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N 000	Initial Comments On 09/05/2024, Surveyor conducted 2 complaint investigations at LindenCourt New Berlin. Five deficiencies were identified. Both complaints were substantiated. Census: 36	N 000		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats.	N 328		

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

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the 30-day discharge notice initiated by the CBRF for Resident 1 included the required Department's regional director's name, address, and phone number.

Findings include:

On 09/05/2024, Surveyor reviewed Resident 1's record.

A 30-day discharge notice dated 05/06/2024 and signed by Executive Director E was issued to Resident 1's legal representative.

The notice did not include the name, address, and phone number of the Department's regional office director.
Additionally, the letter stated LindenCourt was issuing the notice and the name of a different facility was also used in the letter:

" ...LindenCourts New Berlin is giving [Resident 1] a 30-day written advance notice to vacate on or before June 6th, 2024 ...Within 7 days after receipt of your letter for review to the department, the department may ask [name of other facility] to furnish written justification of the discharge. The department will conclude its review of the involuntary discharge within 10 days after receiving written justification for the discharge from [name of other facility].

Cross Reference:
N0382 DHS 83.35(1)(b) Sources Used For Assessment Information
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes
N0433 DHS 83.38(1)(i) Behavior Management

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N 382	83.35(1)(b) Sources used for assessment information. Information gathering. The CBRF shall base the assessment on the current diagnostic, medical and social history obtained from the person ' s health care providers, case manager and other service providers. Other service providers may include a psychiatrist, psychologist, licensed therapist, counselor, occupational therapist, physical therapist, pharmacist or registered nurse. The administrator or designee shall hold a face-to-face interview with the person and the person ' s legal representative, if any, and family members, as appropriate, to determine what the person views as his or her needs, abilities, interests, and expectations. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not conduct a face to face interview to determine Resident 1's needs, abilities, interests, and expectations prior to admission to the facility. Findings include: On 09/05/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted 05/01/2024 and discharged 07/26/2024. Diagnoses included adjustment disorder with mixed anxiety and depressed mood, Alzheimer's disease with late onset, and dementia with agitation. Hospital record received 09/05/2024 from Manager A. The fax cover attached to hospital record was dated 04/22/2024 and identified being faxed from a hospital social worker to the managed care organization.	N 382		

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04/21/2024 Hospitalist Progress Note:
" ...Principal Problem: Severe late onset Alzheimer's dementia with agitation ...Acute metabolic encephalopathy Dementia with behavioral disturbances - Per report, patient's increasingly violent at [his/her] memory care facility, and they are concerned about their ability to safely care for [him/her]. [S/he] has had 2 visits to the ED in as many days ..."

Hospital Flowsheets:
04/20/2024 " ...Up ad lib in room, wander guard in place ...Sitter at bedside. Frequent rounding completed for safety ..."
04/21/2024" ...Sitter in place, call light within reach safety maintained ..."
04/22/2024 " ...Sitter at bedside, safety maintained ..."
There was no further information contained in the hospital record after 04/22/2024.

Pre-Admission Health Questionnaire dated 04/30/2024 identified (summarized): memory loss, anxiety/agitation, history of striking out at someone, and no attempts to wander away from home without help.

30 Day Discharge Notice dated 05/06/2024, 5 days after admission (summarized): Executive Director E issued a 30-day discharge notice due behaviors.

Facility Progress Notes dated 05/01/2024-07/29/2024 identified Resident 1displayed behaviors of verbal and physical aggression toward other residents and staff, destruction of property, resisting cares, elopement attempts and elopement with injury including:, and on 05/29/2024, Resident 1 pulled Resident 2 out of bed and punched him/her in the

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abdomen despite provider's knowledge of Resident 1's aggression toward other residents since 05/06/2024.

On 05/30/2024, 4 residents residing on a unit with Resident 1 were moved from their rooms to other unit(s) due to Resident 1's behaviors.

On 06/21/2024, Resident 1 received stitches to a chin laceration after eloping to a park across the street despite one-to-one staff supervision after other residents were moved off his/her unit on 05/30/2024.

On 07/26/2024, Resident 1 was admitted to hospital for behaviors caused by a urinary tract infection (UTI). The provider denied readmission and Resident 1 was discharged from facility.

On 09/06/2024 at 11:26 AM, Surveyor interviewed Manager A and discussed concern of no face-to face preadmission assessment with Manager A. Manager A stated prior to Resident 1's admission a managed care organization's case manager was at the facility and mentioned Resident 1's need for placement because another facility would not re-admit him/her. Manager A stated they admitted Resident 1 without conducting an onsite admission assessment or reviewing hospital documentation. Manager A stated after Resident 1's admission s/he learned that prior to hospitalization, Resident 1 resided on a memory care unit at LindenCourt New Berlin's sister facility in a neighboring city 12/12/2023 - 04/22/2024 but s/he was unaware why the sister facility did not re-admit Resident 1. Manager A stated the hospital packet provided to Surveyor on 09/05/2024 was emailed from the sister facility to Executive Director E sometime after Resident 1's 05/01/2024 admission. Manager A stated if

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N 382	Continued From page 5 s/he had any documentation from the hospital prior to Resident 1's admission s/he would have denied admission due to Resident 1's behaviors. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0433 DHS 83.38)1)(i) Behavior Management	N 382		
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 observation, record review and interview, the provider did not sure individual service plans were updated when there was a change in a resident ' s needs, abilities or physical or mental condition for 4 of 4 residents reviewed. Resident 1's individual service plan (ISP) did not include interventions to prevent and/or manage behaviors that were harmful to self/staff/other	N 389		

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residents, destruction of property, or medication and meal refusals. Resident 1's ISP was not updated when Resident 1 required one-to-one supervision (due to living alone on unit due to behaviors) or when safety checks were changed from every 2-3 hours to every 15 minutes.

