, as well as foods that break apart without a knife." Source: https://patient.uwhealth.org/healthfacts/363, retrieval datea 10/09/2024. "Mildly Thick (equivalent to nectar thick) drinks may be used if Thin drinks (water, milk, and others) and Level 1 Slightly Thick liquids flow too quickly for you to swallow them safely. Some milk shakes and thick shakes may be this thickness level already, but other drinks may need thickener added to reach the correct thickness level...Mildly Thick drinks flow at a slower rate..." Source: https://www.iddsi.org/IDDSI/media/images/ConsumerHandoutsAdult/2_Mildly_Thick_Adults_consumer_handout_30Jan2019.pdf, retrieval date 10/09/2024 From the documents provided by hospice: 09/24/2024 12:22 AM: "PRN visit due to reports from family that [Resident 5] has aspirated ...Large amounts of sputum and mucus in throat causing [Residing 5] to have a grating sounding voice ...Coughs on any attempts of intake	N 389		

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HIGH POINT RESIDENCE GERMANTOWN SOUTH	W150 N11127 FOND DU LAC AVE GERMANTOWN, WI 53022

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N 389	Continued From page 25	N 389		

including crushed medications. Tracheal congestion and rhonci heard to mid and upper lobes diminished to left and lower lobes ...Nectar thick liquids with mechanical soft diet..."
09/24/2024: "Hospice Physician Order...nectar thick liquids - mechanical soft diet - pleasure food as tolerated."
09/29/2024 7:49 PM: PRN skilled nursing visit due to change in condition. The nurse noted Resident 5 was unable to "...drink any liquids. One small sip and aspiration begins...[Caregiver] stated [s/he] could not find any thickener or thick liquids to give [Resident 5]."

ISP:
Eating: updated 09/16/24 - "Staff to (assist) resident (with) feeding Resident no longer able to do on own."

The ISP did not document:
the diagnoses of dysphagia as identified in the hospice records on 09/14/2024
the incidents of aspiration or interventions to prevent, monitor or respond to aspiration
the hospice order for thickened liquids and mechanical soft food

Surveyor also noted the only signature on the ISP from Resident 5's POA (power of attorney - legal representative) was on 06/18/2024 when the comprehensive ISP was first developed. The ISP contained the aforementioned updates in September and post it note which read, "Scanned to family for signature." At approximately 11:20 AM on 10/07/2024, Administrator C said s/he made the September updates to the ISP and emailed it to POA Y for review and signature. Administrator C said s/he would look for the email to provide to Surveyor.

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N 389	Continued From page 26 During the aforementioned interview with Administrator C at 2:48 PM, s/he stated the following: S/he was not able to locate an email or other evidence that Resident 5's POA was informed of revisions to the ISP after 06/18/2024. S/he was previously unaware of the 09/24/2024 written documentation in the record from hospice regarding the order for nectar thick liquids and mechanical soft food, therefore no changes were made to the ISP. S/he did obtain any written care plans from hospice even though their process is to maintain a facility ISP that incorporates the hospice care plan. On 10/08/2024, Surveyor contacted Family X who said s/he works closely with POA Y to coordinate Resident 5's care. Family X expressed frustration with Resident 5's care at the facility in the areas of fall prevention and aspiration risk. Family X did not recall any communication from the provider regarding revisions to the ISP, but said s/he would ask POA Y. On 10/08/2024 at 8:25 PM, POA Y left Surveyor a voice mail and said s/he did not receive email or other communication regarding the September revisions to the ISP. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0433 DHS 83.38(1)(i) Behavior Management	N 389		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan.	N 391		

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N 391	Continued From page 27 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure all staff who provided resident cares and services had continual access to residents' individual service plans (ISPs). Findings include: On 08/07/2024 1:47 PM, Surveyors asked Executive Director (ED) A, how care staff were aware of resident care needs. ED A explained care needs are documented in ISPs which are kept in a binder stored in an office. S/he also stated "care cards" were posted in all resident rooms. Surveyor checked for care cards in Residents 1, 4 and 6's room. The only room with a care card was Resident 1. Surveyor noted the card did not contain all information required to be in ISPs and did not contain signatures. Surveyor shared his/her observations with ED A. ED A stated s/he didn't know why the cards were not in the rooms. ED A also informed Surveyors the provider switched their electronic record keeping system from ECP (Extended Care Professionals) to PCC (Point Click Care) in March of 2024. S/he said PCC was only utilized for medication records, not for ISPs. On 08/07/2024 at 3:23 PM, ED A provided Surveyors the ISP binder. Surveyors reviewed the binder for Resident 2 and Resident 4's ISPs. Resident 2's was not in the binder. Resident 4's was in the binder, with a signature sheet dated 11/27/2023, but the attached 6 page ISP form was completely blank.	N 391		

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Surveyors informed ED A of the record review. ED A stated it was possible Administrator C had Resident 2's ISP as s/he was auditing ISPs. ED A also thought it was possible Resident 4 had a temporary ISP somewhere in the building, but s/he looked and could not find it.

On 08/08/2024 at 2:03 PM, ED A emailed Surveyors a copy of Resident 2's ISP dated 06/24/2024 and Resident 4's "Initial Assessment - Individual Service Plan" printed 11/27/2024. Surveyor noted Resident 4's ISP was printed from ECP, which had not been in use since March of 2024.

On 08/19/2024 at 9:05 AM, Surveyors interviewed Administrator C. S/he confirmed Resident 2's ISP had been in her desk drawer since 06/24/2024 and as such was not available to caregivers.

On 08/19/2024, Surveyors interviewed Caregiver E at 9:46 AM and Caregiver F at 10:50 AM.

Surveyors asked Caregiver E how s/he accessed ISPs. Caregiver E stated cares are documented in PCC or on care cards posted in resident bathrooms. Caregiver E stated s/he had never seen the aforementioned ISPs binder. Caregiver E said s/he is considered a PRN (as needed) staff member and sometimes s/he is unfamiliar with resident care needs. Caregiver E said s/he relies on residents to inform him/her "what they prefer and need. " At the conclusion of the interview, Caregiver E attempted to show Surveyors Resident 1 and Resident 2's cares in PCC, however cares were not entered for either resident.

Caregiver F told Surveyors s/he was also a PRN

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N 391	Continued From page 29 caregiver filling in today after scheduled caregivers did not show up. Caregiver F said s/he learns about the care needs of residents by looking for copies of care cards in their bathrooms or just asking another caregiver. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations Y3244 Chapter 50.09(1)(l) Care	N 391		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain written schedules during July and August 2024 to include each employee's full name or actual times worked. Findings include: On 07/08/2024, the provider submitted a self-report describing an incident on 07/06/2024. According to the report, Caregivers P and Q were working during day shift on 07/06/2024. On 08/07/2024, Surveyors conducted an onsite visit to the facility. Surveyors arrived at 7:35 AM and were greeted by Caregivers H and L. They stated they worked the overnight shift the night before (7:00 PM to 7:00 AM) but were staying over to cover day shift due to call ins. Surveyor	N 399		

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N 399	Continued From page 30 observed Caregiver L worked until at least 8:30 AM and Caregiver H worked until at least 11:15 AM. Upon request on 08/16/2024, Executive Director A provided Surveyors with staff schedules for July and August 2024. Surveyors noted: The July schedule did not document that Caregiver P and Q worked on 07/06/2024. The August schedule did not document Caregivers H and L worked a portion of the day shift on 08/07/2024. Neither scheduled included last names of the caregivers. On 08/19/2024 at 9:05 AM, Surveyors interviewed ED A. S/he confirmed the schedules did not include the full names of caregivers and was not accurate for 07/06/2024 and 08/07/2024. ED A said, "If someone were to pick up last minute, I don't go back and change it." Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations Y3244 Chapter 50.09(1)(l) Care	N 399		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident.	N 400		

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This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure written practitioner orders were maintained for all prescribed and over the counter medications administered to residents.

On 08/07/2024 and 08/19/2024 the provider did not maintain written practitioner orders for Resident 1 and Resident 2's medications that were managed and administered by the provider.

Findings include:

On 08/07/2024 at 1:47 PM, Surveyors reviewed Resident 1 and Resident 2's medication administration records with Executive Director (ED) A and s/he acknowledged the provider managed and administered medications for both residents. Surveyors requested signed practitioners' orders for medications for both residents. ED A replied, "Signed orders go directly to the pharmacy and are in PCC (electronic record keeping system with a shared pharmacy portal.) It's very rare that we do get a signed order. They (practitioners) just e-scribe all medications to [the pharmacy], we are not the middleman." ED A added, "I could get them for you but it would take a while."

