STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018671	A. BUILDING: _____ B. WING _____	R-C 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE MANOR	711 BAYSHORE ROAD OSHKOSH, WI 54901

(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 01/17/2024 and 01/18/2024, Surveyor conducted unannounced onsite facility visits to investigate 5 complaints, 2 self-reports and to conduct a verification visit. Additional information was received through 01/29/2024. Two (2) of 5 complaints were substantiated. Five deficiencies were identified including 2 repeat deficiencies. Census: 39 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify the resident's legal representative or physician when there was an incident or injury to Resident 1. Findings include: The Department received a complaint that alleged the provider was not notifying legal	N 169		

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

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N 169	Continued From page 1 representatives of falls with injury. On 01/17/2024 at 8:37 AM, Surveyor conducted an interview with Regional Director of Wellness A (RDW A). RDW A stated Resident 1's family was upset about a fall that occurred on 12/11/2023 and shared the provider's response to it. RDW A said s/he immediately initiated an investigation and corroborated the concerns. RDW A said since that time the provider had made systems changes to ensure falls were properly responded to and all required notifications were made going forward. RDW A provided Surveyor with documentation of the investigation which read in part, "On 12/11/23, at 04:25 am...The caregiver...saw the resident fall forward, striking [his/her] face. This resulted in swelling to the nose and a bloody nose... On 12/12/23, [Director of Wellness (DW) C] did observe the bruising to the resident's face ... there was another fall 12/12/23, in which the resident struck the head. The resident was admitted to the hospital and diagnosed with a nasal fracture....Further investigation revealed... [s/he] had had five falls since admission to the facility. The appropriate family member was not called with each fall.....[the power of attorney (POA)] was only notified of one of the falls. The other fall notifications were made to [a different family member] who is not the POA...The residents PCP (primary care physician) was not notified of the numerous falls until 12/13/23. Results of Investigation: It has been determined through investigation that [DW C] was negligent in [his/her] follow up of the resident ....When [DW C] did observe the extent of the injuries, [s/he] did not ...update the POA on the extent of the injuries..."	N 169		

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N 169	Continued From page 2 On 01/17/2024, Surveyor reviewed portions of Resident 1's record. S/he was admitted on 12/07/2023 and had an activated POA (legal decision maker) for Health Care. The record also documented 5 falls between 12/07 and 12/12/2023. On 01/18/2024 at 11:52 AM, Surveyor conducted a follow up interview with Regional Director of Operations (DOO) E. DOO E stated they took the concerns seriously and implemented an internal plan of correction which included retraining and active tracking/regional oversight of response to falls. S/he said the new tracking system included verification that all required notifications were made. DOO E provided documentation of the new tracking system for Surveyor to review.	N 169		
{N 277}	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the	{N 277}		

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{N 277}	Continued From page 3 provider did not ensure 3 of 3 employees reviewed received at least 15 hours of continuing education during 2023 in all of the following topics; (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. Caregiver F, Caregiver L and Caregiver N did not complete 15 hours of continuing education including all required topics during 2023. This is a repeat deficiency. See Statement of Deficiency EXJH12, dated 04/11/2023. Findings include: On 01/18/2024, Surveyor reviewed employee training records for Caregivers F, L and N to determine compliance with continuing education training requirements. The provider used an online program for continuing education. Caregiver F was hired 12/20/2019. During 2023, Caregiver F completed 4.75 hours of online continuing education training. Manager B provided additional documentation of staff meetings that included training. The documentation added approximately 1 hour towards the total number of training hours. Caregiver L was hired 08/30/2022. During 2023, Caregiver L completed 2.25 hours of online continuing education training. The record did not include evidence of training in resident rights, client group or 1st aid. *Surveyor noted some of the assigned training for Caregiver F and Caregiver L during 2023 were	{N 277}		