Resident 3's ISP did not address need for broda chair, concave mattress, fall mat, and was not updated when his/her mobility status, care needs and diet changed.

Resident 4's ISP dated 06/26/2024- The ISP did not address risk of elopement or wander guard use, and the Bedside ISP Report did not identify the monitoring device was a wander guard bracelet or that it was worn on ankle.

Resident 5's ISP did not address Resident 5's history of or need to monitor for UTI's, mood, hallucinations and delusions, behaviors, use of wander guard, withholding personal scissors and nail clippers, or psychiatric services.

Findings include:

On 09/05/2024 at 10:39 AM, Surveyor observed Resident 3 in the dining room sitting in a broda chair. Surveyor proceeded to Resident 3's room and observed a concave mattress on the bed, folded fall mat placed next to the bed, and Hoyer lift parked in Resident 1's bathroom.

On 09/05/2024 at 11:32 AM with assistance from Caregiver F, Surveyor observed a wander guard bracelet on Resident 4's left ankle. At 1:05 PM Surveyor observed Resident 4 approach exit door next to Manager A's office, push on door to open it, wander guard alarmed and s/he turned around and left area.

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N 389	Continued From page 7 On 09/05/2024 at 4:24 PM with assistance from Caregiver G, Surveyor observed Resident 5 was not wearing a wander guard bracelet. On 09/05/2024, Surveyor reviewed Resident 1's, Resident 3's, Resident 4's and Resident 5's records. Example 1- Resident 1 Resident 1 was admitted 05/01/2024 and discharged 07/26/2024. Diagnoses included adjustment disorder with mixed anxiety and depressed mood, Alzheimer's disease with late onset, and dementia with agitation. Facility Progress Notes dated 05/01/2024-07/29/2024 identified the following behaviors exhibited by Resident 1 (summarized): 05/01/2024 Punched, hit, scratched caregiver and broke caregiver's necklace while caregiver attempted to place wander guard on Resident 1. 05/02/2024 - Hit caregiver with soap dispenser, caregiver went to kitchen pantry with medication cart for safety. 05/03/2024- Attempted to remove another resident from his/her wheelchair, chased caregiver and housekeeper with heavy metal décor, hit another resident with a book 3 times, transported to ER for evaluation. 05/05/2024- Hit caregiver with laptop charging cord, threw chairs and knocked over medication cart. 05/08/2024 6:51 PM Dumped glass of juice on dining room table, began yelling and swinging at caregiver. 05/08/2024 9:22 PM - Hallucinating 05/09/2024- Seen by psychiatric services. 05/09/2024 3:58 PM- Grabbed cake box and	N 389		

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Manager A's wrist, hit Manager A with cake box.
05/14/2024 9:25 PM-Took items off shelf, hallucinated, got water on the kitchenette floor, pulled items out of kitchenette cabinets.
05/18/2024 12:30 PM- Hit staff with pan from kitchenette across the back.
05/24/2024 6:30 AM- At 4:00 AM, in kitchenette played with water, mixed coffee, tampered with refrigerator, threw plates, attempted to hit staff with cup and elope.
05/24/2024 1:26 PM- Hit staff with three ring binder.
05/25/24 11:38 AM- Grabbed and hit staff, threw dining room table breaking dining room table leg, removed items from drawers and threw them.
05/27/2024 8:53 PM- Poured water into electrical outlet then tried to plug microwave back into outlet. Pulled on doorknobs and attempted to elope. Hit and attempted to kick and bite caregiver.
5/29/24 9:00 AM- Pulled Resident 2 out of bed and punched him/her in abdomen.
05/31/2024 9:02 PM- Threw chair at staff, refused meds and resistive to cares.
06/04/2024 4:06 PM- Threw home décor ceramic lid at caregiver breaking it.
06/12/24 7:24 PM- Manager A set up ISP meeting with Resident 1's Power of Attorney for Health Care (POA) but POA did not call writer with a time.
6/13/2024 10:23 PM- Seen by psychiatric services.
06/17/2024 10:33 AM- During medication pass, yelled obscenities to caregiver, threatened to kill and hit caregiver.
06/27/2024 11:27 AM- Pulled electric cord out of floor and was pulling on it.
07/01/2024 10:45 AM- During cares, kicked, punched, scratched, cursed and yelled at 2 caregivers. One caregiver's right wrist bled due to

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scratches.
07/16/2024 9:44 PM- Hit caregiver during shower.
07/16/2024 4:36 PM (summarized)- Manager A called POA in attempt to set another ISP meeting. POA requested Manager A leave ISP t the unit for his/her signature.

