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	0015620	A. BUILDING: _____ B. WING _____	R-C 04/26/2024

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(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 04/03/2024, with information gathered through 04/26/2024, Surveyors conducted a verification visit, 3 complaint investigations and a self-report review at Stoughton Meadows Assisted Living. Ten deficiencies were identified. Two of 3 complaints were substantiated. Two of the 10 deficiencies were repeat violations (see Statement of Deficiency (SOD) BTKI12). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 35	{N 000}		
{N 310}	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer,	{N 310}		

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

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{N 310}	Continued From page 1 death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident admission agreement outlined all additional services offered, which are not included in the basic services. Resident 1's room and board fees did not change when s/he was moved to a smaller room when s/he was in default of monthly fees. Resident 1 was not originally charged the room fee that was identified on his/her admission agreement. Resident 4's admission agreement did not outline that the provider used non-emergency EMS (emergency medical services) personnel if resident required assistance in services that staff were unable to provide, with the resident being charged for that service. This is a repeat deficiency. See Statement of Deficiency (SOD) BTKI11, dated 11/15/2023. Findings include:	{N 310}		

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{N 310}	Continued From page 2	{N 310}		

Example 1: Resident 1

On 02/16/2024, the Department received a concern that alleged residents were overcharged room fees.

On 04/03/2024, at approximately 4:20 PM, Surveyors interviewed Executive Director (ED) A. ED A stated Resident 1 was moved to a smaller room so that the larger room could be prepared for a private pay resident. Surveyor requested the providers room fee schedule that was in effect when Resident 1 moved into the facility.

On 04/03/2024, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the facility, 04/20/2023.
Resident 1 originally moved into Room 4 (Grand Studio), at a rate of $4100, per his/her admission agreement.
Resident 1's room charge transactions documented that Resident 1 was charged $4200 in May and June 2023.
Resident 1 moved into Room 1 (Studio), in 06/2023, at a rate of $4350.00.

On 04/03/2024, Surveyor reviewed the providers room fee schedule that was supplied by Registered Nurse H. The fee schedule was not dated and did not correlate with Resident 1's admission agreement or the new fee that s/he was being charged. Registered Nurse H stated s/he was not responsible for room charges.

On 04/25/2024 at 11:10 AM, Surveyor emailed ED A and asked for clarification regarding Resident 1's room charges. ED A stated, "With regards to the room rates. Room 4 and Room 1 are the same for room and board." Surveyor

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{N 310}	Continued From page 3	{N 310}		

asked again if Resident 1 had been moved to a smaller room for non-payment, a room that would be less expensive.

As of 04/26/2024 at 11:00 AM, Surveyor did not receive a response.

Example 2: Resident 4

On 04/03/2024, at approximately 4:20 PM, Surveyors interviewed ED A. Surveyor asked if the facility was still considered a no-lift facility. ED A stated, "That is correct."

Resident 4 moved into the facility, 02/13/2024, with diagnoses including diabetes, weakness, hyperglycemia, and chronic kidney disease.

Resident 4's admission agreement, dated 02/13/2024, did not outline that the facility was a no-lift facility and that non-emergency personnel may be utilized; resulting in a resident being charged for these services, because they are not included in the monthly service fee.

Resident 4's current ISP did not contain language regarding the facility being a no-lift facility and associated fees.

On 04/08/2024 at 3:46 PM, Surveyor emailed Executive Director A and stated, "I do not see any language added to the admission agreement outlining that the facility is a no-lift facility and that the resident is responsible for ambulance fees when called for lift assist."