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{N 277}	Continued From page 4 completed in January 2024. However, the completed training did not satisfy all required topics or hours. Caregiver N was hired 02/07/2020. During 2023, Caregiver N did not complete any of the online continuing education training. Manager B provided additional documentation of a PowerPoint on the topic of abuse, neglect and misappropriation that was reviewed with Caregiver N on 09/11/2023. The amount of time spent on the review was not documented. On 01/18/2024 at 11:52 AM, Surveyor interviewed the management team to include Regional Director of Wellness A and Manager B. Both management staff acknowledged the continuing education requirements were not met for all 3 caregivers.	{N 277}		
N 323	83.31(2) Emergency or temporary transfer. Emergency or temporary transfers. If a condition or action of a resident requires the emergency transfer of the resident to a hospital, nursing home or other facility for treatment not available from the CBRF, the CBRF may not involuntarily discharge the resident unless the requirements under sub. (4) are met. This Rule is not met as evidenced by: Based on record review and interview, the provider involuntarily discharged Resident 4 after an emergency room visit, without assisting with locating or otherwise ensuring a suitable living arrangement was available. As a result, Resident 4 remained in the hospital for 15 days until a suitable living arrangement was found by the managed care organization (MCO).	N 323		

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N 323	Continued From page 5 Findings include: The Department received a complaint regarding an involuntary discharge. Prior to the onsite visit, Surveyor reviewed Department records and noted the provider is licensed to serve residents with irreversible dementia/Alzheimer's. On 01/02/2024, the provider self-reported the following incident: "[Resident 4] was issued a discharge notice...8/17/23 due to [his/her] behaviors ...The resident's [MCO] team began searching for alternate placement, and were successful in determining an alternate facility...However, the resident's POA declined...Following that, the [MCO] team stated they were continuing to search for alternate placement for resident. However, no further communities came to assess the resident. The resident was working with [Nurse Practitioner (NP) P], who is certified in psych (psychiatric care)...On 12/29/23, [Resident 4] was sent to [Hospital R] following what appeared to be a manic episode and multiple falls, and subsequently was dis-allowed from returning to the community. After resident was sent to the emergency room, communications were had with [NP P]...who stated that [s/he] was having difficulty managing resident within the community, and believed [Resident 4] would benefit from a psychiatric stay to stabilize [sic]...Regional Director of Wellness [RDW A], spoke with POA and asked for permission to refer the resident to [Hospital S] Geri-Psych unit for inpatient treatment. The POA agreed. [RDW A] called [Hospital S] and they requested documentation on the resident to be sent for review...Several	N 323		

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hours later...the hospice nurse called to notify staff that the resident was not admitted (to Hospital R), and would be returning to the community. The community expressed concern over this due to the resident's condition and the inability to keep the resident safe, as well as the NP's recommendation. The ER told facility staff POA was refusing transfer to [Hospital S]. Facility staff attempted to speak with the POA regarding this and to discuss alternative psychiatric options. The POA acknowledged that the resident was having multiple changes in condition, but expressed that [s/he] did not want resident to be sent to psych because [s/he] would be admitted, they would stabilize [sic] [him/her], and then they would have a difficult time finding alternate placement for the resident. The POA expressed that "when this happened last year [s/he] was in the hospital for three months...[Hospital R] was updated that the facility would not be accepting the resident back in the community."

On 01/17 and 01/18/2024, Surveyor reviewed portions of Resident 4's record. Resident 4 was admitted on 03/14/2023 and issued an involuntary discharge notice on 08/17/2023. The record did not include documentation of the provider's efforts to secure an alternate, suitable living arrangement. Resident 4 had diagnoses to include severe early onset dementia with psychotic disturbance. Resident 4's record documented dementia associated behaviors and frequent falls. The record did not include evidence that behaviors or falls were consistently assessed to determine the root cause. For example during December 2023, Resident 4 was diagnosed with COVID and then 2 weeks later with pneumonia. There were no documented assessments to determine if Resident 4's illnesses contributed to the 12 falls s/he

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experienced during that month.

On 01/25/2024 at 4:10 PM, Surveyor interviewed NP P. S/he confirmed making multiple medication changes in the months preceding discharge in an effort to manage Resident 4's behaviors. S/he also agreed as of 12/29/2023 s/he thought Resident 4 could have benefited from an inpatient stay to review the medication regime. However, NP P also stated s/he had concerns about the provider's care and treatment of Resident 4 and their decision to issue an involuntary discharge notice. NP P said s/he did not consistently receive adequate information or documentation from the provider to inform his/her medication management decisions. NP P also questioned whether reported behaviors were truly behaviors, or Resident 4's efforts to express unmet needs. NP P described situations where staff said Resident 4 was actively behavioral, but NP observed him/her to have unmet needs for food, toileting or rest; once those needs were met, the behaviors stopped.