7/26/24 - 07/29/2024 Hospitalized due to urinary tract infection. Facility refused to readmit Resident 1 stating a 30-day discharge notice was issued in May 2024. Resident discharged from facility.
Observation notes dated 05/07/2024 - 07/25/2024 with behaviors listed by time (all notes except 06/22/2024, 06/25/2024, and 07/13/2024 also identified walking, wandering, or pacing on unit) (summarized):
5/27/2024 9:02 PM - Played in water; pushed chair; paced; tampered with windows, window blinds, cords and lamps.
05/29/2024 - wandered unit; cussed, repetitively yelled "Shut up!", yelled at caregiver "Whip me!", talked to self; pulled pots and pans out of kitchenette cupboard; pushed dining room tables and chairs, pulled on hallway rail; tampered with kitchenette stove and electrical sockets; pulled on kitchenette's overhead hanging lights; poured juice onto kitchenette counter; attempted to elope; hit and kicked staff; and attempted to rip footboard off his/her bed while sitting on bed.
05/30/2024- in other resident rooms and their garbage; threw items; removed items from kitchenette refrigerator; hallucinated; turned chairs over and stated s/he will cut chairs; refused cares and swung at staff and called them names.
06/10/2024 - spit out medications; touched and yelled at staff; touched books; pushed living room chairs; tampered with the fireplace screen; shook doorknobs; and refused medications.

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N 389	Continued From page 10 6/12/24 - made faces; shouted; pushed chairs, tables, and dresser; wandered with his/her bed sheets, pushed on exit doors; and tampered with fire extinguisher; attempted to pull blind off window; yelled at staff for coughing; hit, kicked and tried to bite staff. 6/16/24 - refused PM medications; set off wander guard door alarms, placed clothes and sheets throughout own room. 06/17/2024 - tampered with paper and took things apart in fax room; tampered with pots and pans; folded and unfolded his/her clothes in his/her room; and yelled and cussed at staff. 06/19/2024 - talked to staff about leaving, knocked on doors and attempted to leave out exit doors. 06/21/2024 - tampered with doors and blinds. 06/22/2024 - walked around with sheets and blankets; sat on living room floor from 3:30 PM-5:00 PM; resistive to eating; knocked on resident's doors and attempted to elope. 06/25/2024 - played with water in bathroom. 06/26/2024 - knocked on resident's doors and refused dinner. 6/29/2024 - pushed tables and chairs and attempted to get out "yard door". 07/02/2024 - pushed big recliner chair over; tried to open windows; tampered with bookshelf and cable box in living room; knocked on glass door to back yard and pushed on doors. 07/04/2024 - pushed on doors to get out. 07/05/2024, 07/07/2024 and 07/09/2024 - tampered with drawers in kitchenette. 07/10/2024 - tampered with drawers, dishes, coffee, and refrigerator in kitchenette and crawled on floor at 4:00 PM and 8:00 PM. 07/13/24 - crawled on floor, played in water in kitchenette and tampered with bookshelves. 07/14/2024 - crawled on floor, was aggressive toward staff and tampered with front and back	N 389		

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N 389	Continued From page 11 doors. 07/22/2024 7:38 PM - pushed on doors. 7/25/24 7:07 PM - pulled pants down and urinated and defecated on carpet. Incident Report dated 06/21/2024 (by Manager A): " ...Resident found on path to park across the street from facility. Resident was laying on [right] side on grass/path. Resident noted to have laceration under chin. 911 called for ambulance transport to hospital ...Resident seen post elopement/fall walking around unit. Resident noted to have stitches to chin ..." Psychiatry Follow Up dated 07/15/2024: " ...Per staff, [s/he] is in [his/her] own unit when [s/he] is agitated, not safe to be around other residents ..." Provider Order Form dated 06/24/2024: " ...15 minute safety checks to be performed due to recent elpoment [sic] ..." Individual Service Plan (ISP) dated 05/02/2024: In the area of Eating/Meals: " ...(Interventions) Report changes in ability to eat or drink to the nurse ..." In the area of Psychotropic Medication: " ... (Interventions) Resident is utilizing Psychotropic [sic] medications for aggressive behaviors ..." In the area of Reluctance To Accept Care: " ...Interventions) If you meet reluctance with ADLs [activities of daily living]: stop, ensure safety, and resume/re-approach at a later time." In the area of Behaviors: "(Goal) Will not act out in a way that is harmful to self or others by hitting, punching, kicking, and throwing objects. (Interventions) Exhibits inappropriate behaviors: taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse or other extreme or erratic behavior	N 389		

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patterns.
Receives mental health services through: [Name of psychiatric service].
Report changes from baseline behaviors to Nurse.
WANDERS aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased. Not a disturbance to others."
In the area of Cognition: " ...(Interventions) Has disorientation or difficulty recalling/retaining information. Needs cueing. Is on safety checks every 2-3 hours at night."
In the area of Medications: " ...(Interventions) Needs help with medications due to cognitive loss. Requires nurse delegations of medications to an aide ..."
In the area of Elopement Risk: "(Goal) Safety will be maintained. (Interventions) Resides within a locked unit. Wears a monitoring device wonder [sic] guard, as ordered by health care practitioner.
Bedside ISP Report (not dated):
" ...Behavior/Mood Exhibits inappropriate behaviors: taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse or other extreme or erratic behavior patterns. Receives mental health services through: [Name of psychiatric service]. Report changes from baseline behaviors to Nurse. WANDERS aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased. Not a disturbance to others. Cognitive/Communication ...Is on safety checks every 2-3 hours at night ..."

