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	0015633	A. BUILDING: _____ B. WING _____	C 06/24/2025

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WILLOW BROOKE POINT SENIOR LIVING RCA	1801 LILAC LN STEVENS POINT, WI 54481

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U 000	INITIAL COMMENTS On 06/23/2025 with additional information gathered through 06/24/2025, Surveyor conducted 2 complaint investigations at Willow Brooke Point Senior Living RCAC. One deficiency was identified. The complaints were unsubstantiated. Census: 35	U 000		
U 211	89.28(6) RISK AGREEMENT UPDATING. The risk agreement shall be updated when the tenant's condition or service needs change in a way that may affect risk, as indicated by a review and update of the comprehensive assessment, by a change in the service agreement or at the request of the tenant or facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Tenant 1's risk agreement was updated when his/her condition changed in a way that affected risk. Tenant 1's risk agreement was not updated when s/he experienced falls, confusion, memory impairment and behaviors, known to the RCAC, which put the tenant at risk of harm or injury. Findings include: On 06/23/2025, Surveyor reviewed Tenant 1's record. S/he was admitted 08/01/2015 and discharged 02/16/2025 to hospital, did not return. Diagnoses included schizophrenia, anxiety	U 211		

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

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U 211	Continued From page 1 disorder, and age-related cognitive decline. Power of Attorney for Health Care was not activated, and s/he remained his/her own health care decision maker. Service Agreement was dated 05/23/2016 and identified Tenant 1 agreed s/he would accept medication administration service. Physician service progress notes: -08/07/2024- " ...seen today in ER follow-up. [S/he] has a history of schizophrenia and anxiety in which [s/he] is on risperidone twice daily, [s/he] is a poor historian. Staff reports that patient had 2 episodes over the weekend in which [s/he] was leaning against [his/her] door and not answering staff or opening the door. Being unable to get into room to check on patient, EMS was called on Friday and POA elected for patient not to be sent to hospital. The same type of situation happened on Saturday where staff was unable tot get into the room and patient was leaning against the door. POA had patient sent to hospital at that time. ...[family] of patient stated that there was no acute changes or concerns found with workup other than a mild bladder infection ...Patient has had improvement in mental status/behaviors since returning from ER ..." 10/14/2024- "Physical Exam: Insight: poor insight. Mental Status: confused. Orientation: oriented to person. Memory: recent memory abnormal and remote memory abnormal ..." -11/25/2024 4:32 PM- "THE RESIDENT TO START REFUSING MEDICATIONS AND STAYING UP ALL NIGHT, STAFF TO REQUEST A TIME FRAME CHANGE FOR THE RESIDENT ..." -12/02/2024 7:03 PM- "[Name of physician service] IN FOR A ROUTINE [follow-up] MEMBER IS WHEELCHAIR/BEDBOUND,	U 211		

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U 211	Continued From page 2 NONAMBULATORY. POOR MEMORY. ORIENTED TO SELF ONLY. STAFF DENY NEW PROBLEMS ..." Hospital documentation received via fax from hospital 06/13/2025 at 8:34 PM (summarized): Tenant 1 presented to emergency room on 02/16/2025 for decreased responsiveness over the last two weeks. On admission s/he was noted to be hypothermic, bradycardic and hypotensive with decreased mental status and pressure injury on left knee, abrasion on sacrum, bruises on left hip and trauma around left eye. Tenant 1 was treated in the ICU and transferred onto hospice service. Level of Care Assessment dated 08/24/2024, not a change of condition evaluation. In the area of Social Factors (summarized): Psycho/Social Needs-requires additional time/place orientation, and frequent behavioral monitoring Mental Status- occasionally requires additional time/place orientation and frequent behavioral monitoring. Staff to observe for signs/symptoms of confusion and/or disorientation. Enjoys spending time with family, solitude of his/her room and likes to go to bed early. Dislikes being disturbed while in bedroom, rarely participates in activities and asks that staff be respectful of this choice. Incident Reports (summarized): 08/14/2015- Fell due to loss of balance while moving a chair during exercise class. 01/08/2019- fell in bathroom due to dizziness, did not use call light, got self up. Facility progress notes: 11/21/2024 11:05 PM- "Resident was behind	U 211		

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U 211	Continued From page 3	U 211		

[his/her] living room door and holding it shut for with all [his/her] might. I got it open with [name of coworker] helping to talk to [him/her] but [s/he] screamed so loudly when I was turning the handle. [S/he] keeps making mutterings about "someone [sic] is going to kill me[sic]" ...[S/he] is repeating a lot of phrases for eg [sic] "[Tenant 1's name] needs to flush the toilet [sic]", which is repeated until [s/he] has flushed the toilet. this [sic] is the first time I have been successful with helping [him/her] when [s/he] is having an episode but I think the familiarity of [name of coworker] talking to [him/her] really helped [him/her] trust me.