On 08/14/2024 at 11:24 AM, Surveyors interviewed Pharmacy Client Relations (PCR) J. S/he said the provider contacted them after concerns were identified by Surveyors on 08/07/2024. As a result there was "an extensive in house meeting" on 08/13/2024." PCR J said s/he educated the provider that copies of orders are sent to them when the medication is delivered. In addition, orders "have always been

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N 400	Continued From page 32 available to them" through the PCC portal. PCR J said during the meeting it came to light their previous nurse had all the login information and did not leave that information with current management when his/her employment ended. On 08/19/2024 at 3:45 PM, Surveyors conducted another interview with ED A. S/he stated there had been meetings with the pharmacy since 08/07/2024 but they were still unable to access the orders in PCC. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0432 DHS 83.38(1)(h) Medication Administration	N 400		
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 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, the provider did not ensure staff accurately	N 415		

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documented the time of medication administration for Resident 2's prescribed carbidopa-levodopa. In addition, the provider did not maintain records of medication administration times for all medications administered to Resident 1 and 2 dating back to 07/01/2024.

Findings include:

The Department received a complaint alleging concerns with documentation of medication administration.

EXAMPLE 1:

Upon request on 08/07/2024, Executive Director (ED) A provided Surveyors a copy of the provider's medication management policy. It read in part, "Documentation of medication administration. As required under DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment will document in the resident record the name, dosage, date and time of medication taken or treatments preformed and initial the medication administration record..."

On 08/07/2024 during an interview with Resident 2 at 7:49 and while observing a medication pass for Resident 1 at 9:02 AM, Surveyors observed concerns with medication administration and documentation. Surveyors also observed medication records were maintained electronically through a system called PCC.

On 08/07/2024 at 10:02 AM, Surveyors requested PCC access from Executive Director A in order to review resident records for medication administration. ED A initially stated s/he would create a login for access but subsequently told

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Surveyors the corporate office said that would not be allowed. ED A said instead s/he would print the records Surveyors needed.

Upon request at 12:10 PM, ED A provided Surveyors printed medication administration records (MARs) for Residents 1 and 2 dating back to 07/01/2024. Surveyors noted the records did not include documentation to show the time the medication was administered. ED A stated s/he was unable to provide documentation of medication administration times based on his/her current access to PCC but s/he would see if s/he could access the information. At 2:05 PM, ED A provided administration times for some of Resident 1 and Resident 2's medications. The documentation only went back to 07/23/2024. ED A said s/he was unable to provide documentation of administration times prior to 07/23/2024. During a return visit to the facility on 08/19/2024 at 9:05 AM, Surveyors again requested documentation of administration times for Resident 1 and Resident 2 dating back to 07/01/2024. ED A said s/he was still unable to provide the documentation.

EXAMPLE 2:

On 08/07/2024 at 9:02 AM, Surveyors observed Caregiver B prepare to administer Resident 1's morning medication. While reviewing PCC, Caregiver B commented there was a duplicate entry for hydrocortisone prompting for both 1.5 tablets and 1 tablet. Caregiver B said s/he just administers the tablets as they are packaged by the pharmacy. Surveyor observed Resident 1's 9:00 AM medication package contained hydrocortisone and 2 other medications. The dosage of hydrocortisone on the label was 1.5 tablets. Caregiver B administered the medications

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from the package.

Surveyor received and reviewed Resident 1's signed medication orders for hydrocortisone from Pharmacy Client Relations J at 2:54 PM on 08/14/2024.
10 mg tablet - 1.5 tablets once a day in the morning
10 mg tablet - 1 tablet once a day in the evening

On 08/07/2024, ED A provided Surveyor with Resident 1's medication administration record (MAR). As observed during the medication pass, the MAR instructed caregivers to administer more medication than was ordered. The instructions read:
10 mg - give 1.5 tablet by mouth two times a day scheduled at 9:00 AM and 8:00 PM
10 mg - give 1 tablet by mouth two times a day scheduled at 9:00 AM and 8:00 PM

For 31 out of 31 days in July, caregivers charted 2.5 tablets were given in the morning for the 9:00 AM dose and for 12 of 31 days caregivers charted 2 tablets were also given at bedtime.

On 08/19/2024 at 9:01 AM, Surveyors observed Resident 1's medication in the medication cart. Medications came packaged from the pharmacy in "strip packaging." The medications were sorted and labeled in individual packages based on time, date and dose.(e.g. the first package in the strip contained morning medications, the next package mid-day medications, etc.) When multiple medications were ordered at the same time, they were combined in one package. Surveyor observed the "evening" dose of Resident 1's hydrocortisone (1 tablet) was packaged and labeled by the pharmacy for administration at 4:00 PM along with 3 other medications in the

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same package. The next package in the strip contained "bedtime" medications scheduled for 8:00 PM and did not contain hydrocortisone.

Surveyors interviewed PCR J. S/he said the pharmacy only dispensed enough medication to satisfy the order during each cycle refill, so the facility would not have had enough medication supply to administer more than was ordered. S/he also described concerns if the facility did not ensure administration times in PCC were consistent with the packaging, it would create a situation prone to errors with administration and documentation.

During an interview with Caregiver E on 08/19/2024 at 9:46 AM, s/he said the discrepancies between administration times scheduled in PCC and administration times on the medication packaging were a persistent problem. Caregiver E said his/her practice is to administer the medications according to the time on the package and then document the time when it is prompted in PCC. S/he did not provide information about how administration would be documented when s/he worked 1st shift and administered a 4:00 PM medication, but the PCC prompt was at 8:00 PM when different caregivers were working during night shift.

Surveyors again reviewed the July 2024 MAR specific to the evening dose of hydrocortisone, scheduled for 8:00 PM.
17 of 31 days caregivers charted the medication was not given
Of those 17 days, 13 days it was charted medication was not available.
Examples of the charting include, "duplicated med", "not in med cart!!!!", "not present", "meds not present!!!" and "meds are not in med cart!!!!"

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N 415	Continued From page 37 On 08/19/2024 at 11:03 AM, Surveyors interviewed ED A and Administrator C. Surveyors identified concerns regarding medications packaged for 4:00 PM administration but the PCC prompt for administration was not until 8:00 PM. Surveyors noted the potential that day shift would administer the medication at 4:00 PM, not chart it, and then at 8:00 PM during night shift, caregivers would either document they administered it when they didn't, or document that it was unavailable. Surveyors also reviewed concerns caregivers were charting inaccurately based on PCC/MAR prompts for more medication than was ordered or available. ED A and Administrator C acknowledged the concerns. EXAMPLE 3: Surveyors reviewed Resident 5's August 2024 MAR on 08/22/2024 and noted the following: --Olanzapine 10 mg tablet scheduled daily, start date 07/09/2024 (no end date). The medication was documented as administered as follows: 08/01-08/09, 08/16-08/17 and 08/21 --Olanzapine 15 mg tablet scheduled daily, start date 08/16/2024. The medication was documented as administered as follows: 08/17, 08/18, 08/20 and 08/21 On 08/22/2024, Surveyors emailed PCR J and wrote, "We noticed that [Resident 5] had an increase in Olanzapine on the 16th of this month. [S/he] was on 10mg and then there was a new order to start 15mg. Was the 10 mg order discontinued on 8/16?...it is documented on the EMAR (electronic MAR) that [s/he] is currently receiving both doses."	N 415		

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N 415	Continued From page 38 PCR J replied, "The olanzapine 10mg was only dispensed for 30 doses on 07/09/2024..." PCR J noted based on that the medication supply dispensed, the 10 mg tablets should have ran out on 08/07/2024. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Right of Residents: Receive Medication Surveyor: Hall, Nichole J. Surveyor: Cadiramen, Krishan A	N 415		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by:	N 432		

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Based on observation, interview and record review, the provider did not ensure the provision of medication administration appropriate to residents' needs.

The provider did not ensure the electronic medication management system prompted for administration of medications at times consistent with practitioner's orders.

The provider did not ensure residents received the supervision they needed during medication administration. Caregivers left medications with residents without observing whether or not they ingested them. In addition, medications were left in resident rooms without obtaining a practitioner's order to ensure it was safe for the resident to self-administer.

The provider crushed and administered medications without ensuring the medications were safe and effective if crushed.

Findings include:

The Department received a complaint alleging concerns with medication administration.

