STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 09/28/2023, the Bureau of Assisted Living, Southern Regional Office, conducted 2 complaint investigations at Sage Meadows of Middleton, a community-based residential facility (CBRF) located in Middleton, WI. As a result of the survey, 3 deficiencies were identified. One complaint was substantiated, one complaint was unsubstantiated. Census: 36	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service 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 record review and interview, the individual service plans (ISPs) for 2 of 2 residents reviewed were not updated to reflect the changes in their needs and abilities.	N 389		

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

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The ISP for Resident 1 was not updated to include fall risk mitigation strategies after s/he experienced 5 falls from 07/01/2023 - 09/28/2023 or elopement prevention strategies after s/he demonstrated verbal exit seeking behavior in July and August of 2023, eloped on 09/10/2023, and demonstrated exit seeking behavior on 09/21/2023.

The ISP for Resident 2 was not updated to include additional fall risk mitigation strategies after s/he continued to experience falls after his/her fall on 08/13/2023 in which s/he fractured his/her cervical spine. Resident 2 had another fall on 09/15/2023 in which s/he fractured 4 ribs.

Findings include:

Example 1 - Resident 1

On 09/28/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 02/15/2023 with diagnoses including dementia with behavioral disturbance. Surveyor reviewed Resident 1's observation notes from 07/01/2023 - 09/28/2023 and observed the following:

- Six entries indicating that incident reports due to falls were created on the following days: 07/08/2023 (unwitnessed fall), 07/20/2023 (witnessed fall), 07/23/2023 (unwitnessed fall), 08/23/2023 (unwitnessed fall), 09/15/2023 (witnessed fall), and 09/21/2023 (witnessed fall).

- One entry indicating that an incident report due to an elopement was created on 09/15/2023

- Entry on 07/08/2023 (2:00 p.m.): "Resident fell in [his/her] room residents[sic] [spouse] was present at the time..."

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N 389	Continued From page 2 - Entry on 07/12/2023 (2:30 p.m.): "...writer noticed that resident was acting out of [his/her] norm. Writer had seen resident gathering up [his/her] clothes and had balled it up in one of [his/her] sweaters...Peer mentioned that resident was packing up because [s/he] was going to go out to look for [his/her] [spouse]..." - Entry on 07/15/2023 (3:45 a.m.): "...Resident put [his/her] shoes on and grabbed [his/her] laptop. [S/he] keeps saying that [s/he] needs a ride home and that [s/he] is not staying here." - Entry on 07/15/2023 (6:45 a.m.): "...Resident has been following care staff all morning saying that [s/he] needs to get out of here and contact a ride to come get [him/her] and all [his/her] belongings. Resident has also had other residents believing that they're being held against their will here and they need to get out." - Entry on 07/15/2023 (8:45 p.m.): "[Resident 1] was very forgetful of [his/her] walker..." - Entry on 07/16/2023 (6:45 a.m.): "The resident was at[sic] fall risk the whole night. [S/he] was not able to walk with the walker freely..." - Entry on 07/16/2023 (9:30 p.m.): "...[Resident 1] keeps forgetting walker..." - Entry on 07/21/2023 (2:30 p.m.): "...Needed reminders to use [his/her] walker..." - Entry on 07/24/2023 (10:00 a.m.): "Writer went to follow up on residents[sic] fall from yesterday..." - Entry on 07/24/2023 (10:15 p.m.): "Resident had	N 389		

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to be reminded to use [his/her] walker..."

- Entry on 08/02/2023 (2:00 p.m.): "resident is confused and insisting that [s/he] needs to go another floor and leave. Resident keeps leaving [his/her] walker near exit door and won't take it with [him/her]. Resident has been redirected multiple times but behavior continues..."

- Entry on 08/16/2023 (2:00 p.m.): "resident kept walking away from walker, peers reminded resident to take it. Around activity time resident became confused and frustrated, resident stated [s/he] needed to leave to find [his/her] [spouse]..."

- Entry on 08/23/2023 (9:45 p.m.): "Resident had a fall."

- Entry on 08/25/2023 (2:30 p.m.): "...Resident had to be reminded to use [his/her] walker..."

- Entry on 08/28/2023 (9:00 p.m.): "...resident attempts to walk with out [his/her] walker and stumbles everytime[sic]."

- Entry on 09/02/2023 (9:30 p.m.): "resident is reminded every time [s/he] gets up to walk that [s/he] needs [his/her] walker..."