Resident 1's individual service plan (ISP) did not include interventions to prevent and/or manage behaviors that were harmful to self/staff/other

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residents, destruction of property, or medication and meal refusals and was not updated when Resident 1 required one-to-one supervision (due to living alone on unit due to behaviors) or when safety checks were changed from every 2-3 hours to every 15 minutes.

Example 2- Resident 3
Resident 3 was admitted 01/17/2024. Diagnoses included vascular dementia, severe, with agitation; severe dysphagia; aphasia; toxic encephalopathy; and lack of coordination. S/he was admitted onto hospice service 05/09/2024.

Nurse's note dated 07/30/2024 and MAR identified all oral medications were discontinued 07/30/2024 except scheduled liquid melatonin, PRN hyoscyamine tablet and PRN liquid morphine.
Facility Nurse's Note dated 08/02/2024- "New orders received, noted, and ordered to discontinue NPO [nothing by mouth] and offer resident fluids at meals and prn [as needed]."

Hospice note received from Manager A on 09/05/2024:
07/10/2024- " ...FOUND [RESIDENT 3] IN [HIS/HER] BRODA CHAIR, NON VERBAL ..."

Hospice assessment and plan of care dated 08/07/2024 (received from Manager A on 09/05/2024) summarized:
-patient is nonverbal, monitor for nonverbal indicators of pain ...has severe dysphagia, "mainly NPO" [nothing by mouth then changed to liquid diet on 08/02/2024]
-stop offering fluids if coughing, holding/pocketing, or spitting liquids out ... will hold fluids in mouth or spit fluids out and requires oral care frequently throughout the day ..."

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N 389	Continued From page 14 -is immobile and incontinent-reposition, check and change every 2 hours to prevent skin breakdown. -history of falls-keep in common area to be monitored, low bed. -requires complete assist with all activities of daily living. Facility ISP dated 06/13/2024 (summarized): In the area of Psychotropic Medication: " ...Resident is utilizing Psychotropic [sic] medications ...Mirtazapine [sic], Memantine [sic], Donepezil [sic], Duloxetine [sic] ..." In the area of Bathing: " ...Assistance x1 required ...cueing to wash self; cueing to dry self ..." In the area of Toileting: " ...Bathroom equipped with adaptive devices for toileting activities (i.e. grab bars, raised toilet, etc.) ..." In the area of Eating/Meals: " ...Is independent with meals and eating and drinking ..." In the area of Transfers: " ...Uses Hoyer Lift [sic] ..." In the area of Bladder: " ...Assistance needed to use toilet and maintain bladder continence ..." In the area of Bowels: " ...Assistance needed to use toilet and maintain bowel continence ..." In the area of Mobility: " ...AMBULATION: Can not ambulate long distances without guidance or assistance..." Resident 3's ISP did not address need for broda chair, concave mattress, fall mat, and was not updated when his/her mobility status, care needs and diet changed. Example 3- Resident 4 Resident 4 was admitted 04/30/2024. Diagnoses included Alzheimer's disease, unspecified and post-traumatic stress disorder.	N 389		

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N 389	Continued From page 15 Pre-Admission Health Questionnaire dated 04/12/2024 (signed by Manager A) identified Resident 4 had wandered away from home or attempted to leave home without help. Elopement Risk Assessments: Resident 4's record contained 3 assessments all signed by Manager A. The assessments stated if score is 5 or greater, the resident is at risk. Scores: 06/08/2024-15; 06/10/2024-18; and 08/15/2024-18. Facility progress note dated 04/30/2024 7:47 PM (summarized): Resident wandering unit, wander guard attached to ankle. Incident report dated 06/07/2024 by CNA H (summarized): Resident eloped and found at gas station by a citizen. Police called and resident was transported to the hospital for evaluation. Resident was transported back to facility via ambulance. No injuries observed post incident. Incident report dated 08/14/2024 by Manager A (summarized): Manager A was asked by Executive Director E if a resident was missing because police were dispatched to a local gym. A head count found Resident 4 was missing. Police returned Resident 4 to facility. No injuries noted post incident. ISP dated 06/26/2024- The ISP did not address risk of elopement or wander guard use. Bedside ISP (not dated): " ...Safety ...Wears a monitoring device (SPECIFY), as ordered by health care practitioner ..." Bedside ISP Report did not identify the monitoring device was a wander guard bracelet or that it was worn on ankle.	N 389		