On 04/09/2024 at 2:37 PM, ED A emailed Surveyor and stated, "I just wanted to ensure that you have everything that you need." Surveyor responded and asked if Executive Director A had

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{N 310}	Continued From page 4 a response to the concern regarding the admission agreement. On 04/25/2024, at approximately 11:20 AM, Surveyor interviewed ED A. ED A stated s/he would need to review Resident 4's documentation. As of 04/26/2024 at 11:00 AM, Surveyor did not receive a response.	{N 310}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 3) received adequate treatment after displaying signs and symptoms that were not baseline. Resident 3 was found by staff deceased. Findings include: On 03/18/2024, the Department received a written report by the provider that stated Resident 3 was observed absent of vital signs on the floor of his/her apartment near his/her bed on 03/15/2024. On 04/03/2024, Surveyor reviewed Resident 3's record.	N 353		

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N 353	Continued From page 5 Resident 3 moved into the facility 12/30/2022. Resident 3's internal death investigation, dated 03/22/2024, documented: "Early in the day, resident was observed to be a little shaky and off balance but not in distress. Staff reported [him/her] appearing unsteady in the hallway after lunch, and when staff approached resident, [s/he] stated [s/he] was tired and wanted to lay down for a nap." Housekeeper I - "Was not [him/herself]. Hand tremoring. 'I didn't know what is wrong.' Wobbling in hallway, didn't look right. Was dropping things at lunch. ... Did not report change in condition to Wellness or [Executive Director A]." Resident 4 - "I noticed [Resident 3]. Was wobbly and shaky at breakfast. [S/he] seemed really off. I didn't tell anyone." Cook J - "At breakfast [s/he] was shaky, which was not normal for [him/her]. [S/he] was at dinner 1.5 hours early (3:30 PM) but when I served dinner [s/he] was no longer there (4:30 PM). Usually the [staff] from wellness do ask if they want a room tray or I will but it did not occur to me." Resident 3's "Individual Service Plan," dated 02/24/2024, documented: "Medication/Pharmacy: Observe for and report to the Wellness Lead any of the following adverse reactions of anticoagulant therapy: ...sudden changes in mental status, significant or sudden changes in vital signs." "Behavior Care: Behavior Monitoring" Resident 3's "Progress Notes," did not document any concerns and did not have any notations since 03/08/2024.	N 353		

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N 353	Continued From page 6 On 04/03/2024, at approximately 2:30 PM, Surveyors interviewed Registered Nurse (RN) H. RN H stated as s/he interviewed staff during the internal investigation, stories did not line up. RN H expressed concern that staff noticed Resident 3 was not baseline and it was not reported to management, so it could be determined if s/he should have been sent out via 911. RN H expressed concern that the wellness team (caregivers) did not observe that Resident 3 had displayed signs and symptoms of not being baseline. On 04/08/2024, Surveyor requested Resident 3's ambulance report which documented: "On 03/15/2024 at 21:44 (9:44 PM), rescuer was called to an echo level, PNB (pulseless nonbreather) and downgraded enroute to a bravo level obvious death. Upon arrival, staff was visibly upset/sad, and patient was lying on [his/her] back, fully dressed, with [his/her] arms stretched out on [his/her] side and [his/her] hands in the air and stiff. Patient legs were crossed and stiff. Patient's eyes were completely blood shot and dry and not responsive to any light. There appeared to be some trauma around the patient's mouth that is suspected to have hit [his/her] CPAP (breathing device) machine during a probably fall of some type. Patient was in full rigor head to toe and cold to the touch, had lividity to [his/her] face, and had a foul smell coming from [him/her]. Due to what we were seeing we agreed there was no need to further investigate. According to staff, they found the patient face down, also in full rigor. No CPR was started by staff due to it being an obvious death. Staff stated [his/her] last known well time was "around lunch" when [s/he] was last seen. Only two staff were able to give us information, so we are unaware if [s/he] was seen by other staff at a	N 353		

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N 353	Continued From page 7 different time. Patient was extremely independent and did not need a lot of care from staff so [s/he] was not someone that was checked on extremely frequently."	N 353		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure an assessment of 1 of 1 resident's physical and mental condition was completed when there was a change in needs. Resident 1 was placed in a smaller room where his/her bathroom door had to be removed so that s/he could utilize his/her wheelchair in and out of it. Findings include: On 04/03/2024 at approximately 1:14 PM, Surveyors observed Resident 1 in his/her room. Resident 1 had a large electric wheelchair in the	N 381		

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room for mobility. Resident 1's room was not big enough for the electric wheelchair or his/her normal wheelchair to turn around easily. The bathroom door of Resident 1's bedroom was taken off because s/he could not easily maneuver around the room and get into the bathroom with his/her wheelchairs. Surveyors observed Resident 1 struggling to get around the room because there wasn't enough room for him/her to maneuver the wheelchair.