- Entry on 09/11/2023 (11:00 a.m.): "Writer went to go follow up on resident eloping from the building yesterday morning...Resident asked what happened yesterday morning and [s/he] told writer [s/he] went, 'for a stroll clearly.'...Alarms were checked and inspected..."

- Entry on 09/12/2023 (10:15 a.m.): "Writer went to follow up on residents[sic] fall from yesterday. Upon arrival to the unit, resident was lying down on the cough[sic] in common area watching

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TV...Resident was asked about [his/her] fall, and [s/he] denied [his/her] fall, [s/he] stated [s/he] was just trying to lay down on the ground to rest like an animal..."

- Entry on 09/22/2023 (11:15 a.m.): "Follow up on the fall 9/21/2023..."

Surveyor then reviewed incident reports for the 6 falls as indicated from the observation notes and observed that falls were documented as occurring on 5 of these 6 occasions - 07/08/2023 (loss of balance), 07/19/2023 (lowered to floor with staff secondary to lower extremity weakness), 07/23/2023 (loss of balance), 08/23/2023 (trip), and 09/21/2023 (controlled fall to knees).

Regarding Resident 1's elopement behaviors, Surveyor observed an incident report dated 09/10/2023 which documented the following: "Upon investigation, at 7:11 a.m. our alarm system shows that the west wing door had been triggered, which is how resident removed [him/herself] from the building. When Administrator asked [him/her] to walk [him/her] through what happened, resident got up, left [his/her] room and walked to the west wing door and told the administrator that [s/he] read the sign that said 'Hold for 15 seconds and push.' [S/he] pushed the door for 15 seconds and then the door opened. Per the police report, they received a call at 7:32 AM. Police arrived to resident's location at 7:45 a.m. and [s/he] was brought back to the facility at 8:06 a.m."

The incident report for Resident 1's 09/21/2023 fall had also documented, "Writer asked resident to grab [his/her] walker to use when [s/he] walks. Resident got upset, placed walker near office

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door and attempted to continue to walk toward the front door..."

Surveyor reviewed Resident 1's current ISP, which was most recently updated on 09/20/2023 and documented the following regarding his/her fall risk/prevention strategies and elopement behaviors:

- Under the "Ambulation - Independent (Fall Risk)" heading: "Resident is independent with ambulation. resident[sic] uses a walker to ambulate...[Resident 1] will continue to safely ambulate independently within the community. [Resident 1] has been identified as a moderate fall risk...Care staff will monitor [Resident 1] and notify community [registered nurse] of any changes or concerns."

Under the "Risk - Moderate Fall Risk" heading: "[Resident 1] has been identified as a moderate fall risk. [Resident 1] uses a walker for ambulation. [Resident 1] desires to remain free from falls for the remainder of the assessment period. Staff will assist [Resident 1] with assistance as needed. [Resident 1] will have all fall prevention methods in place to ensure [his/her] safety. Care staff will continue to monitor [Resident 1] and encourage [Resident 1] to use [his/her] walker for [his/her] safety. Care staff will notify community [registered nurse] of any changes and concerns,[sic]."

There was no information in Resident 1's ISP about his/her elopement behaviors or other information about specific fall prevention strategies utilized by the provider.

At approximately 12:12 p.m., Surveyor interviewed Caregiver D. Surveyor asked if there

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were any specific interventions staff were utilizing to prevent Resident 1 from eloping again. Caregiver D reported that staff were told to do more frequent rounds on him/her. When asked if there was any specific parameter given with this, such as a specific frequency to round on Resident 1, Caregiver D replied that s/he was unaware of any. Caregiver D reported that other interventions may have been discussed at a team meeting that occurred after Resident 1's elopement but s/he didn't attend the meeting and so wasn't sure what was discussed.

At approximately 2:30 p.m., Surveyor interviewed Executive Director A, Director of Operations B, and Clinical Assistant C. Surveyor discussed the concern that it wasn't clear based on Resident 1's ISP what staff were doing to mitigate his/her future elopement risk given his/her history of elopement and exit-seeking behaviors or his/her future fall risk given the 5 falls s/he had and failure to use his/her walker consistently as documented in the observation notes above. Director of Operations B reported that Clinical Assistant C was currently working on updating care plans for residents, including Resident 1. Executive Director A that s/he had an upcoming meeting with Resident 1's family to discuss his/her updated care needs.