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N 389	Continued From page 16 Example 4- Resident 5 On 09/05/2024 and 09/09/2024, Surveyor reviewed Resident 5's record. S/he was admitted 01/22/2024. Diagnoses included anxiety disorder, depression, and unspecified dementia. Facility progress notes dated 03/04/2024 - 08/30/2024 (received 09/05/2024 from Manager A) and 01/23/2024-03/04/2024 (received 09/09/2024 at 9:09 AM via email from Manager A) identified the following behaviors (summarized): 01/28/2024 07:51 AM- refused medication stating staff trying to kill him/her. 02/22/2024 7:55 PM- "constantly" refusing medication. 02/26/2024 7:03 PM- Resident called 911 and police office came and spoke with him/her. Resident hallucinating, seeing people in room that are not there per police office. Staff report increased depression with crying and withdrawal, and refusing medication, POA in agreement for psychiatric services. 02/28/2024 3:15 PM- conversing with someone to his/her right side who is not there. 02/28/2024 9:05 PM- another resident reported that Resident 5 came out of his/her room and yelled obscenities at resident. 03/04/2024 8:44 PM- refusing medication, verbalized sadness regarding loss, changes and adjustment to facility and long-term care. 03/05/2024 3:40 PM- refused breakfast and AM and noon medication. 03/13/2024 6:08 AM- attempting to elope at 1 AM. Resident called 911 requested police take him/her to hospital due to being woke up nightly, and requested police put him/her in a straight jacket and shoot him/her with a medication needle. 03/14/2024 4:33 PM- seen by psychological services.	N 389		

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N 389	Continued From page 17 03/19/2024 11:48 AM- Resident cut wander guard bracelet off "again". Writer and staff searched resident's room found pair of scissors and explained to resident scissors would be removed from room as a safety concern. Resident became highly agitated, left room, and began hitting glass door that leads into courtyard. Resident returned to room and continued to slam door shut a few times. Resident sent to hospital per nurse practitioner recommendation [admitted for a urinary tract infection] 04/01/2024 2:22 PM- Wander guard found in resident's purse along with a pair of scissors and toenail clippers and approximately 50 white pills a plastic zipper bag. Resident punched staff in right shoulder and scratched staff's left hand when staff attempted to reattach wander guard to resident's ankle. 04/02/2024 6:18 AM- Sat by exit door attempting to elope. When staff tried to redirect him/her, resident punched staff in chest and kicked staff's knees causing staff to fall to floor. Resident screamed and yelled and stated s/he was talking to the people in his/her head. Resident was up all night screaming and banging. 04/02/2024 9:50 PM- Refused medication, punched, kicked, and banged on objects. Attempted to elope and break windows. 04/03/2024 1:45 PM- exit seeking, banging, kicking, punching, and attempting to break windows. Manager A advised caregiver to arrange transport to hospital for evaluation. 04/03/2024 1:54 PM- Returned from hospital with diagnoses of UTI. Manager A recommended to POA that resident be moved to a smaller unit for resident's safety and POA agreed. 04/03/2024 7:35 PM- Resident's family member looked at room that resident would be moving to and did not like room. Writer stressed importance of keeping resident safe. Plan to send resident	N 389		

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back to hospital for treatment of UTI with IV antibiotics. Resident transferred back to hospital via ambulance. Manager A spoke with psychiatric nurse practitioner regarding resident's increasing behaviors.
04/10/2024 7:55 PM- Resident seen by psychiatric services.
05/08/2024 1:48 PM- Resident refused to go to scheduled appointment with transportation and family escorting.
05/15/2024 9:48 AM- Resident broke slider door and attempted to elope. Manager A instructed caregiver to send resident to emergency room related to UTI as exit seeking is a typical behavior when s/he has a UTI. Resident refused transport and POA was notified. Resident supplied urine sample.
05/17/2024 8:11 PM- Resident moved to a room on a smaller unit for resident's and other resident's safety when attempting to elope. POA in agreement. Resident moved.
06/07/2024 1:06 PM- Resident threw cup of coffee at caregiver.
06/13/2024 1:35 PM- Seen by psychiatric services.
06/13/2024 4:43 PM- Refused to be seen by audiologist stating s/he had to feed twin babies but did not know where the twins were.
06/21/2024 11:37 AM- Removed urine collection hat from toilet multiple times.
07/19/2024 3:29 PM- For the past few days had yelled and hit walls. Kicked family member out when s/he came to visit. Order received for urinalysis to rule out UTI.
07/29/2024 8:59 PM- Removed using collection hat from toilet.
08/15/2024 9:02 PM- Yelled profanities and kicked bedroom wall, talking to someone not present. Per Manager A's request, a family member arrived at facility to accompany resident

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to hospital for further eval [returned from hospital on 08/19/2024].
08/21/2024 8:38 PM- Resident agitated and attempting to open door to elope to another unit. Hit wall and yelling profanities to someone not present.
08/21/2024 8:58 PM- Resident kicking medication room door and swung at and hit staff.
08/27/2024 9:33 PM- Very anxious, attempting to elope, using profanity, yelling and rude to other residents and staff.

Incident report dated 03/18/2024 (summarized): Receptionist received a call from neighboring assisted living facility asking if LindenCourt was missing a resident. Head count completed and Resident 5 was missing. Resident returned to facility with 2 small abrasions to right knee. Resident sent to emergency room for evaluation.

Resident 5's ISP dated 07/19/2024:
In the area of Psychotropic Medication: "Resident is utilizing Psychotropic [sic] medications ...Diazepam [sic]/anxiety, Sertraline [sic]/depression, Quetiapine [sic]/Psychoses [sic] ..."
In the area of Elopement: " ...Distract resident from wandering by offering pleasant diversion, structured activities, food, conversation, television, book ..."
The ISP did not address Resident 5's history of or need to monitor for UTI's, mood, hallucinations and delusions, behaviors, use of wander guard, withholding personal scissors and nail clippers, or psychiatric services.