*Note: during the aforementioned record review, Surveyor reviewed visit notes from NP P. The notes documented his/her concerns about the discharge decision, the lack of communication and concerns about unmet needs being perceived as behaviors.

On 01/26/2024, Surveyor reviewed hospital records, "HOSPITALIST PHYSICIAN HISTORY AND PHYSICAL... Admission Date: 12/29/2023...HISTORY OF PRESENT ILLNESS...as noted below...[Resident 4] is here today for placement. Patient with severe dementia at baseline and cannot provide any meaningful information....Reportedly had a fall earlier today and has been cleared by the

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ER...Lakeshore reportedly has refused to take the patient back, reportedly stating that the 'doors are locked and [s/he] will not be light [sic] in' and also that 'we will take the fine' for not taking the patient back. [Ambulance company] as well as Oshkosh Police Department were reportedly involved. They refused to transport the patient back to Lakeshore Manor since the facility has said [s/he] will not be accepted there. ER provider has spoken numerous times with the patient's POA. Patient's POA has stated that [s/he] does not want the patient to go to...psychiatric facility...While in the ER, patient has been a 'model citizen' and has been sleeping frequently...Patient has been in the ER for approximately 10 hours while this has played out...It is currently Friday night prior to the holiday weekend. Patient will be placed in an observation bed on the medical floor due to the high risk associated with [his/her] social situation...imminent risk of homelessness...has nowhere to go and lacks the mental capacity to care for [him/herself]. Patient does not meet medical necessity for admission otherwise... anticipated length of hospital stay less than 2 midnights..."

On 01/29/2024 ad 8:31 AM, Surveyor interviewed MCO Coordinator Q who expressed concerns about the provider's handling of Resident 4's discharge. Coordinator Q said the discharge notice in August was surprising because Resident 4's dementia related behaviors were not far from his/her baseline or inconsistent with his/her known diagnoses. However, their agency began looking for an alternate living arrangement. In September 2023, a placement was found but the POA declined because it was approximately 1.5 hours away which was a barrier to frequent visits. The POA also thought it was too small and not

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well suited for Resident 4's tendency to walk the halls. Coordinator Q said they tried more than 50 other facilities but were unable to find any with openings or willing to admit. Coordinator Q said after being sent to the ER on 12/29/2023, Resident 4 had to stay in the hospital for 15 days until a living arrangement could be found. Ultimately, s/he was placed at the facility from September. Given the urgent need to place Resident 4, Coordinator Q and the POA agreed it was the only viable option. Coordinator Q said to date, the new provider has not reported concerns with Resident 4's behaviors.

Surveyor interviewed RDW A and other members of the management team on 01/17/2024 at 3:17 PM and on 01/18/2024 at 11:52 AM. RDW A said as a team, they felt strongly they could not meet Resident 4's needs, his/her behaviors impacted other residents and inpatient psychiatric treatment was the only viable option. Surveyor noted Resident 4 was deemed to be stable at the hospital and asked if they considered allowing Resident 4 to return, and then calling a care team meeting to discuss placement and/or referral to a psychiatric treatment facility. RDW A said that was not an option because the POA previously stated s/he would not accept any placement other than their facility.

On 01/25/2024 at 3:31 PM, Surveyor interviewed POA O. S/he recalled, "It was all happening so fast ... I didn't know what the heck to do ...they wanted [him/her] out of there ...[RDW A] wasn't going to budge. It was time to get rid of [him/her]. That is how I felt they felt." POO A said s/he ultimately declined transfer to Hospital S because s/he didn't know anything about it and was worried about where Resident 4 would go once released.