EXAMPLE 1: medication administration times

On 08/07/2024 at TIME and 08/19/2024 at 9:00 AM, Surveyors observed caregivers administer medications. Surveyors noted the following:
The provider utilized an electronic medication administration system (PCC) which prompted caregivers to administer medications at scheduled times.
Medications came packaged from the pharmacy in "strip packaging." The medications were sorted and labeled in individual packages based on time

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and date (e.g. the first package in the strip contained morning medications, the next package mid-day medications, etc.) When multiple medications were ordered at the same time, they were combined in one (or more) packages for administration at the same time.
There were discrepancies (Resident 2 example below) between scheduled administration times in PCC and administration times on the medications packaged and labeled from the pharmacy.

During an interview with Caregiver E on 08/19/2024 at 9:46 AM, s/he said the discrepancies were a persistent problem and thought it was due to "management putting it in the system incorrectly." Caregiver E said his/her practice is to administer medications according to the pharmacy labeling. S/he explained, "I personally follow the package because I trust the pharmacy is more accurate than our system because there are issues with our system and it's fairly new." Caregiver E provided an example; if a medication is scheduled in PCC for 12:00 PM but the time on the packaging is 4:00 PM, s/he will chart the medication administered at 12:00 PM consistent with PCC schedule but then administer it at 4:00 PM according to the instructions on the package. Caregiver E said s/he could not be sure if other staff were administering according to the time in PCC or the time on the package. Caregiver E stated this is a concern that has been brought to ED A's attention by staff in the past and as recently as 3 weeks ago, a co-worker made a detailed list of all the discrepancies and provided it to ED A. Caregiver E said the issues were still not rectified.

Surveyor noted based on the information provided by Caregiver E, the documentation of administration the medication administration

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record (MAR) would not be a reliable representation of the time the medication was given.

Surveyors interviewed ED A on 08/07/2024 at 2:43 PM. ED A acknowledged some discrepancies between the PCC schedules and orders. ED A said the scheduled times were generated by the pharmacy when they entered the orders and ED A was instructed by their corporate office not to make changes. ED A did not describe any steps s/he had taken to rectify the discrepancies.

Surveyors interviewed Pharmacy Client Relations (PCR) J on 08/14/2024 at 11:24 AM. She said when the pharmacy receives a medication order, they enter it in the PCC and, "When they (the provider) accept the order they accept the time the pharmacy associated with that drug. Or they can adjust it. We obviously tell them never to adjust it because then it doesn't match the packaging" which is labeled with times consistent with the order. PCR J did not describe any efforts from the provider to resolve discrepancies between the PCC administration schedule and the administration times on the packaging prior to 08/07/2024. PCR J said after Surveyors were onside, there was a meeting on 08/13/2024 and pharmacy staff tried to educate the provider on the system.

On 08/19/2024 at 11:12 AM Surveyors conducted a follow up interview with ED A and Administrator C was also present. Surveyors reviewed concerns about the PCC administration times that were in conflict with orders. ED A responded, "That's not us, that's the pharmacy. Our PCC (schedule) is pharmacy initiated." ED A said there have been problems with schedules in PCC since

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they started using it in March of 2024 and confirmed s/he has received complaints from caregivers about it. Surveyor asked what steps have been taken with the pharmacy to address the problem. Administrator C responded, "We do have a meeting with [the pharmacy] again tomorrow to resolve."

Resident 2: Surveyor reviewed portions of Resident 2's facility record provided by ED A on 08/07, 08/08 and 08/21/2024. The documentation included July and August 2024 MARs (through 08/07) and the ISP. According to the documents, Resident 2 had diagnoses to include Parkinson's disease and relied on staff to administer all medications.

Surveyors received medications orders from PCR J on 08/15/2024 at 8:43 AM:
--Carbidopa/Levodopa - 25/100 mg, take one tablet by mouth morning, noon and evening 8:00 AM, 2:00 PM and 8:00 PM. Order date: 06/10/2024

Surveyor observed the pharmacy packaging and labeling of the medications on 08/19/2024 at 9:44 AM and it was consistent with the times as ordered by the prescriber:
--8:00 AM dose packaged alone
--2:00 PM dose packaged alone
--8:00 PM dose packaged with 2 other medications scheduled for the same time

July and August (08/01-08/07) MARs:
--Carbidopa/Levodopa: "instructions" mirrored the order for administration at 6 hour intervals at 8:00 AM, 2:00 PM and 8:00 PM.
--However, the scheduled administration times on the MAR were 9:00 AM, 12:00 PM and 4:00 PM.

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N 432	Continued From page 43 Surveyor note: the provider operates with twelve hour shifts running 7:00 AM - 7:00 PM and 7:00 PM to 7:00 AM. The 4:00 PM dose scheduled in PCC during day shift was packaged with other 8:00 PM medications administered during night shift. Surveyors reviewed the MARs specific to the 4:00 PM dose. Thirteen times it was documented as not administered. The associated notes underscored concerns with the scheduling of the medication: 07/05 - 5:54 PM n/a take it at 2 07/08 - 5:37 PM does not have in cart 07/09 - 5:46 PM n/a 07/16 - 5:00 PM on order 07/17 - 12:06 PM given at 2 07/17 - 6:35 PM n/a 07/18 - 5:58 PM n/a 08/04 - 11:28 AM not in med cart 08/04 - 4:59 PM schedule at a different time On 08/26/2024 at 1:00 PM, Surveyors conducted an exit interview with ED A and Administrator C. Administrator C confirmed the risks associated with medication administration and documentation when medications were scheduled during day shift but ordered and packaged for administration during the night shift. ED A said the facility contracts with Registered Nurse M, but s/he only works 16 hours/week and time is shared with 2 other facilities in the company. S/he said RN M's responsibilities included medication cart audits but agreed s/he did not identify the aforementioned concerns. ED A said after Surveyors' 2nd visit on 08/19/2024, s/he began auditing the medication cart twice a week. Administrator C said they had not yet resolved	N 432		

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N 432	Continued From page 44 their reported issues with the pharmacy and electronic transfer of prescriptions. NOTE: According to the National Library of Medicine, "Patients with Parkinson's disease require strict adherence to an individualized, timed medication regimen of antiparkinsonian agents. Dosing intervals are specific to each individual patient because of the complexity of the disease. It is not unusual for patients being treated with carbidopa/levodopa to require a dose every one to two hours. When medications are not administered on time and according to the patient's unique schedule, patients may experience an immediate increase in symptoms. Delaying medications by more than one hour, for example, can cause patients with Parkinson's disease to experience worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating..." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5737245/, retrieval date 08/27/2024. EXAMPLE 2: supervision of medication administration Resident 2 - On 08/07 at 7:50 AM, Surveyors interviewed Resident 2. S/he said s/he has Parkinson's and staff are responsible for [his/her] medication management. Surveyors asked Resident 2 if staff observe [him/her] take medications or if they leave medications in the room for him/her to take later. Resident 2 stated, "They are all over the map on this one. Sometimes it seems the person passing the meds is busy on the phone with personal issues...there is some, the rare person, who will tell you what each pill is for, which is what I've been trying to get them to do here. Don't just hand me a cup with 4 pills, hand me a cup and	N 432		

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tell me what pills are in there and for what purpose.. I used to supervise a CBRF I know what they're supposed to do with meds ... They mean well. They're not wanting to do it poorly it just takes an accident to have a problem."

During an interview with ED A on 08/07/2024 at 2:10 PM, s/he described Resident 2 as an accurate reporter. ED A states "When you talk to [him/her] s/he's pretty sharp... "

Resident 4 - On 08/07/2024 at 8:23 AM while breakfast was being served, Surveyors observed Caregiver L give Resident 4 his/her medication cup at the dining table and walk away. Surveyors observed Resident 4 consume the medications without staff present.

On 08/07/2024 at 8:40 AM Surveyors interviewed Resident 4 in his/her room. Resident 4 said staff help him/her with medications. Surveyors observed an empty medication cup in the bathroom and at bedside. Resident 4 stated sometimes caregiver wait for him/her to take his/her pills but other times they leave for him/her to take later and added, "it depends." Surveyors also observed over-the-counter (OTC) pain relieving gel in Resident 4's room and Resident 4 said s/he administers the gel him/herself.

Surveyors reviewed Resident 4's current individual service plan (ISP) on 08/08/2024. ISP signed by ED A on 11/27/2023. The ISP read, "Resident is dependent on staff for medication management."