Example 2 - Resident 2

On 09/28/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 03/20/2023 with diagnoses including Alzheimer's disease, repeated falls, and weakness. Surveyor reviewed Resident 2's observation notes, dated 07/01/2023 - 09/28/2023 and observed the following related to his/her fall history:

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N 389	Continued From page 7 - 4 entries indicating that incident reports due to falls were created on the following days: 08/13/2023 (unwitnessed fall), 09/15/2023 (unwitnessed fall), 09/20/2023 (witnessed fall), and 09/25/2023 (witnessed fall). - Entry on 08/13/2023 (2:00 p.m.): "Resident had a fall today family was notified and they come[sic] and took [him/her] to the hospital." - Entry on 08/14/2023 (7:45 a.m.): "Per residents[sic] after visit summary from [emergency room] visit due to fall, resident has a C7 fracture and will be needing to wear a rigid neck brace at all times..." - Entry on 09/21/2023 (9:15 a.m.): "...Resident also had a fall right before [family] got here and hit the back of [his/her] head on the wood floor..." - Entry on 09/21/2023 (2:30 p.m.): "Writer received a phone call from staff stating that resident is having balance troubles and needed two staff assistance with transferring and walking with walker..." - Entry on 09/26/2023 (2:15 p.m.): "resident has been in [his/her] wheelchair to provent[sic] falls...has an alarm now for chair." Surveyor then reviewed incident reports for the 4 falls as indicated in the observation notes and observed the following: - Fall from 08/13/2023: "staff were doing rounds and found resident sitting on a chair with an abrasion on [his/her] right eye...resident was being taken to hospital for evaluation. Resident has abrasion above [his/her] right eye and	N 389		

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underneath [his/her] right eye...Resident stated [s/he] was going to the bathroom and upon entering [s/he] caught the sole of [his/her] shoe on the floor causing [him/her] to fall forward onto bilateral knees. Resident was able to get [him/herself] up and was found sitting in a chair."

- Fall from 09/15/2023: "Writer was passing bedtime medication for [Resident 2], when [s/he] told Writer[sic] that [s/he] had a fall. Writer asked [him/her] how [s/he] fell, and [s/he] told Writer[sic] that [s/he] was getting out of bed and going to get [his/her] walker. Resident stated [s/he] fell and hit the countertop in [his/her] room. Resident told [him/her] that [s/he] was able to get [him/herself] up from the floor..."

- Fall from 09/20/2023: "Resident was sleeping in common area green chair, when [s/he] woke up, [s/he] got up from the chair and attempted to walk without [his/her] walker. Before staff could get to [him/her], resident had fallen backwards while losing [his/her] balance and hit [his/her] head on the floor..."

- Fall from 09/25/2023: "Resident lost balance and fall[sic] onto [his/her] right side...[Resident 2's activated power of attorney for healthcare] decided that resident should be sent out for evaluation at the Hospital[sic], due to falling on [his/her] side where [s/he] had broken ribs before."

On 09/28/2023, Surveyor reviewed Department files for the provider and observed 2 self-reports submitted for falls experienced by Resident 2 on 08/13/2023 and 09/15/2023 (correlating with the above incident reports). Surveyor observed the following under the "Action Taken" section of each self-report:

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N 389	Continued From page 9 - 08/13/2023 fall in which Resident 1 experienced orbital-area abrasions and a cervical spine fracture at C7: "Resident will be placed on frequent checks. Resident is currently working with physical therapy and occupational therapy." - 09/15/2023 fall in which Resident was found to have 4 right rib fractures: "Resident will be placed on frequent checks. Resident is currently working with physical therapy and occupational therapy. [S/he] has transitioned from a stand by assist to 1 assist with ambulation and [activities of daily living]." Surveyor reviewed Resident 2's ISP, most recently updated on 09/25/2023, and observed the following: - Under the "Supervision" heading the box for "Needs some supervision" was checked with the added comment, "Fall risk." - Under the "Ambulation - 1 Person Assist" heading: "[Resident 2] requires 1 staff member to assist [him/her] when ambulating. [Resident 2] uses a wheelchair to ambulate." - Under the "Risk - Fall" heading: "[Resident 2] is now enrolled with [physical therapy] and [occupational therapy] to help with mobility. Care staff will monitor [him/her] frequently and report any concerns...[Resident 2] has been identified as a fall risk...Care staff will monitor [Resident 2], Care staff will do safety checks to ensure [Resident 2] safety. Care staff will notify community [registered nurse] with any changes and concerns." - Under the "Transferring - One Person Assist"	N 389		