On 04/03/2024 at approximately 1:14PM, Surveyors interviewed Resident 1. Resident 1 stated the facility had moved him/her from a larger room into the smaller room after s/he transitioned from private pay to a managed care organization, and s/he has a harder time getting around in the room. Resident 1 stated the bathroom door was removed because s/he was having a hard time getting in and out of the bathroom due to the small area and the bedroom door being right next to the bathroom door. Resident 1 stated s/he had a conversation with Executive Director A letting them know s/her could not maneuver around the room as well and couldn't get into the bathroom very well.

On 04/03/2024, at approximately 4:30 PM, Surveyors observed Resident 1 in the dining room and asked him/her if s/he could speak with the Surveyors in the common area. Resident 1 attempted to maneuver his/her electric chair. Resident 1 backed into another resident at a dinner table, caught the wheelchair on the edge of the table causing the table to move. Once away from the table, Resident 1 maneuvered the wheelchair into the common area, rubbing along the wall the entire length with the appearance of becoming hung up. Registered Nurse (RN) H walked over and observed Resident 1 and

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appeared to be determining if Resident 1 needed assistance.

On 04/02/2024, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the facility, 04/20/2023.

Resident 1's "Wisconsin Level of Care Assessment," dated 04/04/2023, documented: "Mobility - Walker. Resident will demonstrate ability to use assistive device safely and consistently through next review date."

Resident 1's "Wisconsin Level of Care Assessment," dated 05/18/2023 and 11/16/2023, documented:
"Mobility - Wheelchair. Resident will demonstrate ability to use assistive device safely and consistently through next review date."

On 04/02/2024, at approximately 4:22 PM, Surveyors interviewed Executive Director A. Executive Director A stated Resident 1 was moved into the smaller room because s/he wasn't paying his/her bill. Executive Director A stated Resident 1 was removed from the larger room to get the room ready for a private pay resident. Executive Director A stated the room ended up being rented by 2 people that were on public assistance. Surveyors asked if Resident 1 had been reassessed to determine if s/he was able to maneuver his/her wheelchair appropriately in his/her new room. Executive Director A stated s/he did not have the electric wheelchair when s/he was moved into the room. Surveyors asked if Resident 1 was assessed to determine if s/he was able to maneuver his/her manual wheelchair freely in his/her room. Surveyors did not receive a response.

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N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's Individual Service Plan (ISP) was signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and agreement with the plan for 1 of 1 resident reviewed. Resident 1's ISP was updated with language regarding service fees for non-emergency lift service, but the ISP was not signed by Resident 1. Findings include: On 04/03/2024, at approximately 1:30 PM,	N 387		

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Surveyor interviewed Resident 1. Surveyor discussed his/her previous lift-assist charges and if s/he had received assistance in determining his/her bills. Resident 1 stated, "I don't think so." Surveyor observed the stack of ambulance bills on Resident 1's desk. (Resident 1's record had been reviewed during the 11/15/2023 survey where it was determined s/he had been charged for at least 11 lift assists.)

On 04/03/2024, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the facility, 04/20/2023, with diagnoses including weakness, heart failure, major depressive disorder, and malignant neoplasm of prostate.
Resident 1 was his/her own person and was private pay. (Resident had been in communication previously with family members who expressed concerns that Resident 1 would benefit from a power of attorney for healthcare and finance.)

Resident 1's "Individual Service Plan," dated 11/16/2023, documented:
Personal Safety: "Resident is aware of the fact that we are a no lift community and that if [s/he] were to have an incident and was unable to be guided by 1 caregiver, that EMS (emergency medical service) will need to be called to assist resident off the floor and a cost to the resident will occur by the EMS department that the resident is required to pay."
"Mental Status: Resident requires additional cueing due to impaired judgement."