On 08/07/2024 at 3:18 PM, ED A accompanied Surveyors to Resident 4's room. ED A confirmed Surveyors observations of the empty pill cups and pain gel which remained in the room. ED A

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removed the pain gel from the room and told Resident 4 s/he would need to get an order to keep them at bedside.

Resident 1 - On 08/07/2024 at approximately 9:15 AM, Surveyors interviewed Resident 1. S/he told Surveyors caregivers usually leave the pills in the room with the breakfast tray and come back later to collect the pill cup. Resident 1 went on to say that certain caregivers go by the rules and others don't.

During the interview, Surveyors observed Resident 1 had 2 bottles of Icy Hot pain relief spray, a package of Biofreeze pain relief cream, a bottle of antacid tablets and a prescription albuterol inhaler on his/her bedside tables. Surveyors asked about the over-the-counter pain relieving products and s/he said, "I use whatever one I pick up. It is for...back pain." Resident 1 said sometimes the topical medications will "irritate my spine." Surveyors asked about the antacid tablets and s/he said s/he obtained them from his/her family member.

On 08/07/2024, Surveyor reviewed portions of Resident 1's record to include his/her ISP and July & August 2024 medication administration records (MARs). The current ISP signed by Administrator C on 12/11/2023 read, "Staff to administer all medications." The MARs did not include information that s/he utilized over the counter topical pain medication or antacid tablets. The MARs did include documentation of the prescribed albuterol inhaler as needed but use of the inhaler was not documented at all during July or August.

On 08/07/2024 at 3:20 PM, ED A accompanied Surveyors to Resident 1's room and confirmed

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the observations of the medications. ED A informed Resident 1 s/he would need to remove them until s/he could obtain orders from the prescriber to keep them bedside for Resident 1 to self-administer. Resident 1 replied, "That's not gonna [sic] work for requesting something it takes 2 hours for it to get here. I need it immediately." ED A ensured Resident 1 s/he would resolve the matter quickly.

On 08/19/2024 at 8:50 AM, Surveyors again observed Resident 1's rescue inhaler was at bedside. At 11:12 AM, ED A stated s/he had not yet obtained an order to keep at bedside.

EXAMPLE 3: crushing medications

On 08/07/2024 at 9:00AM, Surveyors observed Caregiver A administer morning medications. S/he prepared all morning medications for Resident 1 by crushing them and placing them in applesauce. Surveyors observed the medications included pantoprazole & potassium chloride extended release which are both contraindicated for crushing (see below). Caregiver A stated his/her practice is to crush them or Resident 1 won't take them. Then s/he brought the medications to Resident 1 in his/her room along with the breakfast meal and administered them.

On 08/07/2024 at 12:05 PM and 1:41 PM, Surveyors interviewed Resident 1. Resident 1 said s/he was just offered a shower but needed to delay it due to nausea. At 1:41 PM Resident 1 said s/he was feeling a little better but still was too "dizzy" and hoped for a shower later in the evening. At 2:45 PM, Surveyors interviewed ED A who confirmed nausea and dizziness are baseline for Resident 1 but did not offer information as to why.

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N 432	Continued From page 48 On 08/07/2024 at 2:43 PM, Surveyors interviewed ED A and informed him/her of the concerns with crushing pantoprazole. ED A said their process is to obtain orders at admission allowing medications to be crushed if needed. Surveyor requested portions of Resident 1's record to include face sheet, ISP, MARs and orders from a physician indicating medications were safe and effective to crush. On 08/07/2024, ED A provided Surveyors with the requested records with the exception of the crush order which s/he could not locate. ED A subsequently email the document on 08/08/2024 at 2:03 PM. Surveyors noted the following: Admission Date -11/11/2023. Diagnoses to include: unspecified adrenocortical insufficiency, gastroesophageal reflux disease (GERD) and carpel tunnel syndrome of bilateral upper limbs. Resident 1 required assistance with medication administration. July and August 2024 MARs - morning medications included pantoprazole sodium 40mg delayed release tablets prescribed for GERD and potassium chloride 20mg extended release tablets. The MAR was silent to medications that could be crushed or those that were contraindicated. The MAR did not list OTC chewable antacids. Admission orders signed by Physician N dated 11/07/2023, which included a list of standing orders for OTC PRN (as needed) medications. The admission order form also contained a blanket statement that read "May crush appropriate medications." [sic] The form did not prompt the physician to initial or check that part of the form or specify which medications were appropriate to crush.	N 432		

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N 432	Continued From page 49 On 08/19/2024 at 8:40 AM, Surveyors again observed the medication pass for Resident 1. Surveyors observed Caregiver D open all medication strips for Resident 1 and put them in a medication cup. S/he said s/he was going to crush "the big pill" as it was Resident 1's preference. Surveyors asked if Caregiver D knew which medication the "big pill" was and s/he stated s/he was not sure as there are many pills in one package. Surveyors observed the size and markings on the pill to be consistent with potassium chloride extended release. Caregiver D attempted to administer the medications to Resident 1, who stated that s/he wanted all the medications crushed, not just the one big one. While going back to the medication cart to crush the rest of the medications, Caregiver D volunteered to Surveyor "There is no order to crush it on PCC" At 9:00 AM, Surveyor interviewed Resident 1. Surveyor asked about the nausea and dizziness that Resident had experienced at the prior visit on 08/07/2024. Resident 1 stated it happens often, usually in the morning after breakfast. She added, "I never had that before, before I was here. So I don't know what's triggering it". "Pantoprazole comes as a delayed-release (releases the medication in the intestine to prevent break-down of the medication by stomach acids) tablet and as delayed-release granules to take by mouth ... Swallow the tablets whole; do not split, chew, or crush them. If your doctor has prescribed the 40 mg tablet and it is too big for you to swallow, ask your doctor to prescribe two of the 20 mg tablets instead." source: https://medlineplus.gov/druginfo/meds/a601246.h	N 432		

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N 432	Continued From page 50 tml retrieval date 08/28/20242 "Pills with special coating (for example, enteric-coated pills) or that are released into the body in a certain way, like extended-release (ER), sustained-release (SR) or long-acting (LA) medicines should typically not be split, cut, crushed or chewed. This can alter how the medicine is release and absorbed into your body, which may cause a dangerous overdose in some cases." source: https://www.drugs.com/article/pill-splitting.html, retrieval date 08/28/20242 "Pantoprazole sodium delayed-release tablets are prepared as enteric-coated tablets so that absorption of pantoprazole begins only after the tablet leaves the stomach." source: https://www.drugs.com/pro/pantoprazole.html Retrieval date: 08/28/20242 "Potassium comes in oral liquid, powder, granules, effervescent tablets, regular tablets, extended-release (long-acting) tablets, and extended-release capsules ... Swallow extended-release tablets and capsules whole. Do not chew them or dissolve them in your mouth." source: https://medlineplus.gov/druginfo/meds/a601099.html Retrieval date: 08/28/2024 "Do not crush, chew, break, or suck on an extended-release tablet or capsule. Swallow the pill whole. Breaking or crushing the pill may cause too much of the drug to be released at one time." https://www.drugs.com/potassium_chloride.html Retrieval date: 08/28/2024	N 432		

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HIGH POINT RESIDENCE GERMANTOWN SOUTH	W150 N11127 FOND DU LAC AVE GERMANTOWN, WI 53022

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N 432	Continued From page 51 "The most common adverse reactions to oral potassium salts are nausea, vomiting, flatulence, abdominal pain/discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by diluting the preparation further, taking the dose with meals or reducing the amount taken at one time." source: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=f9d85c4f-aa46-40b2-ad76-89dbf6ec8e4d&type=display#:~:text=The%20most%20common%20adverse%20reactions,meals%20or%20reducing%20the%20dose. Retrieval date: 08/28/2024 Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations Y3244 Ch 50.09(1)(l) Care	N 432		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services adequate to meet Resident 5's needs for behavior	N 433		

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management for behaviors that were harmful to Resident 5 or others.

During August and September 2024, Resident 5 displayed aggressive and combative behaviors directed towards staff and residents as a result of his/her disease progression. The provider did not ensure an effective behavior management plan was implemented.

Findings include:

The provider self-reported the following incident to the Department: On 09/14/2024 at 11:17 AM, "[Resident 5] was agitated and grabbed [Resident 8]. [Caregivers O and BB] were trying to redirect [Resident 5] and get [his/her] hands off of [Resident 8]...[Resident 8]'s family walked in and saw this happen and notified Germantown PD. Caregivers were able to redirect [Resident 5] to loosen [his/her] grip and walk with [him/her] away from other residents...[Resident 5] has frontal lob dementia and behaviors have been more frequent...[Administrator C] reminded staff to speak calmly and slowly when needing to redirect [Resident 5] and when possible spend some time with [him/her] as as this can help [him/her] calm down, and when [Resident 5] is up and walking around that a staff is to be walking with [him/her] so [s/he] does not get to close to other residents..." [sic - all]

On 09/25/2024, the Department received a complaint alleging concerns with behavior management.