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N 389	Continued From page 10 heading: "[Resident 2] will continue to ambulate with [his/her] wheelchair for the remainder of the assessment period until which time [s/he] can safely ambulate again with [his/her] walker." There was no other information in Resident 2's ISP about his/her chair alarm use (as indicated from the observation notes) or other fall prevention strategies utilized by the provider to mitigate Resident 2's fall risk. At approximately 2:30 p.m., Surveyor interviewed Executive Director A, Director of Operations B, and Clinical Assistant C. Executive Director A confirmed that a chair alarm was currently being used for Resident 2 and that s/he had been using the wheelchair for ambulation as a fall mitigation strategy after his/her cervical fracture post-fall on 08/13/2023 due to him/her continuing to be unsteady on his/her feet and not wanting to risk further injury. Executive Director A acknowledged Surveyor's concern that Resident 2's chair alarm use was not documented on his/her ISP. All 3 acknowledged Surveyor's concern that other than therapy and wheelchair use, which seemed to be interventions utilized after his/her first fall on 08/13/2023, that it wasn't clear from Resident 2's ISP what other strategies the provider was utilizing to further prevent falls after each successive fall experienced by Resident 2. Director of Operations B reported that Clinical Assistant C was currently working on updating care plans for residents, including Resident 2. Executive Director A that s/he had an upcoming meeting with Resident 2's family to discuss his/her updated care needs.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication.	N 408		

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N 408	Continued From page 11 As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plan (ISP) for Resident 1, who was prescribed as-needed (PRN) Olanzapine for "for severe anxiety/agitation," included the rationale for use and a detailed description of the behaviors indicating the need for its use. Findings include: On 09/28/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 02/15/2023 with diagnoses including dementia with behavioral disturbance. Resident 1's prescriptions included Olanzapine 5 mg tablets. The order active from 02/23/2023 - 09/08/2023	N 408		

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included directions to "take 1/2 tablet (5 mg) by mouth twice a day as needed for behavioral disorders associated with dementia." The order active from 09/08/2023 through current had the same dosage with instructions to take "as needed for severe anxiety/agitation." Surveyor reviewed Resident 1's medication administration record (MAR) from 09/01/2023 - 09/27/2023 and observed that Resident 1 was administered his/her PRN Olanzapine once on 09/18/2023 at 8:20 p.m. In the MAR, the "rationale for use" was documented as "anxiety" and the "description of behaviors requiring use" was documented as "keep walking without walker and shoes."

Surveyor then reviewed Resident 1's ISP, most recently updated on 09/20/2023. Surveyor observed a heading for "PRN Psychotropic Medication" which documented the following: "[Resident 1] is currently taking psychotropic medications. Please see Mar[sic]...Care staff will administer [Resident 1] psychotropic medication as scheduled/as needed. Care Staff[sic] will notify community [registered nurse] on any changes and concerns."

Surveyor did not observe a rationale for use and detailed description of the behaviors indicating the need for his/her PRN Olanzapine administration.

At approximately 2:30 p.m., Surveyor interviewed Executive Director A, Director of Operations B, and Clinical Assistant C. All 3 acknowledged Surveyors' concern that the rationale for use and detailed description of Resident 1's behaviors indicating the need for his/her PRN Olanzapine was not documented in his/her ISP. After reviewing the regulation with Surveyor, Executive Director A reported s/he and Clinical Assistant C

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

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N 408	Continued From page 13 would work to update Resident 1's ISP.	N 408		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide supervision appropriate to residents' needs in response to an incident where Resident 1 eloped from the facility on 09/10/2023. On 09/10/2023, Former Caregiver E silenced a door alarm that had sounded at 7:10 a.m. without attempting to account for residents. Resident 1 is thought to have eloped from the same door at that time, and was not discovered missing by staff until approximately 50 minutes later. Shortly after discovered missing, Resident 1 was returned to the facility by law enforcement from a location approximately 0.4 miles away. Findings include: On 09/28/2023, Surveyor conducted a complaint investigation into adequate supervision related to	N 426		