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{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 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 record review and interview, the provider did not ensure Resident 1 and Resident 2 received all prescribed medications. Resident 1 was admitted on 12/07/2023. The provider did not ensure s/he arrived with a supply of all prescribed medications or promptly ensure refills were obtained. Between 12/07/2023 - 12/09/2023, Resident 1 did not receive some doses of acetaminophen, famotine and nystatin powder. Between 12/10/2023 - 12/12/2023, Resident 1 did not receive any doses of the following 8 prescribed medications; acetaminophen, allopurinol, aspirin, famotidine, losartan, nystatin powder, sertraline and vitamin D3. Resident 2 began running out of medication on 12/04/2024. The provider did not promptly determine why the pharmacy was not delivering refills. During that time, Resident 2 did not receive 16 doses of sertraline or 22 doses of potassium. In addition, between 01/13/2024 - 01/15/2024 Resident 2 did not receive any doses of the following 9 prescribed medications; amlodipine, buproion, calcium carbonate, vitamin D3, docusate sodium, magnesium, metoprolol succinate, montelukast and furosemide.	{N 352}		

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{N 352}	Continued From page 11 This is a repeat deficiency. See Statement of Deficiency EXJH12, dated 04/11/2023. Findings include: The Department received a complaint about medication administration. RESIDENT 1: On 01/17/2024 at 8:37 AM, Surveyor conducted an interview with Regional Director of Wellness A (RDW A.) RDW A volunteered that during December 2023, s/he conducted an investigation into care concerns for Resident 1. S/he provided Surveyor a copy of the investigation which read in part, "...investigation revealed that the resident....missed several medications during [his/her] stay at Lakeshore Manor Assisted Living..." Surveyor reviewed portions of Resident 1's record on 01/18/2024. Resident 1 was admitted on 12/07/2023 with diagnoses to include dementia. S/he had an activated power of attorney for health care and relied on assistance from facility staff for administration of medications. On 12/12/2023 at approximately noon, s/he was sent to the emergency department, admitted to the hospital and did not return. The record contained orders signed 12/05/2023 by Resident 1's Nurse Practitioner (NP) which included 8 medications: acetaminophen ER 650 MG twice daily for pain allopurinol 300 mg once daily for gout aspirin 81 mg once daily for heart health famotidine 20 mg twice daily for GERD losartan 50 mg once daily for hypertension	{N 352}		

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nystatin powder four times once daily for rash
sertraline 25 mg once daily for depression and anxiety
vitamin D3 once daily for low vitamin D

Surveyor reviewed the December 2023 medication administration record (MAR) and noted the following:
12/07/2023 - HS (bedtime) dose and 12/08/2023 AM dose of of nystatin powder were documented as not administered due to "medication not available - reordered from pharmacy."
12/09/2023 - HS doses of acetaminophen, famotidine and nystatin powder were documented as not administered due to "resident refusal."
12/10/2023, 12/11/2023 and 12/12/2023 - all 8 medications scheduled for AM were documented as not administered due to "medication not available - reordered from pharmacy."
12/12/2023 - all 8 medications scheduled for AM were documented as not administered.

Intermittently, some doses of some medications were documented as administered. This included nystatin at least once each day and HS doses of acetaminophen and famotidine on 12/10/2023 and 12/11/2023. Surveyor noted this documentation of administration contradicted previous documentation that the medications were unavailable. In addition, Surveyor noted all 8 medications were charted as administered on the morning of 12/13/2023 but Resident 1 was not in the facility.

During interviews with RDW A on 11/17/2023 at 3:17 PM and on 01/18/2024 at 9:28 AM, s/he described the following timeline:
12/05/2023 - the provider notified Resident 1's pharmacy s/he would be moving from a sister facility to Lakeshore Manor on 12/07.

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{N 352}	Continued From page 13 12/06/2023 - the pharmacy delivered Resident 1's medications to the sister facility in error. The medications were included with the sister facility's monthly refills, which were not due to be entered in the system for several days so they did not notice the medications. 12/07/2023 - Resident 1 arrived at Lakeshore Manor with a few days' worth of medications. By 12/10/2023 - Resident 1 was out of most medications and caregivers used the electronic MAR system to request refills from the pharmacy. Refills are normally received the same day but they did not arrive. 12/11/2023 - caregivers made a second electronic request for refills. Again, the medications did not arrive. 12/12/2023 - the provider called the pharmacy and the pharmacy explained the medications were delivered to the sister facility a week prior. RDW A said in hindsight, it would have been important to request the refills before the medications ran out or follow directly with the pharmacy when the medications did not arrive on 12/10/2023. RDW A explained the caregivers did not think critically about the medication situation and at the same time the facility was transitioning to a new management team. RDW A said since that time, they have implemented a new system where Manager B reviews all medications errors/omissions on a daily basis so s/he is aware of and can follow on concerns. Surveyor asked about the inconsistencies on the MAR where medications were charted as unavailable, but then subsequently charted as administered or refused. RDW A said s/he had not specifically reviewed the MAR for that inconsistency, but said it was possible caregivers charted medications were administered or	{N 352}		

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refused when they were not. RDW A confirmed that is what occurred on 12/13/2023 when Resident 1 was not in the facility but the administration was charted. RDW A said it was also possible the AM medication cards ran out before the PM medications cards. Surveyor noted this explanation did not account for the inconsistencies with the nystatin powder which would not have been packaged in a medication card.