Surveyor interviewed Caregiver BB on 10/07/2024 at 10:42 AM. Caregiver BB's stated, "I was here to see [his/her] whole change. (At first) [Resident 5] walked...[s/he] was confused but

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[s/he] was sweet." Caregiver BB said in August 2024, Resident 5 became more resistive to assistance, was aggressive to other residents and behaviors occurred daily. Caregiver BB commented, "There's 2 [caregivers] on the shift and [s/he] is running up to [Resident 8] and choking [him/her]...I've seen [him/her] hit residents in the face. I seen [him/her] run into a residents room and grab [that resident's] juice and throw it...[s/he] would throw chairs...went behind wheelchairs and flipped them backwards...[s/he]'s a strong [person]...We were told just to deal with [him/her]... ...I feel like the [caregivers] weren't fully trained...[s/he] was forced on us with ho help...There was no care plan for [him/her] and we didn't know what to do." Caregiver BB said there was no system to document behaviors and if other staff were documenting in the computer, s/he wasn't aware and did not have access. Caregiver BB said in mid-September hospice started and medications including morphine were added. S/he said in recent weeks, there had been fewer behaviors.

Surveyor interviewed Caregiver CC on 10/07/2024 at 9:10 AM. Caregiver CC said in early September, Resident 5 was "behavioral, pulling railings off the wall. [S/he] attacked other residents...If [s/he] had drinks [s/he] would throw them. It was a lot." Caregiver CC said sometimes distraction would work but other times it would not. Caregiver CC said s/he was not trained on Resident 5's needs or interventions and s/he was unfamiliar with [his/her] diagnoses. Caregiver CC said as time went by Resident 5 declined and recently Resident 5 became non-ambulatory and less responsive. Caregiver CC said some staff can chart behaviors in the computer, but s/he doesn't have access to the electronic records. Caregiver CC explained, "This is probably one of

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the first places I've been where they don't do charting...There is no where I can go to chart...I never know what's going on (with residents), unless I see it myself."

Surveyor interviewed Nurse Practitioner I (NP I) on 10/07/2024 at 9:49 AM. NP I explained s/he met Resident 5 in early July and recalled his/her second meeting with Resident 5 on 08/15/2024. NP I said, "It was later afternoon...[s/he] was at the table going off on the [staff]. Finally, [s/he] picked up a knife and I'm sitting right (there.)" NP I decided, "We gotta do something. [S/he] can't be a threat...I started to make med changes and make them fast. (Eventually) s/he calmed down and hospice took over. This will be my last visit." Surveyor reviewed findings from the 08/19/2024 visit with NP I. During that visit Surveyors identified concerns with the provider's follow up to ensure Resident 5's psychotropic medications were available. Surveyor informed NP I during August 2024, Resident 5 did not receive all prescribed doses of olanazpine or risperidone. NP I said the provider did not share their medication administration records or inform him/her about any missed doses of medication. NP I said, "I've been trying to get PCC access (PCC - electronic record keeping system) since August like I get at other facilities...That would solve problems so I could go and look (at medication administration)...that's where communication gets lost." NP I said s/he did not have information about whether PRN (as needed) medications were being used appropriately. S/he also stated s/he was not provided documentation of behaviors and the provider would only offer verbal reports or occasional emails. NP I questioned whether staff were offering non-pharmacological interventions to anticipate or meet Resident 5's needs. S/he recalled an

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instance when s/he observed, "[Resident 5] was ready to go through the window looking for water. [S/he] was that agitated." NP I said maybe Resident 5 would throw the water, but s/he also could have just been thirsty. Likewise, NP I said Resident 5 would urinate in common areas and a toileting schedule could have been tried. NP I commented it may not have been successful but, "You don't know unless you try."
.
Surveyor reviewed Resident 5's complete facility file provided by Administrator C on 10/07/2024. Progress notes contained routine entries about behaviors. Examples include:

08/20/2024 - "staff has tried to redirect the resident all day and all night...is verbally abusive towards staff as well as residents...does not follow redirection at any given time...nothing we do seems to keep [him/her] calm..."
08/29/2024 - "staff has to stay with resident all day to redirect...is aggressive with everyone...it is highly suggested that [s/he] has one on one so that [s/he] receives the proper care and the rest of our residents are comfortable and safe..."
09/04/2024 - "[Resident 5] is now 12 for 12 on interrupting my tours. This time [s/he] violently swore and slammed the door because I asked [him/her] to please hold on a second...knocked things over as the staff tried to corral [him/her]. I had to stop my tour. Apologize. And explain the situation...[s/he] is beyond the point of being manageable and has nearly scared off every tour I've brought through." Author: Marketing Director
09/05/2024 - "inappropriately urinated 4x through the day and around the facility...when staff tried to redirect...grabbed a picture off the wall and broke it...harder to redirect..."

Surveyor reviewed hospice documentation on

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N 433	Continued From page 56 10/08/2024 and noted the following: 09/14/2024: admission note, "[Person under 60 years old]...diagnosed with degenerative disease of the nervous system last November...gradual decline...moved into High Point this past May... [Resident 5] was out of medication (after admission), causing significant decline and worsening symptoms...now requiring assistance with ADLs...and increased behavior...unable to make needs know [sic]...with increased frustration and aggitation [sic]. Family states agitation is worst around 2-3PM. [Resident 5] has gotten physical with staff and other residents...ripped railings and pictures off facility walls...is up most nights pacing...Residents are now keeping doors locked due to [Resident 5] wondering into bedrooms...staff and family noted that [Resident 5] enjoys back/shoulder rubs. It helps calm [him/her] down...Facility staff also has behavior plan on place [sic]." 09/14/2024: visit note: "After admission...received phone call from [Family X] that the police were called by the facility because [Resident 5]...attempted to harm another resident..." In person visit, "calmer this evening...(likes) to move things around, moves night stand and bedding...speech is garbled and incoherent most of the time...is unable to make needs known...Writer keeps calm presence and [Resident 5] is receptive. [S/he] even smiled a few times. But [Resident 5] gets fixated on tasks and is difficult to redirect. Advised staff to keep calm, safe, clutter-free environment. Use redirection as able. If needed ensure [Resident 5] is safe, step away and reapproach task again a bit later." 09/15/2024: email referral to another agency, "[Resident 5] is diagnosed with dementia - neurological and also PPA - Primary Progressive	N 433		

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Aphasia...has behaviors...Will go near other residents, drop [his/her] pants and defecate or urinate. Unfortunately approach is a lot - and I don't believe the staff have the ability (caught them sleeping yesterday when we were there) to care for [him/her] - just a lack of knowledge. [S/he] does have a behavior care plan in place. Not being followed. Yesterday the facility asked for 1:1 care for [him/her] - we can't provide that..."
09/18/2024: visit note, "Reminded staff to keep calm environment. Use redirection and be very patient. [Resident 5] is receptive to gentle approach."
09/21/2024 - visit note, "lying on bedroom floor upon arrival...remains irritable. Writer began to talk in a calm, reassuring voice and rubbed [Resident 5]'s back...eventually became more calm, and willing to get up..."
09/24/2024 - visit note, "will sit and then walk...seen to sit on the floor, get up and continue...today it appears [s/he] is working and wanting to go to the bar. [S/he] cursed and was in a state where [s/he] seemed to be recalling or remember a past event...is not able to make [his/her] needs known...relies on staff to anticipate [his/her] needs. This is due to disease progression."

Surveyor reviewed Resident 5's individual service plan (ISP) provided 08/22/2024 by ED A and an updated version located in the record on 10/07/2024 and noted the following:

Urination: 06/18/2024 - "Concern: will urinate in places other than toilet bowl. Interventions: Staff to remind resident to only urinate in toilet." Update 09/16/2024 - "staff to put briefs on to try to avoid inappropriate urination."
Bowel: added 09/16/2024 - "Concern: Resident having BM not in toilet. Interventions: Staff to

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redirect [Resident 5] to bathroom for BMs." Emotional/Behavioral 06/18/2024 - "Concern: Will get argumentative and combative (with) staff and other residents. Interventions: Staff are to redirect resident when upset by going for a walk...putting on a movie, giving [him/her] a wordsearch, or bringing [him/her] somewhere private to have a conversation. Psych NP oversees medications...Staff are to give PRN psych medications when resident is having emotional or behavioral outbursts (undated addition) if redirection of going for a walk is not working."