11/22/2024 5:03 AM- "[s/he] [sic] just came down for breakfast and [s/he] said [s/he] thought [s/he] was told to come down now. I showed [him/her] the dining room and [s/he] allowed me to take [him/her] back to [his/her] room. I offered to change [his/her] clothes since they are dirty but [s/he] said that [s/he] is going to pray the rosary and [s/he] will do it him/herself]. [s/he] [sic] was smiling and not crying anymore."

12/05/2024 10:33 AM- "On 12/04/2024 at [4:10 PM] resident had a fall in [his/her] room ...had a follow-up appointment with [primary care physician] ..."

01/24/2025 8:09 PM- "[Tenant 1] was [refusing] to come out of [his/her] room for dinner and take [his/her] Meds [sic] night [sic] [s/he] [sic] was holding [his/her] bedroom doorknob where I could not come In [sic] [his/her] room [sic]."

02/01/2025 7:00 PM- "[s/he] [sic] is screaming and Yelling [sic] and Holding [sic] onto [his/her] door Knob [sic] will not let me In [sic] and s/he is Refusing [sic][his/her] pills at night [sic]"

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U 211	Continued From page 4 02/02/2025 11:30 AM- "Resident was very confused and fell while self transferring ...No complaints of pain. Resident received a black eye from fall. Resident refused to be sent out and POA was unavailable when called ..." 02/09/2025 1:10 PM- "Resident locked [him/her] self [sic] in his/her room all morning/afternoon. [S/he] was sitting in front of [his/her] door holding the handle. [S/he] is also having full conversation with [him/herself] in [his/her] room and calling [him/herself] Audrey. Earlier in the day [s/he] was sitting in [his/her] room screaming and refused assistance from staff. When staff went to open [his/her] door [s/he] would hold the handle and scream." 02/11/2025 5:58 PM- "Follow up from fall on 02/06/2025 Resident has had no falls since 02/06. Resident continues to have bouts of confusion. Resident is now locking [him/herself] in room and screaming and having conversations with [him/herself] and referring to [him/herself] as Audrey. [Wellness director] and [clinical director] have been made aware." 02/11/2025 9:00 PM- "I was getting a resident An [sic] Ice [sic] cream bar and saw [Tenant 1] out side [sic] going to the others [sic] building [sic] when [sic] I went out there to get here [sic] back to the building safe I put [him/her] by the Fireplace [sic] to warm up [sic]" 02/12/2025 9:12 PM- "[Tenant 1] is trying to exit out the front doors I had to lock the front door so [s/he] would not get outside in the cold. [sic] tried to Reapproach [sic] [him/her] a couple of time the 3rd time I got [him/her] to go back to [his/her] room for now ..."	U 211		

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U 211	Continued From page 5 02/15/2025 11:15 AM (summarized)- Unwitnessed fall on 02/15/2025 at approximately 5:30 AM, EMS called for assistance getting [him/her] off the floor. 02/18/2025 1:00 PM "Type of Incident, Date & Time: 02/16/2025 at 9:30 AM, unwitnessed fall/observed on the floor ...Staff assisted the resident to [his/her] wheelchair and observed for injuries or marks, none present at the time ...had call light within an arm reach and did not pull it ...Staff then proceeded to bring resident down to the dining room for breakfast ..." 02/19/2025 11:19 AM "Follow up from fall on 02/15/2025 Resident had another fall the next day and ended up getting sent out to the hospital for becoming unresponsive. Hospital stated [s/he] is actively dying and will keep up [sic] notified." Handwritten statement signed and dated 02/12/2025 by Housekeeper F "On the 11th at night about 9pm [sic] [s/he] came out of [his/her] Room [sic] wanting supper time I reinsured [sic] [him/her] That [sic] it was night Time [sic] [s/he] didn't Believe [sic] me, so I took [him/her] to the kitchen window. [S/he] was fully Dressed [sic] and had [his/her] shoes on and [his/her] big red jacket on all day when I came on to my shift at 2 PM [sic] Show [sic] [his/her] it was night time and saw [2 other tenants] outside. Took [sic] A [sic] Ice [sic] cream Bar [sic] to [room #] and saw [him/her] outside heading next-door [sic] I ran out and grabbed [him/her] and brought [him/her] Back [sic] in put [him/her] By [sic] the fireplace. [S/he] was outside for maybe about 4 to 5 [minutes] then I eventually took [him/her] Back [sic] to [his/her] room for the night [sic] I did let the nurs [sic] know and told night shift to."	U 211		