RESIDENT 2:

On 01/17/2024 at 1:39 PM, Surveyor interviewed Caregiver F. S/he said "for the most part" the provider does not run out of medications, but recently there was an issue with Resident 2's medications. Caregiver F said s/he thought it had something to do with the pharmacy.

Surveyor reviewed portions of Resident 2's record. S/he was admitted on 09/26/2023 with diagnoses to include traumatic brain injury and anxiety disorder and relied on staff assistance with medication administration.

On 01/18/2024 at 09:28 AM, Surveyor interviewed Manager B. S/he confirmed there were problems with Resident 2's medications in late December 2023 resulting in missed medications including sertraline, potassium and vitamin D3 "for over 3 days." Manager B said during that time caregivers were trying to reorder electronically through the MAR, but because Resident 2's preferred pharmacy (Pharmacy H) was not the house pharmacy (Pharmacy G), the electronic re-order option was not effective. Manager B said as a result, s/he spoke with Resident 2's POA about switching to the house pharmacy. Manager B concluded by saying

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{N 352}	Continued From page 15 Resident 2's medications actually arrived today (versus late December) and s/he was just beginning an investigation to more fully understand what occurred. Manager B said s/he would look into the matter and update Surveyor. On 11/18/2024 at 10:32 AM, Manager B provided Surveyor records to include Resident 2's medication orders, communication with NP I's office and MARS October 2023 - January 2024. Surveyor and Manager B reviewed some of the records together. Since the first interview, Manager B discovered the issues was not related to Pharmacy H because Resident 2 has been utilizing Pharmacy G for some time. Rather, it appeared the issue was due to Pharmacy G needing updated prescriptions from NP I. Manager B said based on his/her preliminary review of the situation, Resident 2 went without prescribed sertraline for 6 or 7 days between 12/23/2023-12/29/2023. Manager B said on 12/30/2023 s/he located some doses of the medication in the bottom drawer, so Resident 2 received the medication between 12/30/2023-01/11/2024. However, Resident 2 again went without the medications for 5 days from 01/11/2024-01/16/2024. Manager B acknowledged there were also problems with refills for prescribed potassium and vitamin D3 and during December and January resulting in missed doses. Surveyor reviewed the documentation provided by Manger B: Sertraline Signed medication order dated 10/31/2023 read, "Start sertraline 50 mg, take 1/2 tab po x (by mouth for) 7 days then increase to 50 mg, take 1	{N 352}		

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tab po daily for depression."
12/11/2023, 12/14/2023-12/18/2023 and 12/26/2023-12/29/2023: sertraline 50 mg tab was not administered . For all 10 days the explanation was, "MEDICATION NOT AVAILABLE - REORDERED FROM PHARMACY."
12/30/2023 -01/05/2024: sertraline 25 mg tab was administered (with the exception of 01/01 when it was documented not available.) Surveyor noted this was inconsistent with the order that prescribed 25 mg only for a 7 day period starting 10/31/2023. After 7 days, the 50 mg tab was prescribed. Surveyor noted 12/30/2023 was also the date Manager B said s/he found medication in the bottom drawer and staff administered it for a brief period of time.
01/06/2024: the MAR again prompted for sertraline 50 mg tab. On 01/06/2024 and between 01/11/2024-01/15/2024, the medication was not administered. For all 6 days the explanation was, "MEDICATION NOT AVAILABLE - REORDERED FROM PHARMACY."
The records did not explain why administration was charted intermittently in between times when it was documented the medication needed to be reordered.
In summary - between 12/11/2023 and 01/15/2024,Resident 2 did not receive prescribed sertraline for at least 16 days and did not receive the correct dose of sertraline for 6 days.