Surveyor noted the ISP was not updated based on assessment between 06/18/2024 and 09/16/2024 to identify strategies and approaches to manage Resident 5's increased behaviors. The updates that were made on 09/16/2024 were vague and did not offer specificity on potentially effective ways to redirect. Interventions for reminders had minimal potential for success given Resident 5's disease progression. There was no behavioral care plan in the record.

Surveyor conducted an interview with Administrator C on 10/07/2024 at 2:48 PM. Surveyor reviewed the ISP with Administrator C. S/he confirmed it did not include effective, individualized interventions to meet Resident 5's needs related increased behaviors. S/he also confirmed the ISP did not contain information about Resident 5's diagnoses or the interventions identified by hospice. Administrator C said some interventions were implemented like offering Resident 5 a busy blanket, however s/he confirmed it was not in the ISP and s/he did not have documentation to show it was communicated to all caregivers. Administrator C said there was not a specific behavior plan that was developed and acknowledged the facility has

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N 433	Continued From page 59 struggled to manage Resident 5's behaviors. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Right of Residents: Receive Medication N0389 DHS 83.35(3)(d) Service Plan Updated Annually Or On Changes N0433 DHS 83.38(1)(i) Behavior Management	N 433		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure all residents received adequate and appropriate care within the capacity of the facility.	Y3244		

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Y3244	Continued From page 60 The provider did not ensure Resident 3 was medically assessed by hospice after exhibiting a change in condition during lunch on 07/05/2024. After lunch, Resident 3 experienced a fall. The provider informed hospice of the fall but did not inform the responding nurse of the change in condition that proceeded it. Increased monitoring was not provided during the overnight hours. During the morning of 07/06/2024, Resident 3 had very high blood pressure and was too weak to transfer. Caregivers left Resident 3 alone in his/her wheelchair while waiting for the hospice nurse to arrive. While left unsupervised, Resident 3 fell from his/her wheelchair to the ground. S/he sustained facial fractures and lacerations and died the next day due to blunt force trauma to the head. Resident 1 did not receive showers twice weekly as identified in his/her individual service plan (ISP.) Resident 1 went up to two weeks without receiving showers. Residents 1 and 10 did not receive prompt assistance when they activated their call lights. On 08/07/2024, Resident 6 who had Parkinson's disease and experienced confusion waited at least 30 minutes for staff to respond. On 08/19/2024, Resident 1 who was a known risk for falls, waited at least 57 minutes for staff to respond. Interviews and observations attributed wait times and delayed care to staffing shortages and problems with the call light system. The provider is licensed to serve up to 46 people from the following client groups; developmental disability, terminally ill, advanced age, emotionally disturbed/mental illness and traumatic brain injury.	Y3244		

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Y3244	Continued From page 61 Findings include: The Department received a complaint alleging care concerns. EXAMPLE 1 - RESIDENT 3 response to change in condition On 07/08/2024, the provider submitted a self-report to the Department regarding an incident the morning of 07/06/2024 which read in part, "[Resident 3] was admitted to [hospice] on May 24th, 2024 for decline due to dementia. Resident's baseline was alert but moderately confused. The week prior to the incident, resident's confusion was severe. Staff noticed a change in condition with increased fatigue as well as not responding to others on 7/5/2024. The hospice RN followed up on 7/5/2024 with no medical changes needing to be made at the time..." On 07/06/2024 in the morning, "[Resident 3] was sitting in [his/her] wheelchair in the living room. Staff went to...administer [his/her] medications. [Caregiver P] noticed [s/he] was not swallowing [his/her] medications and [s/he] was cold to the touch. Staff asked resident if [s/he] was '"OK' and resident was not responsive, but [his/her] eyes were open. [Caregiver P] and [Caregiver Q] wheeled [Resident 3] to [his/her] room to obtain vitals. Staff could not get resident to [his/her] bed safely and obtained vitals while still in the wheelchair. After obtaining the blood pressure, which was 183/139, [Caregiver P] went to call [hospice]. After [Caregiver P] grabbed a phone, [s/he] returned to resident's room (underlined by Surveyor for emphasis) where [s/he] found the resident on the floor and noted bleeding on [his/her] face. [Caregiver P] called	Y3244		

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Y3244	Continued From page 62 911 immediately. Resident was transported to...Inpatient Hospice...Resident passed away...on 7/7/2024..." Surveyor note: According to Mayo Clinic blood pressure 180/120 or greater is considered hypertensive crisis and is life threatening. Symptoms may include anxiety, confusion, unresponsiveness and shortness of breath. https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/hypertensive-crisis retrieval date 09/06/2024 RECORD REVIEW: On 08/19/2024 beginning at approximately 11:15 AM, Surveyor reviewed Resident 3's closed record and noted the following: Incident Report (IR) dated 07/06/2024 at 9:30 AM - "Staff noticed resident was not looking well today. Staff took vitals and called Hospice [sic]. When Hospice [sic] arrived, staff went back in room with hospice aide and resident was on the floor. (underlined by Surveyor for emphasis) Blood was everywhere. Due to the trauma to [his/her] face and the residents acute fall risk, it was decided to send resident out to [inpatient hospice]." The form documented Resident 3 had bruising, swelling and a wound. The form also noted a black eye, open lip and bloody nose. Author: Caregiver P. IR dated 04/22/2024 - unwitnessed fall History of urinary tract infections including a hospital admission on 01/30/2024. The hospital record noted Resident 3 was elderly with underlying diagnoses of chronic kidney disease, Alzheimer's and Mayasthenia Gravis. His/her baseline was alert and oriented times two but was sent to the emergency room after facility staff observed s/he was "slumped over in chair and	Y3244		

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unable to arouse." S/he was diagnosed with acute metabolic encephalopathy due to UTI and pneumonia. The provider was given educational material related to this hospital stay which detailed signs/symptoms of UTIs.
NOTES: Metabolic encephalopathy is a change in brain function due to an underlying condition that can cause confusion, memory loss and loss of consciousness. Myasthenia Graves causes muscle weakness.
Individual service plan (ISP) last reviewed and revised 08/27/2023. The only update after 08/27/2023 was a note 05/24/2024 indicating s/he was placed on hospice. Resident 3 required staff assistance with transfers, mobility, medication administration and all activities of daily living. The ISP did not identify Resident 3's fall risk or interventions to prevent falls. The ISP did not identify Resident 3's history of UTIs or interventions to monitor for signs/symptoms. Resident 3 had an activated power of attorney (POA) for health care.

ED A and Administrator C also provided Surveyors with hospice visit notes on 08/07/2024: 07/05 03:24 PM: "FACILITY NOTIFIED WRITER THAT PATIENT HAD AN UNWITNESSED FALL. VISIT MADE TO ASSESS...FACILITY STAFF REPORTS NO ADDITIONAL CONCERNS ..." Author: Registered Nurse (RN) Care Manager R
07/06 08:54 AM: "PRN VISIT MADE TO ASSESS PATIENT'S CONDITION. UPON ARRIVAL PATIENT WAS FOUND LYING ON THE FLOOR WITH A POOL OF BLOOD UNDERNEATH [HIM/HER]. PATIENT WAS GIVEN 10 MG OF MORPHINE AND 911 WAS CALLED TO PICK PATIENT UP. FACIAL BLEEDING NOTED FROM MOUTH AND NOSE ...LEFT EYE BLACK AND BLUE. PATIENT TRANSFER ...HOSPICE ACUTE." Author: RN G

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Y3244	Continued From page 64 Resident 3's record did not include documentation of: a change in condition on 07/05/2024, or the days preceding notification to the POA or hospice of a change in condition on 07/05/2024 INTERVIEWS: Surveyors interviewed ED A and Administrator C on 08/19/2024 at 11:12 AM and 1:25 PM. Administrator C said this is one of 3 facilities s/he manages. Although s/he is in the building weekly, ED A provides daily oversight and would have the most information about Resident 3's care. ED A confirmed Resident 3's ISP was not updated after 08/27/2023 to identify his/her risk of falls or UTIs. ED A recalled Resident 3 was "more anxious than normal" and "really took a turn" in the "24-48 hours" preceding the 07/06 fall. ED A said on 07/05 during lunch "I noticed...[s/he] was not responsive...[s/he] looked right through me...lunch is when I knew something was wrong." ED A thought his/her staff informed hospice of the change in condition on 07/05 and it was his/her impression the hospice RN visited in the evening after ED A left for the day. Surveyors reviewed the 07/05 hospice note with ED A which documented the hospice visit at 3:54 PM was only in response to a fall and caregivers "reported no additional concerns." ED A acknowledged Surveyors review of the hospice note. ED A said until s/he collected the record for Surveyors, s/he was unaware Resident 3 had a fall on 07/05 after lunch. ED A was unable to provide information about	Y3244		