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U 211	Continued From page 6 Physician orders included: meclizine 25 MG 1 tablet at bedtime for vertigo; melatonin 3 MG 2 tablets at bedtime for insomnia; Risperdal 1 MG 1 tablet in AM and 2 MG 1 tablet at bedtime and for schizophrenia; simvastatin 10 MG 1 tablet in evening for high blood pressure; hydrochlorothiazide 12.5 MG 1 capsule once daily for high blood pressure; and Losartan potassium 100 MG 1 tablet daily for high blood pressure. Medication Administration Record (MAR) dated 11/01/2024-02/16/2025: Number of times staff documented refusals of physician ordered medications: Meclizine 25 MG 1 tablet at bedtime for vertigo November 2024- 3 December 2024- 6 January 2025- 3 February 2025- 3 Melatonin 3 MG 2 tablets at bedtime for insomnia - November 2024- 18 December 2024- 9 January 2025- 3 February 2025- 3 Risperdal 1 MG 1 tablet in AM for schizophrenia- December 2024-2 January 2025- 3 February 2025- 3 Risperdal 2 MG 1 tablet at bedtime for schizophrenia November 2024- 4 December 2024- 8 January 2025- 4 Simvastatin 10 MG 1 tablet in evening for high	U 211		

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blood pressure-
November 2024- 16
December 2024- 13
January 2025- 7
February 2025- 3

Hydrochlorothiazide 12.5 MG 1 capsule once daily for high blood pressure-
February 2025- 2

Losartan potassium 100 MG 1 tablet daily for high blood pressure-
February 2025- 2

Individual Service Plan dated 03/18/2024
In the area of Mobility-
" ...The resident educated on the importance of calling for assistance when transferring signs hung in [his/her] room 12/4 Date Initiated: 12/09/2024
In the area of Mental Status: " ...Resident occasionally requires additional time/place orientation Date Initiated 02/05/2023 ...Resident requires frequent behavioral monitoring Date Initiated: 08/22/2023 ...staff have access to key for rooms and can open upon emergency or request by resident Date Initiated 03/18/2024 ..."

Tenant 1's record contained 3 negotiated risk agreements dated 05/16/2016, 07/11/2022, and 09/14/2023:
05/16/2016- (summarized): The concern/issue identified was self-administration of medication.

07/11/2022- " ...Pursuant to HFS chapter 89, as a protection for both resident and the facility, facility and resident are required to enter into a jointly negotiated risk agreement by the date of occupancy. Situation, condition, or course of action that may be taken by resident which could

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U 211	Continued From page 8 put the resident at risk of harm or injury and possible consequences of such actions. A. Violation of facility policies and procedures (as identified in the admission agreement, service agreement, and other information periodically distributed to residents) or disregarding the instructions of facility staff can result in disruption to other residents, inconvenience, and/or injury. Resident accepts responsibilities for such results. B. Unless resident is unable to recognize or communicate changes in condition, facility staff do not physically assess resident except as ordered by a physician in response to a specific resident complaint or readily apparent change in condition or function, or as otherwise identified below. Resident accepts responsibility for injuries or medical complications resulting from residents failure to report changes in medical or physical status to facility staff. B1. Describe conditions for which resident has requested physical assessment below (e.g. edema) None ... C. Resident has experienced one of more falls ... D. Resident has exhibited wandering/elopement behaviors ... E. Resident has chosen to independently manage medication ... F. Other: describe course of action, resident preference, compromise (if any) and residents' acceptance of responsibility for risk: Resident shall maintain current level of independence. G. Identify all services identified in the comprehensive assessment that are needed by the resident but are not provided directly or under contract by the facility: Staff shall assist resident [as needed] ..." Options A. and B. were checked. 09/14/2023- " ...A. Violation of facility policies and procedures (as identified in the admission	U 211		