Potassium
Signed medication orders dated 09/25/2023 read, "vitamin D3...Take 800 unites by mouth" and "potassium chloride...take 20 mEq by mouth daily."
12/04/2023 - 12/06/2023, 12/08/2023, 12/11/2023, 12/14/2023-12/18/2023, 12/23/2023-12/24/2023 and 12/26/2023-12/29/2023: potassium was not

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administered. For all 16 days the explanation was, "MEDICATION NOT AVAILABLE - REORDERED FROM PHARMACY."
01/03/2024 and 01/12/2024 - 01/16/2024: potassium was not administered. For all 6 days the explanation was "MEDICATION NOT AVAILABLE - REORDERED FROM PHARMACY."
The records did explain why administration was charted intermittently in between times when when it was documented the medication needed to be reordered.
In summary - between 12/04/2023 and 01/16/2024, Resident 2 did not receive prescribed Potassium for at least 22 days.

Other medications
Signed medication orders dated 09/25/2023 also included the following 9 medications daily; amlodipine 5 mg, bupropion XL 300 mg, calcium carbonate 600 mg, vitamin D3, docusate sodium 100 mg, magnesium 250 mg, metoprolol succinate XL 150 mg, montelukast 10 mg and furosemide 20 mg.
The January 2024 MAR documented 9 of 9 medications were not administered 01/13/2024-01/15/2024. For all 3 days the explanation was, " MEDICATION NOT AVAILABLE - REORDERED FROM PHARMACY"

Communication with NP I's office:
12/26/2023 Manager B wrote, "After discussion with the POA, [Resident 2] will be moving to [Pharmacy G]. [S/he] has not taken [his/her] Potassium CL., Sertraline 50Mg...or Vitamin D3 in over 3 days. Can I get an updated script send over to [Pharmacy G]..." [sic - all] Staff J from NP I's office replied, "Looks like we have [Pharmacy G] listed as [his/her] pharmacy. Sertraline was already sent to [Pharmacy G] back in October.

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{N 352}	Continued From page 18 Would you like us to send all new scripts to [Pharmacy G] so [s/he] has a fresh set of refills for everything?" Manager B replied, "If you could that would be amazing as [s/he] has not received the meds I listed in sometime!" 12/28/2023 the Staff J wrote, "I tee'd up refills for [NP I] but it is concerning that you don't have the sertraline that was ordered back in October. Please verify that it was never received." (The documentation did not include a response.) 12/29/2023 NP J wrote, "See order on 10/31/23...please ensure this is started as ordered." Manager B replied, "Can you provide an updated script on resident's sertraline as I only have an order for 50 mg, and I see that it is entered as 25 mg." (The documentation did not include a response.) 01/15/2024 Manager B wrote, "[Pharmacy H] has sent all their orders over to [Pharmacy G] and residents meds will start to go through [Pharmacy G]. With that being said, they have no scripts for Sertraline, Pot Cl..." [sic - all] Staff J replied, "Just spoke with [Pharmacy G]. They were not informed by the facility that they were to be supplying these medications..." Manager B replied, "I just talked to [Pharmacy G], and they are awaiting a complete signed med list from you. Would we be able to get this STAT as [Resident 2] is out of all of [his/her] medications."	{N 352}		
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	N 381		

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N 381	Continued From page 19 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, interview and record review, the provider did not ensure Resident 1 and Resident 3 were assessed to determine the need for updated interventions after each resident experienced frequent falls. Findings include: The Department received a complaint that alleged the provider did not ensure effective interventions were implemented to prevent falls. RESIDENT 1: On 01/17/2024 at 8:37 AM, Surveyor conducted an interview with Regional Director of Wellness A (RDW A.) RDW A volunteered that Resident 1's family was upset about a fall that occurred on 12/11/2023 and the provider's response to it. RDW A said s/he immediately initiated an investigation and corroborated the concerns. RDW A said since that time the provider has made systems changes to ensure falls are properly responded to. RDW A provided Surveyor with documentation of the investigation which read in part, "On 12/11/23, at 04:25 am...The caregiver...saw the resident fall forward, striking [his/her] face. This resulted in swelling to the nose and a bloody	N 381		