On 09/05/2024 at 10:39 AM, Surveyor interviewed Resident Assistant F who stated incontinent care was provided to Resident 3 while in bed and anytime s/he was in bed other than

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when cares were being provided, Resident 3's bed was in the lowest position and fall mat placed on floor next bed.

On 09/05/2024 at 10:56 AM, Surveyor interviewed Resident Assistant C who stated Resident 1 was very aggressive, combative with other residents and difficult to redirect. Resident Assistant C stated Resident 4 wore a wander guard bracelet on ankle and staff checked the wander guard's functioning daily because sometimes the door malfunctioned.

On 09/05/2024 at 4:24 PM, Surveyor interviewed Resident Assistant G who stated s/he did not follow either Resident 3's ISP or hospice care plan, and only followed instructions on whiteboard written by Resident 3's family.

On 09/05/2024 at 4:30 PM, Surveyor interviewed Manager A who stated s/he took scissors and nail clippers away from Resident 5 but family kept bringing them back.

On 09/05/2024 at 4:37 PM, Surveyor discussed concern of ISP's not updated with Manager A and RN B. Manager A stated Resident 5's risk of elopement increased with UTI's and s/he thought the wander guard was addressed on the ISP. Manager stated "Okay" regarding concerns with Resident 1's ISP. Manager A stated s/he did not know why Resident 4's was wander guard was missed on the ISP. Manager A stated Resident 3's incontinent care was provided on his/her bed, bed was kept in the lowest position.

On 09/06/2024 at 11:26 AM, Surveyor interviewed Manager A who stated after the other 4 residents were moved 05/30/2024 Resident 1 resided on the unit alone and received one-to-one staff

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N 389	Continued From page 21 supervision. Cross Reference: N0426 DHS 83.38(1)(b) Supervision N0433 DHS 83.38(1)(i) Behavior Management	N 389		
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 ensure services were adequate to meet the needs of the residents in the area of supervision for 2 of 2 residents reviewed. Despite Resident 4 wearing a wander guard bracelet, s/he eloped from facility twice due to courtyard gate left unsecured and was found by citizens near busy intersections. Staff were unaware Resident 4 was not at facility during both incidents until police made contact with staff. On 03/13/2024, staff documented Resident 5 attempted to elope from facility. On 03/18/2024, Resident 5 eloped and was found at a neighboring assisted living. Staff were not aware	N 426		

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Resident 5 was missing until neighboring assisted living called facility and asked if they were missing a resident. A wander guard bracelet was initiated for Resident 5 after the 03/18/2024 elopement.

Findings include:

The facility is licensed as a nonambulatory CBRF able to serve up to 49 residents within the client groups of Alzheimer's dementia.

On 08/14/2024, the Department received a complaint regarding elopements.

On 08/21/2024 at 5:49 AM, Surveyor received 2 police reports via email from the police department regarding Resident 4.

Police Report dated 06/08/2024 (summarized): On 06/07/2024 at 10:03 PM, police were dispatched to a gas station on W. Cleveland Ave after gas station staff reported an elderly person (Resident 4) inside the gas station appearing disoriented and confused. On police's arrival Resident 4 was able to state correctly state his/her name and date of birth and stated s/he lived alone but did not know his/her address and had no identification with him/her. Using law enforcement resources, police called a family member who stated they had not had contact with Resident 4 for over 20 years and stated Resident 4 was a veteran. Police asked Resident 4 if s/he would like to go to the VA hospital at which point Resident 4 talked about his/her knee hurting and showed police his/her wander guard bracelet on ankle. Police transported Resident 4 to the VA hospital and upon arrival a VA staff recognized Resident 4 as the sibling of his/her neighbor (Family Member I). Police spoke with Family

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Member I then proceeded to LindenCourt and spoke with overnight staff who stated they were unaware Resident 4 was not at the facility, and they checked on specific residents every 1 to 2 hours. Police called PM shift worker CNA H who stated s/he observed Resident 4 at approximately 6:00 PM or 7:00 PM walking around and helped him/her get to his/her room and based on police investigation Resident 4 left the facility sometime after 7:00 PM before making his/her way to the gas station.

Police Report dated 08/14/2024 (summarized): On 08/14/2024 at approximately 4:19 PM police were dispatched to a fitness center on W. National Avenue regarding an elderly person (Resident 4) walking around the parking lot sounding confused. Up on arrival, Resident 4 was able to tell police his/her name but was unable to explain how s/he arrived at the fitness center. While speaking with Resident 4 a fitness center member stated s/he worked at LindenGrove New Berlin (the skilled nursing facility attached to LindenCourt New Berlin) and called facility management. When police transported Resident 4 back to LindenCourt staff stated they were not aware s/he had left the facility. The police report stated " ...Of note, Linden Grove is an inpatient care facility for patients with memory loss issues, on the north side of National Avenue, east of Sunny Slope Road. [Resident 4] was unaccounted for, for an unknown amount of time. [Resident 4] would have had to cross National Avenue during rush hour traffic to reach [name of fitness center], which is located on the southeast corner of Sunny Slope Road from Linden Grove ..."