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N 426	Continued From page 14 a recent resident elopement. On 09/28/2023, Surveyor reviewed a self-report submitted to the Department by Executive Director A on 09/10/2023, which detailed an incident where Resident 1 eloped on that same day and was brought back by law enforcement. The report documented, "On 09/10/2023, facility Administrator received a phone call from care staff [Caregiver D] at 8:10am. [S/he] stated that [Resident 1] had eloped from the facility and the police found [him/her] and brought [him/her] back to the facility at 8:06 a.m. After our investigation and looking at the police report, at 7:11 AM our alarm system shows that the west wing door had been triggered, which is how [Resident 1] removed [him/herself] from the building. When Administrator asked [him/her] to walk [him/her] through what happened, [Resident 1] got up, left [his/her] room and walked to the west wing door and told the administrator that [s/he] read the sign that said 'Hold for 15 seconds and push.' [S/he] pushed the door for 15 seconds and then the door opened. Per the police report, they received a call at 7:32 AM. Police arrived to [Resident 1]'s location at 7:45 AM and [s/he] was brought back to the facility at 8:06 am. After the investigation, disciplinary action was taken and a care staff was terminated." On 09/28/2023, Surveyor reviewed the police report for the same incident. The report documented that police were dispatched to Resident 1's location at 7:37 a.m. after a call came in from an outside member of the community indicating that a person (later identified as Resident 1) was sitting on the curb at a location approximately 0.4 miles away from the provider appearing confused and not being sure where s/he was. The report documented that	N 426		

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N 426	Continued From page 15 Resident 1 "appeared frail and exhausted" but reported that s/he was uninjured. The report also documented that Former Caregiver E, who was working the provider's unit during this time, reported that s/he was moving residents to the common living area when s/he noticed that Resident 1 was not in his/her room. Former Caregiver E reported s/he immediately started to look for him/her both inside and outside. On 09/28/2023, Surveyor reviewed the provider's internal investigation documents regarding Resident 1's elopement, provided by Executive Director A. The documents included the following: -A snapshot from a door alarm report, which showed that a sensor was triggered at 7:10 a.m. on 09/10/2023 at the "West Exit M1 Office" (the door Resident 1 is thought to have left from) and that the alarm was turned off via the keypad at 7:11 a.m. - Written statement from Caregiver D which documented that at 8:07 a.m. on 09/10/2023 Former Caregiver E approached him/her asking of s/he had seen Resident 1. Upon discovering that Resident 1's whereabouts were unknown, Caregiver D wrote that s/he and Former Caregiver E began looking for him/her and that shortly after they began looking, law enforcement arrived on site returning Resident 1 to the facility. - Written statement from Caregiver F who worked the overnight shift from 09/09/2023 - 09/10/2023, which documented that s/he left the building at the end of his/her shift at around 7:10 a.m. and that the "tape at the exit door close to [Resident 3's room, where the west exit door is located near] was still on at the time."	N 426		

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N 426	Continued From page 16 On 09/28/2023, at approximately 12:12 p.m., Surveyor interviewed Caregiver D. Caregiver D reported that on 09/10/2023 s/he got to the facility at approximately 7:57 a.m. and s/he observed Former Caregiver E getting residents ready for breakfast. Caregiver D reported that approximately 10 minutes after s/he came on site s/he saw Former Caregiver E "moving fast" pacing through the facility. Caregiver D reported that Former Caregiver E then approached him/her and asked if s/he had seen Resident 1. Caregiver D reported s/he spent the next several minutes assisting Former Caregiver E in looking for Resident 1. Caregiver D reported that shortly after this, s/he observed a police squad car drive to the building and a police officer bring Resident 1 back. Caregiver D denied hearing any door alarms going off since s/he first entered the building that morning. Caregiver D reported that when door alarms go off staff are expected to check the immediate area to see if any residents exited the facility and also account for all residents. At approximately 2:00 p.m., Surveyor interviewed Executive Director A. Executive Director A reported that the provider has cameras near the facility exit doors and so between reviewing the camera footage and door alarm report as part of the provider's investigation it was determined that Former Caregiver E had turned the door alarm off at 7:11 a.m. without looking around and checking to see if any residents had left the building. Executive Director A reported that they would have expected Former Caregiver E to account for residents upon hearing the door alarm go off. Executive Director A reported that Former Caregiver E's employment with the provider was terminated as a result of him/her not handling Resident 1's elopement appropriately.	N 426		

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