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nose. The caregiver called [Director of Wellness (DW) C], who asked if the bleeding had slowed. The caregiver was able to get the bleeding to stop. [DW C] advised the caregiver to assist the resident back to bed, and that [s/he] would check on the resident in the morning. [DW C] did not check on the resident on 12/11/23. The resident had two other falls 12/11/23, both of which were reported to [Administrator D]. On 12/12/23, [DW C] did observe the bruising to the resident's face and stated [s/he] was 'shocked' at the bruising. However, the resident was not sent to the hospital until there was another fall 12/12/23, in which the resident struck the head. The resident was admitted to the hospital and diagnosed with a nasal fracture...Further investigation revealed... [s/he] had had five falls since admission to the facility ...Results of Investigation: It has been determined through investigation that [DW C] was negligent in [his/her] follow up of the resident. The resident should have been sent to the ER at the time of the fall due to injury. [DW C] did not assess the resident the next day. When [DW C] did observe the extent of the injuries, [s/he] did not seek further medication [sic] treatment for the resident..."

Surveyor reviewed portions of Resident 1's record. S/he was admitted on 12/07/2023 and discharged on 12/12/2023. Resident 1 was elderly with diagnoses to include dementia. S/he ambulated with the use of a walker.

12/08: unwitnessed fall 2:04 PM
12/09: unwitnessed fall 4:11 PM
12/11: witnessed fall 4:25 AM. Pain, bleeding, bruising and swelling of the nose.
12/11: unwitnessed fall 6:30 PM. Complained of left shoulder, left hip and back pain.
12/11: unwitnessed fall 9:30 PM. Complained of

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N 381	Continued From page 21 back and shoulder pain. 12/12: unwitnessed fall 11:10 AM. Complained of back pain, sent to emergency room. Resident 2's record did not contain documentation of assessments after each fall to determine the extent of the injuries, needs for health monitoring, the root cause of the fall or to establish interventions to prevent falls. Surveyor conducted interviews with RDW A and Regional Director of Operations (DOO) F on 01/17/2024 at 3:17 PM and 01/18/2024 at 11:52 AM. RDW A confirmed their process is to complete assessments after each fall on a document titled "IDT Post Fall Assessment" and Resident 2's record did not contain any. RDW A said after the fall on the 8th there was one intervention identified for the application of non-slip strips at the beside, but it was not promptly or fully implemented. DOO F explained they were concerned about how the onsite managers (DW C and Administrator D) responded to Resident 1's falls, injuries and change in condition. They took the matter seriously, immediately investigated and ultimately employment was separated with both managers. DOO F said they implemented a plan of correction to include of staff re-education and a new tracking system with regional oversight to ensure falls are properly responded to. DOO F said they are still working on full implementation of the plan and there was still progress to be made, however s/he felt they have improved since mid-December. DOO F showed Surveyor documentation to verify completion of training and implementation of the tracking system.	N 381		

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N 381	Continued From page 22 RESIDENT 3: On 01/17/2024 at 11:20 AM, Surveyor interviewed Caregiver K and asked which residents are at highest risk for falls. Caregiver K replied, "Resident 3...over the weekend I heard [s/he] fell 3 times." Surveyor asked what strategies are in place to help prevent falls. Caregiver K replied, "That's a good question. I don't know. [S/he] just kind of walks around freely still. I think staff are trying to pay more attention when [s/he] is walking by [him/herself]...[S/he] walks the whole building." On 01/17/2024 at 1:39 PM, Surveyor interviewed Caregiver F. Caregiver F stated, "[Resident 3] is a tough one. [S/he] has progressively gotten weaker and is on hospice. It's near impossible to get [him/her] to use any adaptive equipment...it's hard to find any working intervention for [him/her]. In the past it was found [s/he] was dehydrated...every 2 hours we give [him/her] something to drink...(but) [S/he]'s had more falls again." Caregiver F said they are also completing frequent checks but they are not documented. S/he also stated Resident 3 needs appropriate footwear which means socks with non-slip grips on the bottom. On 01/17/2024 at 2:35 PM, Surveyor interviewed Caregiver L. S/he confirmed Resident 3 falls frequently and said, "I don't really know of any interventions in place for [him/her]. I know they are pushing fluids ..." Caregiver L said they are also administering morphine to help with pain and improve sleep. On 01/17/2024 at 11:01 AM and 2:35 PM, Surveyor observed Resident 3 wandering the common hallways without the assistance of staff.	N 381		

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S/he was unsteady, leaning to the side and at times leaned up against the hallway walls. S/he was wearing socks but it was unclear if they were socks with non-stick bottoms. Resident 3 did not have a walker nearby, staff did not offer cues or reminders about a walker and staff did not provide stand by assistance while Resident 3 ambulated.