On 04/25/2024 at 11:20 AM, Surveyor emailed Executive Director A. Surveyor stated Resident 1's ISP to include language that s/he will be

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N 387	Continued From page 12 charged for lift assistance. The ISP was not signed and it is determined that his cognition is impaired, how do you know he understands and/or agreed to this being added to the ISP.	N 387		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) was followed as written. Resident 1's ISP documented s/he was to utilize a call light when requesting assistance due to being assessed as a fall risk. The response time was delayed. Resident 3 did not receive scheduled frequent checks throughout the day/evening. Resident 3 was found deceased by a staff member and was informed by emergency personnel that Resident 3 had been deceased for approximately 6 to 8 hours. Findings include: Example 1: Resident 1 On 03/28/2024, the Department received a complaint alleging that staff are not awake during scheduled hours resulting in residents sitting in their incontinence. On 04/03/2024, at approximately 1:00 PM, while visiting with Resident 1, Resident 1 stated s/he	N 388		

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was to utilize a call light when s/he needed assistance, but staff are known to be slow to respond. Surveyors pressed Resident 1's call light at 1:14 PM and waited to see how long it would take staff to respond. After approximately 10 minutes, Surveyors pressed the call light again. At approximately 1:42 PM, a staff member arrived (28 minutes). During this timeframe, Surveyors walked around the facility, looking for a staff member. There were no staff members available. Surveyor observed the call light alert system and noted the only lights activated were Resident 1's and Resident 7's. One Surveyor waited with Resident 1, while the other Surveyor went to Resident 7's room and did not observe a staff member(s) in that room. Surveyor interviewed him/her. Resident 7 stated staff are always slow, "Never know where they are."

On 04/03/2024, Surveyor reviewed Resident 1's record.

Resident 1's Individual Service Plan documented: "Mobility - Falls: 03/01/2024 - Resident to call for assistance; 08/18/2023 - anticipate needs-learn past patterns and coping styles; 06/28/2023 - place in common area during high risk fall times; 06/23/2023 - signage posted to remind resident to ask for help; 05/08/2023 - frequent checks; 04/24/2023 - call light pendant ordered for resident to keep call light close by. 04/23/2023 - resident reminded to use call light for transfers. Call light within reach when in room."

On 04/03/2024, at approximately 2:00 PM, Surveyors interviewed Registered Nurse (RN) H. Surveyor explained their observation regarding Resident 1's call light response time. RN H stated residents should not have to wait 28 minutes for a staff member to respond, especially since

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Resident 1 is a fall risk. RN H did not have a response when Surveyors stated they walked around the facility looking for a staff member and one Surveyor waited with Resident 1, while the other waited with Resident 7. RN H stated s/he did not have an answer as to why the Surveyors were unable to locate a staff member. RN H stated, "There have been staffing concerns related to being unable to locate staff while they are 'on shift.'"

Example 2: Resident 3

On 03/18/2024, the Department received a written report by the provider that stated Resident 3 was observed absent of vital signs on the floor of his/her apartment near his/her bed on 03/15/2024. Resident 3 was last seen by staff around 1630 (4:30 PM) and was independent with cares, transfers, and ambulation. Resident 3 was pronounced deceased by the medical examiner at 2242 (10:42 PM).

On 04/03/2024, Surveyor reviewed Resident 3's record.

Resident 3's "Individual Service Plan," dated 02/24/2024, documented:
"Personal Safety: Resident is visually checked on frequently through the day and night to promote safety and to encourage participation in activities."
"Advance Directives: Full Code."

On 04/03/2024, at approximately 2:30 PM, Surveyors interviewed Registered Nurse (RN) H. Surveyors asked RN H to recap when Resident 3 was last seen by staff and when s/he was found deceased. RN H stated an internal investigation had been conducted. RN H stated, "There are

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some inconsistencies on the information that has been collected from staff, but it sounds like the last time [s/he] was seen by staff was somewhere between 3:30 and 4:00." Surveyors stated Resident 3's ISP identified that s/he was on frequent checks. RN H stated, "That is correct. Staff should have found [Resident 3] prior to 9:30 PM."