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U 211	Continued From page 9 agreement, service agreement, and other information periodically distributed to residents) or disregarding the instructions of facility staff can result in disruption to other residents, inconvenience, and/or injury. Resident accepts responsibilities for such results. B. Unless resident is unable to recognize or communicate changes in condition, facility staff do not physically assess resident except as ordered by a physician in response to a specific resident complaint or readily apparent change in condition or function, or as otherwise identified below. Resident accepts responsibility for injuries or medical complications resulting from residents' failure to report changes in medical or physical status to facility staff. B1. Describe conditions for which resident has requested physical assessment below (e.g. edema) None noted at time of assessment ... F. Other: describe course of action, resident preference, compromise (if any) and residents acceptance of responsibility for risk [Blank] G. Identify all services identified in the comprehensive assessment that are needed by the resident but are not provided directly or under contract by the facility: Staff shall assist resident [as needed]. [Blank] ..." Options A. and B. were checked. On 06/23/2025 at 1:03 PM, Surveyor interviewed Case Manager G who stated Tenant 1's Power of Attorney for Health Care document was activated at the hospital on 02/16/2025. Case Manager G stated Tenant 1's medication refusals occurred now and then through the years and previously his/her family member was contacted to encourage Tenant 1 to take them. Tenant 1 thought s/he was being poisoned if medications	U 211		

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were given in pudding or yogurt so the Risperidone was given in MiraLAX. Case Manager G stated the incident on 02/11/2025 when Tenant 1 went outside was investigated by county adult protective services (APS) and since APS closed the incident s/he assumed APS had no findings.

On 06/23/2025 at 1:18 PM, Surveyor interviewed Housekeeper F who stated s/he was a med tech prior to switching to housekeeping and had worked with Tenant 1 as a med tech. Housekeeper F stated Tenant 1 refused medications which s/he passed on in shift report and reported to Clinical Director C. Housekeeper F stated Tenant 1 would hold his/her door knob to keep staff out of his/her room and elopement attempts increased on the PM shift. Housekeeper F stated s/he was trained that Tenant 1 was paranoid, delusional and hallucinated.

On 06/23/2025 AT 2:07 pm, Surveyor interviewed Med Tech D who stated a few weeks prior to Tenant 1's discharge s/he cried, yelled and screamed and another tenant called police for Tenant 1 because s/he thought someone had broken in. Med Tech D stated it was hard to know what Tenant 1 needed because s/he would stay in his/her room almost every night and cry and staff consistently checked on him/her.

On 06/23/2025 at 2:29 PM, Surveyor discussed concern with Tenant 1's risk agreement with Executive Director A, Clinical Director C and Business Office Manager E. Executive Director A stated Tenant 1 was experiencing more psychological issues and they tried to find him/her placement to stabilize his/her psychotropic medications but most would not accept geriatric patients. Executive Director A stated Tenant 1's

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U 211	Continued From page 11 behaviors were very odd for him/her and the behavior change occurred quickly. Executive Director A stated they tried to find someone to oversee his/her psychiatric medication, and the physician service was seeing him/her regularly. Executive Director A stated a change in condition assessment was not completed because they did not consider the changes to be long term and 30 days was considered long term. Executive Director A stated Tenant 1's behavior change occurred quickly. Clinical Director C stated Tenant 1 locking him/herself in his/her room was common and was his/her right. Clinical Director C stated s/he would lock his/her door when hallucinating and fearful someone would come in and they did not consider that a risk because it was his/her way of feeling safe. Executive Director A stated it was Tenant 1's right to refuse medications and they would ask with Wellness Director B if any additional risk agreements were completed with Tenant 1 and submit to Surveyor by 2:30 PM on 06/24/2025. On 06/24/2025 at 1:05 PM, Surveyor received an email from Executive Director A stating the provider did not create any new risk agreements as they felt resident was locking door per their right and refusing medications per their right. On 06/24/2025 at 3:53 PM, Surveyor replied via email indicating concerns documented in Tenant 1's record regarding falls, elopements, and the atypical physical blocking of his/her apartment door with significant verbal outbursts evidenced risks to Tenant 1 to be addressed in a risk agreement. As of 6/26/2025 at 8:00 AM, Executive Director A did not respond and did not submit additional risk agreement(s).	U 211		

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