On 01/18/2024 beginning at 8:10 AM, Surveyor observed Resident 3 walk the hallways that spanned the length of the large facility. Resident 3 did not have a walker nearby, staff did not offer ques or reminders about a walker and staff did not provide stand by assistance while Resident 3 ambulated. At 8:37 AM Resident 3 was unsupervised by staff and sat down in a chair in the common area. Resident 3 sat partially on the arm of the chair and landed in an awkward, sideways position in the chair. Surveyor attempted conversation with Resident 3 but s/he was not able to communicate. Surveyor observed s/he was wearing black socks without non-slip bottoms. Surveyor observed at 9:48 AM, Resident 3 was wearing different, mismatched socks. Surveyor observed 1 sock had a worn non-slip bottom and it was unclear if the other sock had a non-slip bottom.

On 01/18/2024 at 11:50 AM, Surveyor interviewed Caregiver J. S/he confirmed Resident 3 should wear socks or slippers with non-slip bottoms to prevent falls, but whoever dressed him/her today applied regular socks. Caregiver J said s/he subsequently changed Resident 3's socks to ensure s/he was wearing proper footwear. Caregiver J said the socks were mismatched because that's all s/he could find.

Surveyor reviewed portions of Resident 3's record

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N 381	Continued From page 24 on 01/17/2024 and 01/18/2024. The record documented at least 23 falls since 07/04/2023; 19 of 23 falls were unwitnessed. The 7 most recent falls all occurred since 12/14/2023: 12/14: unwitnessed fall - found behind staff desk with a bump on head. 12/18: unwitnessed fall 12/28: unwitnessed fall 01/01: unwitnessed fall. 01/01: witnessed fall - 2nd fall that day - substantial bleeding from head requiring 3 staples. 01/09: witnessed fall - walking in the hallway, off balance and fell. Skin tear right elbow 01/14: unwitnessed fall Post fall assessment forms were completed in response to 3 of 7 most recent falls: 12/14/2024 - intervention to secure the area behind the desk 01/01/2024 for both falls - interventions to request a trial dose of bedtime morphine from the "psych doctor" to ensure s/he was well rested and to order "Hipsters and helmet" to minimize injury 01/09/2024 - intervention to request an order from hospice for scheduled morphine so s/he would sleep better at night and be less unsteady during the day. Surveyor noted the following: The assessment forms did not include evaluations to determine if previous interventions were implemented and effective. They did not assess for the potential need for staff reminders to use his/her walker, for standby staff assistance while walking if s/he refused/forgot the walker, for frequent checks to anticipate needs or for increased supervision to prevent unwitnessed	N 381		

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LAKESHORE MANOR	711 BAYSHORE ROAD OSHKOSH, WI 54901

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N 381	Continued From page 25 falls. On 01/17/2024 and 01/18/2024, Surveyor did not observe Resident 3 wearing a helmet or hip protection to minimize injuries during falls. The January 2024 medication administration record (MAR) did not include scheduled doses of morphine at bedtime to improve sleep. The MAR included morphine which was ordered for pain or shortness of breath, written 12/21/2023. The medication was administered on 01/01/2024, 01/02/2024, 01/03/2024, 01/09/2024 and 01/14/2024. Times were not noted on the document provided to Surveyor. On 01/18/2024 at 11:52 AM, Surveyor interviewed RDW A, DOO F and Manager B. They stated the following: Manager B said s/he had not yet obtained the order for scheduled morphine because Resident 3's psych doctor had been on leave. S/he also confirmed the helmet/hipster had not yet been obtained. DOO F acknowledged Resident 3 needs a thorough reassessment and complete revision of the individual service plan. S/he said interventions implemented months ago may not be effective or still relevant. S/he also agreed a stronger focus needed to be placed on assessment of the root causes of the falls so more effective fall prevention interventions can be implemented.	N 381		