On 04/03/2024, at approximately 4:00 PM, Surveyor interviewed Caregiver K. Surveyor asked if s/he was aware of the events that led up to Resident 3's death. Caregiver K stated s/he was told that Resident 3 had been deceased like 6 to 8 hours prior to staff finding him/her. Caregiver K stated, "I don't know how they figure that out." Surveyor asked if Resident 3 was on frequent checks. Caregiver K stated, "I think [s/he] was on one hour checks, maybe 1 1/2 hour checks."

On 04/08/2024, Surveyor requested Resident 3's ambulance report which documented:
"On 03/15/2024 at 21:44 (9:44 PM), rescuer was called to an echo level, PNB (pulseless nonbreather) and downgraded enroute to a bravo level obvious death. Upon arrival, staff was visibly upset/sad, and patient was lying on [his/her] back, fully dressed, with [his/her] arms stretched out on [his/her] side and [his/her] hands in the air and stiff. Patient legs were crossed and stiff. Patient's eyes were completely blood shot and dry and not responsive to any light. There appeared to be some trauma around the patient's mouth that is suspected to have hit [his/her] CPAP (breathing device) machine during a probably fall of some type. Patient was in full rigor head to toe and cold to the touch, had lividity to [his/her] face, and had a fowl smell coming from [him/her]. Due to what we were seeing we

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N 388	Continued From page 16 agreed there was no need to further investigate. According to staff, they found the patient face down, also in full rigor. No CPR was started by staff due to it being an obvious death. Staff stated [his/her] last known well time was "around lunch" when [s/he] was last seen. Only two staff were able to give us information, so we are unaware if [s/he] was seen by other staff at a different time. Patient was extremely independent and did not need a lot of care from staff so [s/he] was not someone that was checked on extremely frequently." "Rigor mortis appears approximately 2 hours after death in the muscles of the face, progresses to the limbs over the next few hours, completing between 6 to 8 hours after death. [10] Rigor mortis then stays for another 12 hours (till 24 hours after death) and then disappears." (Source: National Institute of Health (NIH) website, Methods of Estimation of Time Since Death, May 30, 2023, https://www.ncbi.nlm.nih.gov (retrieval date: April 25, 2024).) On 04/08/2024 at 2:30 PM, Surveyor emailed Executive Director (ED) A and asked for the provider's policy on 'frequency checks.' ED A stated the provider did not have a policy on frequency checks, but s/he would define it as before and after meals, upon rising, at bedtime and 1-2x per night."	N 388		
{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	{N 389}		

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{N 389}	Continued From page 17 on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the Individual Service Plan (ISP) for 1 of 1 resident were not updated when there was a change in resident needs and abilities. This is a repeat deficiency. See Statement of Deficiency (SOD) BTKI11, dated 11/15/2023. Resident 1's ISP was not updated to include guidelines regarding his/her air mattress. Resident 1's ISP did not provide guidelines regarding his/her ability to safely operate his/her electric wheelchair. Findings include: On 04/03/2024, at approximately 4:30 PM, Surveyors observed Resident 1 in the dining room and asked him/her if s/he could speak with the Surveyors in the common area. Resident 1 attempted to maneuver his/her electric chair. Resident 1 backed into another resident at a dinner table, caught the wheelchair on the edge of the table causing the table to move. Once away from the table, Resident 1 maneuvered the wheelchair into the common area, rubbing along the wall the entire length with the appearance of	{N 389}		