On 08/27/2024 at 5:56 PM, Surveyor interviewed Police Officer (PO) - J who stated s/he was

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involved with the 08/14/2024 incident regarding Resident 4. PO-J stated National Avenue where Resident 4 was found is a treacherous because "people drive insane." PO-J stated upon arrival back to LindenCourt staff did not know how long Resident 4 was gone from facility. PO-J stated tis type of situation is challenging because cruel people would take advantage of Resident 4's situation. PO-J stated on 03/18/2024 police responded to a report of Resident 5 found in his/her wheelchair at LindenCourt's neighboring assisted living facility on National Ave. PO-J stated Resident 5 was found with a scraped knee and refused ambulance transport to hospital. PO-J stated the police report did not reference a time-frame Resident 5 was absent from LindenCourt.

On 09/05/2024, Surveyor reviewed facility Resident 4's and Resident 5's records.

Example 1- Resident 4
Resident 4 was admitted 04/30/2024. Diagnoses included Alzheimer's disease, unspecified and post-traumatic stress disorder.

Pre-Admission Health Questionnaire dated 04/12/2024 (signed by Manager A) identified Resident 4 had wandered away from home or attempted to leave home without help.

Elopement Risk Assessments: Resident 4's record contained 3 assessments all signed by Manager A. The assessments stated if score is 5 or greater, the resident is at risk. Scores: 06/08/2024-15; 06/10/2024-18; and 08/15/2024-18.

Facility progress note dated 04/30/2024 7:47 PM (summarized): Resident wandering unit, wander

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N 426	Continued From page 25 guard attached to ankle. Incident report dated 06/07/2024 by CNA H (summarized): Resident eloped and found at gas station by a citizen. Police called and resident was transported to the hospital for evaluation. Resident was transported back to facility via ambulance. No injuries observed post incident. Incident report dated 08/14/2024 by Manager A (summarized): Manager A was asked by Executive Director E if a resident was missing because police were dispatched to a local gym. A head count found Resident 4 was missing. Police returned Resident 4 to facility. No injuries noted post incident. ISP dated 06/26/2024- The ISP did not address risk of elopement or wander guard use. Bedside ISP (not dated): " ...Safety ...Wears a monitoring device (SPECIFY), as ordered by health care practitioner ..." The Bedside ISP Report did not identify the monitoring device was a wander guard bracelet or that it was worn on ankle. Example 2 Resident 5 On 09/05/2024, Surveyor reviewed Resident 5's record. S/he was admitted 01/22/2024. Diagnoses included anxiety disorder, depression, and unspecified dementia. Facility progress note dated 03/13/2024 6:08 AM (summarized)- attempting to elope at 1 AM. Incident report dated 03/18/2024 (summarized): Receptionist received a call from neighboring assisted living facility asking if LindenCourt was missing a resident. Head count completed and Resident 5 was missing. Resident returned to	N 426		

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facility with 2 small abrasions to right knee. Resident sent to emergency room for evaluation.

ISP dated 07/19/2024:
In the area of Elopement: " ...Distract resident from wandering by offering pleasant diversion, structured activities, food, conversation, television, book ..."
The ISP did not address Resident 5's need for wander guard.

Resident Aide C stated Resident 4 wore a wander guard bracelet on ankle his/her ankle.

On 09/05/2024 at 1:15 PM, Surveyor interviewed Manager A who stated the facility's courtyard was partly surrounded by building and a fence and the door to the courtyard did not have a wander guard alarm so residents could freely access the courtyard. Manager A stated there were 2 gates on the courtyard fence that were kept locked. Manager A stated on 06/07/2024, Resident 4 exited the courtyard through a gate left unlocked by contracted lawn care staff. Manager A stated after Resident 4's elopement on 06/07/2024, s/he told contracted lawn care staff to notify staff when they were leaving and s/he told staff to monitor Resident 4 when lawn care work was being done. Manager A stated after Resident 4 exited out of the unlocked gate on 08/14/2024 s/he told staff to lock the door to the courtyard when contracted lawn care staff were there. Manager A stated s/he told maintenance and Executive Director E the courtyard gate was a "big" problem. Manager A stated a key code lock was added to the gate Resident 4 exited from and demonstrated to Surveyor how the gait locks work.

On 09/05/2024 at 4:30 PM, Surveyor interviewed Manager A who stated s/he took scissors and nail

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clippers away from Resident 5 because s/he cut the wander guard bracelet off, but family kept bringing them back.

On 09/05/2024 at 4:37 PM, Surveyor discussed concern of supervision to prevent elopements with Manager A and RN B. Manager A stated Resident 5's incident on 03/18/2024 was the first time s/he had eloped and so a wanderguard bracelet was placed then. Manager A stated staff have been locking the courtyard door during lawn care in the courtyard.

According to Wisconsin DOT, the average daily traffic count (closest to the fitness center where Resident 4 was found on 08/14/2022) on W. National Ave was 18,100 and Sunny Slope Road was 11,400 in 2022. The average daily traffic count nearest the gas station where Resident 4 was found on 06/07/2024 on Sunny Slope Road was 12,500 and W. Cleveland Ave. was 9,500 in 2022. (Source: https://wisdot.maps.arcgis.com/apps/webappviewer (retrieval date 09/10/2024)).