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Y3244	Continued From page 65 Resident 3's condition overnight from 07/05 until 07/06 and stated s/he did not implement increased monitoring because s/he thought hospice had already assessed specific to the change in condition. ED A stated vitals were not monitored between lunch 07/05 and breakfast 07/06. ED A said his/her review of the fall consisted of talking with Caregivers P and Q so s/he could write the self-report. The caregivers told ED A Resident 3 had a change in condition and said they took him/her to his/her room to get vitals. They reported the blood pressure was very high, Resident 3 was "dead weight" and they were unable to transfer him/her to bed. Caregiver P told ED A s/he left Resident 3 to call hospice and Caregiver Q said s/he "was just watching [him/her] or in the room somewhere." ED A told Surveyors, "I guess apparently [Resident 3] took a nosedive on the ground, s/he just flopped over. So [s/he] ended up on the ground and got bruising and I believe [his/her] nose was bleeding." Surveyors noted the IR written by Caregiver P and the visit note written by Hospice RN G both described an unwitnessed fall; indicating Caregiver Q did not stay with Resident 3 in spite of a serious change in condition. ED A acknowledged even if Caregiver Q was in the room s/he should have been close enough to prevent the fall and s/he was not. Surveyors asked ED A if s/he investigated any further by interviewing hospice or other staff to determine if Resident 3 was left unsupervised and s/he said s/he did not. Surveyor interviewed Hospice RN R on 08/21/2024 at 3:01 PM. RN R said s/he reported to the facility the afternoon of 07/05/2024 to assess Resident 3 after a fall. RN R did not recall	Y3244		

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receiving any information about a change in condition in the days or hours preceding the fall.

Surveyor interviewed Hospice RN G on 08/21/2024 at 07:46 AM. RN G stated Caregiver P notified their agency on 07/06/2024 at 8:38 AM that Resident 3 had elevated blood pressure and shakiness. RN G was nearby and arrived at the facility at 8:54 AM. RN G recalled meeting a caregiver in the common area who accompanied him/her to Resident 3's room. RN G did not recall any sense of urgency on behalf of the caregiver. When they arrived in the room they found Resident 3 alone, "belly down" on the floor with a "small pool of blood next to him/her." They contacted EMS for lift assistance and placed Resident 3 back in bed. S/he assessed Resident 3 and noted bleeding coming from his/her mouth, a skin tear, a black eye and 2 teeth were knocked out. Resident 3 was then sent to their inpatient hospice facility.

Surveyor interviewed POA S on 08/26/2024 at 4:26 PM. POA S said s/he was very upset about the care Resident 3 received in the days preceding his/her passing. POA S explained s/he was not informed of a change in condition during that timeframe and therefore was not able to help Resident 3. POA S said after s/he was informed of the 07/06 fall s/he reported to the facility the same day. S/he observed a large area of blood on the carpet and a caregiver's handwritten note which is how s/he learned of another fall on 07/05. POA S sent Surveyor a photo of the note which read, "Change in condit with [Resident 3] vitals are whacky! declining secreting [s/he] had a fall yesterday 7/5/24 02 73% 183/139 pulse 137." [sic - all]. POA S sent Surveyors a photo of the death certificate which documented "FACIAL FRACTURES" sustained due to an

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"UNWITNESSED FALL." The date of death was 07/07/2024 and the cause was "COMPLICATIONS OF BLUNT FORCE TRAUMA TO HEAD."

EXAMPLE 2 - Resident 1 showers

On 08/07/2024 at 9:16 AM, Surveyors observed Caregiver B tell Resident 1 s/he would check the shower scheduled to see if it was Resident 1's day. Resident 1 replied, "I was supposed to have a shower yesterday and nobody came in." Resident 1 told Surveyor, "Sometimes I have to wait 2 weeks to get a shower...I'm supposed to have a shower on Tuesday and Thursday but it doesn't work out that way. It's whenever they have free time. But they don't have free time." Surveyor asked Resident 1 when s/he last had a shower and s/he replied, "I couldn't even tell you...It's been more than 2 weeks...I have to have someone with me because I'm off balance and I won't walk good at all." Surveyor observed Resident 1's hair appeared greasy.

Surveyor asked Caregiver B his/her thoughts on Resident 1's statements. Caregiver B said s/he didn't know when Resident 1 last had a shower and acknowledged sometimes staffing is challenging.

On 08/07/2024 at 10:45 AM, Surveyors interviewed Caregiver H in the staff office. S/he volunteered, "[Resident 1] sometimes refuses [his/her] showers...[s/he] likes to lay around in [his/her] bed all day...I tried to give [him/her] one last week and s/he refused." Caregiver H said s/he charts shower refusals in PCC (Point Click Care - electronic charting system.) Later in the same interview Caregiver H gave a conflicting statement and said, "I don't really do [Resident

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1]'s shower. I don't (usually) work 1st shift...That's what was told me, [s/he] refused last week." Surveyor asked who told him/her about the refusal and Caregiver H said, "Whoever worked 1st shift I can't remember." During the interview, Surveyors observed a shower schedule posted on the office wall. Resident 1 was scheduled for showers on Tuesdays and Thursdays at 3:00 PM.

On 08/07/2024 at 10:55 AM, Surveyors interviewed Caregiver O and asked about Resident 1's showers. Caregiver O stated said Resident 1 gets showers on "Mondays and Fridays...the last time I was here a week ago Monday (07/29/2024)...I tried to get [him/her] to shower. S/he refused...[s/he] sleeps a lot that's all [s/he] do [sic]." Surveyor asked what Resident 1's diagnoses are and Caregiver O replied, "I don't really know I'm still learning...getting trained...I just became a lead (caregiver.)" Caregiver O said completed showers are documented on skin assessment/shower forms and left in ED A's mailbox.

Surveyor reviewed portions of Resident 1's records received from ED A on 08/22/2024. The face sheet identified diagnoses to include adrenal insufficiency and chronic kidney disease both of which can cause fatigue, weakness and tiredness.

On 08/07/2024 at 11:37 AM, Surveyors interviewed ED A. ED A said sometimes Resident 1 refuses showers. ED A said completed showers are only documented on forms if there are skin integrity concerns. ED A also told Surveyors shower refusals are not documented but are communicated verbally to ED A and to other caregivers during shift report. ED A later changed his/her statement and said sometimes refusals

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are documented, "depends on how serious the situation is. If someone is going 2 weeks of course I'm going to document on that. It goes case by case." ED A told Surveyors it was unlikely Resident 1 had gone 2 weeks without a shower. ED A retrieved a chart which documented showers for Resident 1. A total of 3 showers were documented; 06/20, 07/19 and 07/23. Surveyor noted this was consistent with Resident 1's statements it had been about 2 week since his/her last shower and ED A agreed. ED A then reviewed the internal communication notes in PCC for any information about showers being given or refused and s/he said "Yeah, I don't have anything on here." However, ED A remained dismissive of the accuracy of Resident 1's reports and commented s/he has psychiatric issues and an activated power of attorney for health care.

Upon request on 08/07/2024, ED A provided Surveyors with Resident 1's current ISP signed and dated 12/11/2023 by Resident 1. When providing the ISP to Surveyors, ED A corrected his/her earlier statement and said Resident 1's POA is not activated. The ISP noted Resident 1 required the assistance of one staff for bathing/showers. There was a revision on 01/15/2024 initialed only by Administrator C which read, "...incontinent daily...refuses bathing, change schedule to twice weekly." The ISP did not identify interventions based on assessment to determine the cause of refusals or strategies/interventions caregivers could use to encourage showers. The ISP identified Resident 1 as "forgetful at times" but did not identify behaviors or an inability to accurately communicate information.