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{N 389}	Continued From page 18 becoming hung up. Registered Nurse (RN) H walked over and observed Resident 1 and appeared to be determining if Resident 1 needed assistance. On 04/03/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the facility, 04/20/2023, with diagnoses including weakness, heart failure, major depressive disorder, and obstructive sleep apnea. Resident 1's Individual Service Plan documented: "Chronic/Acute Pain Lower Back Pain - Pain will be managed per the resident's tolerance and will not interfere with the resident's daily living." "Mobility - Falls: Resident will demonstrate ability to use assistive device safely and consistently. 08/03/2022 - high low bed requested; 05/11/2023 - staff to help make sure resident is centered in the bed; 06/08/2023 - resident reminded not to sit on the edge of bed due to air mattress; 06/30/2023 - resident to sleep in bed without hanging legs over the edge of bed; 07/03/2023 - bolster mattress requested; 08/16/2023 - make sure furniture is neither too high or too low." "Wheelchair is primary mode of transportation." "03/01/2024 - Resident to call for assistance; 04/24/2023 - call light pendant ordered for resident to keep call light close by. Call light within reach when in room." The ISP did not document guidelines for the air mattress, such as weight settings, that should be set at currently in Resident 1's room. The ISP did not document that Resident 1 utilized an electric wheelchair and if s/he had been assessed to determine if s/he needed assistance during the utilization of the wheelchair.	{N 389}		

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{N 389}	Continued From page 19 On 04/25/2024, at approximately 11:25 AM, Surveyor interviewed Executive Director (ED) A. ED A stated s/he was not responsible for completing the ISPs and would speak with the appropriate staff. Cross Reference: N0483 DHS 83.43(2)(b) Clean, Comfortable Mattress And Pad	{N 389}		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did maintain a proof-of-use record for 1 of 1 resident's (Resident 6) schedule II medication, Morphine. The proof-of-use sheets did not consistently align with the number of actual available narcotics. Findings Include: On 04/10/2024, the Department received a concern alleging misuse of Morphine with hospice residents. On 04/26/2024, Surveyor reviewed Resident 6's	N 409		

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N 409	Continued From page 20 record. Resident 6's March 2024 Medication Administration Record (MAR) documented: Morphine 100 MG (milligram) / 5 ML (milliliter) - Take 0.25 ML by mouth every 2 hours as needed (PRN) for pain or shortness of breath. Start Date: 03/20/2024. Discontinued Date: 03/28/2024. The medication was administered: 03/22/2024 7:30 AM 03/25/2024 8:42 AM, 11:20 AM, 3:07 PM, 5:10 PM, 7:31 PM 03/26/2204 11:17 PM Resident 6's pharmacy packing slip, dated 03/20/2024, documented 7.5 Morphine 100 MG / 5 ML were delivered. This is the equivalent of 30 doses (7.5 times 4). Resident 6's destruction record, dated 03/28/2024, documented 16 doses were destroyed. Per the March MAR, the PRN Morphine was given 7 times, leaving a balance of 23 doses. On 04/26/2024 at 2:13 PM, Surveyor emailed Executive Director (ED) A and Registered Nurse H and asked if there was a narcotic count sheet for Resident 6's Morphine. ED A stated the narcotic count sheet was unavailable. Surveyor asked for clarification on where the remaining 7 unaccounted doses were (30 - 7 = 23 - 16 destroyed = 7 unaccounted). Surveyor did not receive a response. ED A responded to other requests.	N 409		
N 415	83.37(2)(d) Documentation of medication administration.	N 415		

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N 415	Continued From page 21 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 1of 1 resident medications were properly documented. Resident 6's as needed (PRN) Lorazepam destruction record did not correlate with his/her MAR and Controlled Drug Record. Findings include: On 04/10/2024, the Department received a concern alleging misuse of comfort meds for hospice residents. On 04/26/2024, Surveyor reviewed Resident 6's record. Resident 6's March 2024 Medication Administration Record (MAR) documented: Lorazepam tablet 0.5 MG (milligram) - Take 1 tablet by mouth every 4 hours as needed for anxiety. Start Date: 03/20/2024. Discontinue Date: 03/20/2024. Lorazepam tablet 0.5 MG - Take 1 tablet by	N 415		

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mouth every 1 hour as needed for terminal restlessness. Start Date: 03/20/2024. Discontinued Date: 03/28/2024.
The medication was administered:
03/20 12:06 PM
03/21 10:02 PM
03/23 2:46 AM
03/25 9:31 AM, 11:36 AM, 3:06 PM, 4:40 PM, 6:31 PM, 7:32 PM

Resident 6's pharmacy packing slips, dated 03/20/2024 and 03/27/2024, documented 35 tablets of Lorazepam 0.5 MG were delivered.