On 08/19/2024 at 8:49 AM, Surveyors interviewed Resident 1 and asked about showers received

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since the last visit 12 days prior. Resident 1 replied, "Last Thursday is the only one." Surveyor asked if there are times s/he declines showers. Resident 1 said sometimes if it is offered when s/he eating or taking a walk s/he will ask for it later, but s/he won't refuse. Resident 1 said s/he has not declined a shower since 08/07/2024 and added, "I grab the showers I can. I thought I'd have a shower twice a week at least. And I understand they are busy...they are short staffed...(but) once or twice a week would be nice." Surveyors again observed Resident 1's hair did not appear clean and s/he had noticeable stubble of approximately 1/8 inches on his/her chin.

On 08/19/2024 at 10:38 AM, Surveyors interviewed Caregiver E. S/he said the provider has recently implemented a shower refusal form and the documents are kept in a binder in the office. Caregiver E showed Surveyors the binder which had 2 completed forms for other residents who had declined showers on 08/12 and 08/17. No refusals were documented for Resident 1.

On 08/19/2024 at 2:45 PM, Surveyors interviewed ED A and shared the observations of Resident 1's hygiene and the information received that Resident 1 was still not receiving showers twice weekly. ED A did not have additional information to provide.

During the exit conference with Administrator C and ED A on 08/26/2024 at 1:00 PM, Surveyors reviewed the concerns with Resident 1's showers as identified on 08/07 and 08/19/2024. Surveyors asked if any changes had been implemented to ensure Resident 1 was receiving shower. Administrator C said they did a "soft opening" of a shower refusal form and it would be fully

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implemented at the upcoming staff meeting. The managers said no updates to Resident 1's ISP had been made since Surveyors visits.

EXAMPLE 3: long wait times

Surveyors observed the facility is expansive and the resident roster provided on 08/07/2024, identified 42 resident rooms and a census of 39 residents. The building is divided into side 1 and side 2. Each side has its own dining room, a large living room and offices for staff.

During 2 of 2 visits, Surveyors observed concerns with call light response times due to staffing and the facility's call light system.

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At 7:49 AM, Surveyors interviewed Resident 2. Resident 2 said s/he is prescribed carbidopa-levodopa. Surveyors noted the medication needs to be administered at consistent times daily. Resident 2 said it varies whether s/he gets medications at the same time every day and added, "I am aware they're struggling constantly with staffing issues and they're serious." During a follow up interview with ED A at 2:10 PM, s/he described Resident 2 as an accurate reporter.

At 8:45 AM, Surveyors interviewed Resident 6 and Family T who said Resident 6 was new to the facility, had Parkinson's disease and was often confused. Resident 6 said s/he's tried to push the call pendant but "nothing happened." Family T explained maybe Resident 6 wasn't pushing it hard enough, so at 8:49 AM, Resident 6 pushed the pendant which turned red and vibrated indicating it was activated. As of 8:56 AM, staff

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had not responded and Surveyors said they would check back later to see what time staff responded. At 9:20 AM Surveyors checked with Family T and staff had not yet responded.

At 9:25 AM, Surveyors interviewed Resident 1 and asked about call light response times. S/he replied, "It's at least a half and hour. In could be an hour or two hours...I'm thinking they don't have enough people..." Resident 1 said s/he usually uses the call light when his/her medications are late.

At 9:44 AM, Surveyors observed Caregiver B was not wearing a pager or a walkie talkie and asked how s/he is aware if a resident has activated their call pendant. Caregiver B said the lead caregiver lets him/her know. Surveyors asked how that is communicated and s/he replied, "It's just weird. We just, you kind of just hear."

At 9:58 AM, Surveyors interviewed ED A about the call light system. ED A said when the pendants are activated they illuminate on the computer screens in the offices. S/he explained they should also go to pagers, but the facility needs new pagers and currently there is only 1 pager in use and no walkie talkies for 5-6 staff. ED A also said 5-6 care staff during day shift is the number of staff they have identified as necessary to meet resident needs. ED A said new pagers were already on order. ED A said in the meantime, staff need monitor the computer screens in the offices (one on each side of the building) and also walk the halls to see if residents need anything. ED A said s/he monitors wait times and if they are more than 20 minutes "I'm right on it with corrective actions." Surveyors requested documentation of call light response times for Residents 1 and 10.

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Y3244	Continued From page 73 At 10:55 AM, Surveyors interviewed Caregiver H. Contrary to ED A's statement, s/he said there were no pagers in use today and "the only way to see if call lights are on is to look at the computer." S/he explained this can lead to long wait times because if they providing cares to residents they are not able to frequently check the offices for call lights. S/he also said some residents have complained about long wait times. On 08/16/2024 at 9:59 AM, Surveyor conducted a phone interview with ED A. S/he said said since the 08/07 visit they implemented the use of 5 pagers. S/he also stated s/he was unable to provide the previously requested call light times because all data was deleted from the system on 08/09 when the new pagers were added. 08/19/2024 At 7:55 AM, Caregiver D informed Surveyors there were "a lot of no shows" for day shift beginning at 7:00 AM and "We are understaffed." Surveyors observed 2 other caregivers for the whole building, Caregivers F and E. At 8:12 AM, Surveyors observed a pager laying on a medication cart and another pager partially tucked in a recliner cushion in the common area, both on side 1. Surveyor interviewed Caregiver E at 9:46 AM and observed s/he did not have a pager or walkie talkie. Caregiver E confirmed Surveyor's observation and said staff have to check the computer "every so often" to see if call lights are active. S/he said, "it was more effective when every person had a pager. They got rid of the pagers...a couple months ago." Caregiver E said	Y3244		

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s/he heard they were starting to reissue the pagers but no one has offered one to him/her. Caregiver E described him/herself as PRN (as needed staff) and said s/he usually works at least 24 hours/week. Caregiver E said on days like today when they are short staffed, there can be "quite a wait...I would say a half and hour."

At 8:17 AM, Surveyor observed the computer/call light monitor in the office on side 1. Two active calls were displayed.
"Assistance Required...[Resident 7]...last known location...floor." Call light activated 23 minutes ago.
"Assistance Required...[Resident 1]..." Call light activated 57 minutes ago.

At 8:49 AM, Surveyors interviewed Resident 1. Resident 1 confirmed s/he activated the call light when s/he woke up, "I was thirsty, I needed a drink." Resident 1 said s/he waited "more than 1/2 hour. I know that for a fact. You really have to wait...I see it, they are short staffed. I don't get what I want. When I ring this buzzer thing which is really no good anyway, it works but (only) once they get the notice of this. I have to wait most of the time an hour." Resident 1 also described him/herself as unsteady on his/her feet and relying on a walker for ambulation.

Surveyors reviewed documentation that confirmed Resident 1 was at risk for falls. At 10:45 AM, Surveyors reviewed an IR binder located in the office. It included an IR dated 05/09/2024 which documented Resident 1had an unwitnessed fall while experiencing an episode of dizziness.

At 9:05 AM, Surveyors interviewed ED A and Administrator C. ED A confirmed after Surveyors

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	0019672	A. BUILDING: _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH POINT RESIDENCE GERMANTOWN SOUTH	W150 N11127 FOND DU LAC AVE GERMANTOWN, WI 53022

(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
Y3244	Continued From page 75 first visit, "I looked and found 5 old pagers." While trying to locate pagers s/he discovered two lead caregivers "had them, they just weren't using them." ED A said since the pagers have been back in use, "I am on top of them. When I'm here I'll do rounds and make sure no call lights are going...there is a camera facing the computer so I can watch (remotely) over the weekend...periodically I can look." Surveyors informed ED A of the observations of the 2 pagers in the common areas and of Resident 1's 57 minute wait time. ED A said the caregivers on duty today were "PRN people" and may not have known about the pagers. S/he added, "they don't get the same information as our full time staff do. It's a matter of training." ED A said the facility has been without pagers for months and added, "they are expensive." ED A was unable to provide more information about why call log wait times could not be provided and said, "Maintenance U has been in contact with the [call system company]." At approximately 1:15 PM, Surveyor interviewed Maintenance U who said s/he would be able to provide call wait times for the past 7 days. Surveyor requested them for Resident 1 and Resident 3. At 3:21 PM, Surveyors interviewed ED A. S/he said Maintenance U had left for the day and the provider would not be giving Surveyors the requested documentation of the call wait times. Cross Reference: N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0391 DHS 83.35 (3)(f) Staff Access to Assessment And ISP N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0432 DHS 83.38(1)(h) Medication	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HIGH POINT RESIDENCE GERMANTOWN SOUTH	W150 N11127 FOND DU LAC AVE GERMANTOWN, WI 53022

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Y3244	Continued From page 76 Administration	Y3244		