Resident 6's "Controlled Drug Record" documented the following administration times:
03/21 9:30 PM
03/23 2:41 AM, 8:30 AM
03/25 9:31 AM, 11:36 AM, 3:06 AM, 4:41 PM, 7:32 PM
03/27 10:45 AM, 1:30 PM
The record did not include the 03/20 administration date documented on the MAR.
The record documented 2 doses administered on 03/23 where the MAR documented one dose.
The record documented 2 doses administered on 03/27 that were not documented on the MAR.
The record documented 5 doses administered on 03/25 where the MAR documented six doses.

Resident 6's destruction record, dated 03/28/2024, documented 22 doses of Lorazepam were destroyed. Per the MAR and the Controlled Drug Record information, the Lorazepam was administered 12 times between 03/20/2024 and 03/27/2024, leaving a balance of 23 (35-12 = 23).

On 04/26/2024 at 2:13 PM, Surveyor emailed Executive Director (ED) A and Registered Nurse H and asked for clarification regarding Resident

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N 415	Continued From page 23 6's Lorazepam medication documentation. Surveyor did not receive a response.	N 415		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure a safe, clean and home like environment. Findings include: On 04/02/2024 at approximately 12:42 PM, Surveyors toured the facility. The following was observed on the tour: 1.) Resident 1's room had food debris all over the floor, a used urinal that contained urine, burnt out light bulbs, soiled clothes sitting in a basket in the shower, the bathroom door was missing, the door stop on the floor was broken, and brown matter on the side of the garbage can. 2.) The wall outside of Resident 1's room was scraped up badly and missing trim pieces. 3.) The fire place in the activities room had broken glass on the floor by the fire place. The fire place glass had been broken out.	N 481		

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N 481	Continued From page 24 On 04/05/2024 at approximately 1:50 PM, Surveyor shared findings with Administrator A. Administrator A stated the hallway is getting redone and they have started to take off the wall paper and that is why the walls look the way they do. Administrator A stated the remodeling was supposed to be done, but is hoping it is done by next quarter.	N 481		
N 483	83.43(2)(b) Clean, comfortable mattress and pad. Bedroom furnishings. If a resident does not provide the resident ' s own bedroom furnishings, the CBRF shall provide all of the following: A clean, comfortable mattress covered with a mattress pad and when necessary, waterproof covering. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 1 had a comfortable mattress. Findings include: On 04/03/2024, at approximately 2:00 PM, Surveyors observed Resident 1 in his/her room, sitting on his/her bed, leaning back to the right. When Resident 1 transferred to his/her wheelchair for dinner, Surveyors observed Resident 1's bed to appear sunken in the center of the bed, covered with a fuzzy brown bedspread. Surveyor commented to Resident 1 that it appeared his/her bed sunk in. Resident 1 stated, "Yeah, it does." Surveyors removed the blankets and observed what appeared to be a two-mattress system that had approximately a six-inch gap between mattresses. Surveyors	N 483		

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N 483	Continued From page 25 requested Resident 1's record. Resident 1 moved into the facility, 04/20/2023, with diagnoses including weakness, heart failure, major depressive disorder, and obstructive sleep apnea. Resident 1's Individual Service Plan documented: "Chronic/Acute Pain Lower Back Pain - Pain will be managed per the resident's tolerance and will not interfere with the resident's daily living." On 04/12/2024 at 10:05 AM, Surveyor emailed Executive Director (ED) A. Surveyor described the observation of Resident 1's bed. ED A stated, "There is a gap at the head of the bed when the bed is raised. As far as the mattress is concerned, it is well inflated." Surveyor responded that the gap was in the middle of the bed, while Resident 1 was lying on the bed. As of 04/25/2024 at 10:00 AM, Surveyor did not receive a response.	N 483		