LindenCourt New Berlin and the neighboring assisted living where Resident 5 was found on 03/08/2024 are both surrounded by Sunny Slope Road, National Avenue, and Fieldpointe Drive. According to Wisconsin DOT, the average daily traffic count (closest to LindenCourt New Berlin) on National Ave. was 15,300 and Sunny Slope Road was 11,400 in 2022. (Source: https://wisdot.maps.arcgis.com/apps/webappviewer (retrieval date 09/10/2024)).

Cross Reference:
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes

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N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide adequate services to manage Resident 1's behaviors that were harmful to self, staff, and other residents. Staff did not provide adequate nonpharmacological interventions to manage Resident 1's behaviors to prevent self-harm, verbal and physical aggression toward other residents and staff, and destruction of property. On 05/06/2024, 4 days after admission Resident 1 was issued a 30-day discharge notice due behaviors. On 05/29/2024, Resident 1 pulled Resident 2 out of bed and punched him/her in the abdomen despite provider's knowledge of Resident 1's aggression toward other residents since 05/06/2024. On 05/30/2024, 4 residents residing on a unit with Resident 1 were moved from their rooms to other unit(s) due to Resident 1's behaviors.	N 433		

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N 433	Continued From page 29 On 06/21/2024, Resident 1 received stitches to a chin laceration after eloping to a park across the street despite one-to-one staff supervision after other residents were moved off his/her unit on 05/30/2024. On 07/26/2024, Resident 1 was admitted to hospital for behaviors and diagnosed with a urinary tract infection (UTI). The provider denied readmission and Resident 1 was discharged from facility. Findings include: The facility is licensed as a nonambulatory CBRF able to serve up to 49 residents within the client groups of irreversible dementia/Alzheimer's. On 08/01/2024, the Department received a complaint regarding behaviors. On 09/05/2024, Surveyor conducted a complaint investigation. On 09/05/2024, Surveyor reciewed Resident 1's record. Resident 1 was admitted 05/01/2024 and discharged 07/26/2024. Diagnoses included adjustment disorder with mixed anxiety and depressed mood, Alzheimer's disease with late onset, and dementia with agitation. Facility Progress Notes dated 05/01/2024-07/29/2024 identified the following behaviors exhibited by Resident 1 (summarized): 05/01/2024 8:26 PM (by Manager A)- "Aide was attempting to place wonder [sic] guard on resident for [his/her] safety. Resident scratched aide on neck by grabbing aide's necklace, [sic]	N 433		

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and breaking it. Resident then attempted to kick aide."

05/02/2024 4:24 PM (by Manager A)- " ...was at med cart [sic] resident came up behind [him/her] and attempted to hit aide with a soap dispenser. Aide was able to remove [him/herself] from the situation, [sic] and went to the kitchen pantry with med cart for safety."

05/03/2024 4:27 PM (by Manager A)- "Resident was attempting to remove a resident on the unit from [his/her] wheelchair that is wheelchair bound. Aide on unit attempted to redirect resident, however resident punched aide in face twice. Aide was able to get away when resident went and grabbed the heavy medal [sic] house decor and chasing aide, and housekeeper swinging medal [sic] decor to hit them. Another resident on unit tried to help when [s/he] picked up a book and hit [him/her] three times with. Writer called EMS for transport to hospital for aggressive behavior. Resident was transported to [name of hospital] for eval ..."

05/05/2024 4:35PM (by Manager A)- "Writer received a call from aide working on unit that resident had the laptop computer charger swinging it, [sic] and hitting aid with it. Writer advised aide to call 911 for aggressive behavior. Writer received call from New Berlin police officer that they could not take resident to jail as [s/he] is not appropriate for jail. [S/he] further explained that crisis was called, and crisis could not do anything as resident only has a dx [diagnosis] of Alzheimer's/Dementia [sic]. [S/he] did not fit the criteria. Once New Berlin police left [sic] I received another call from the aide on the floor that resident was throwing chairs, and knocked over the med card. I advised writer to call EMS

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for transport to the hospital. EMS would not come to facility for transport without the police being involved. Writer received a call from the crisis worker [name of crisis worker] that [s/he] did not qualify for chapter [sic] 51] and that [s/he] suggested to have family come be with resident. I reached out to the [family member/POA] and advised of resident's behaviors. [Family member/POA] told me [s/he] would send a family member to be with [him/her]. Writer did reach out to resident caseworker for advisement, and awaiting return call."

05/06/2024 8:26 PM (by Manager A)- Writer spoke with [resident case manager] via phone. Writer explained resident [sic] aggressive behavior since arrival to facility. Being sent to hospital police and crisis involvement from the weekend."

05/08/2024 6:51 PM (by Manager A)- "Writer was in residence housing unit. Writer noted to see resident walking around. Resident then went to the dining table when [s/he] dumped over a glass of juice all over the table. Aide on unit went to clean table, and redirect resident when resident began swinging at aid, and yelling. Writer removed resident from situation to calm resident and redirect [him/her]. Resident gave writer a hug, and then kissed writer's cheek. Writer then sat resident on lounge chair and offered [him/her] two mighty [sic] shakes that [s/he] consumed." 05/08/2024 9:22 PM- "Resident was talking to and seeing people that didn't [sic] exist."

05/09/2024 11:10 AM (by Manager A)- "Psych in to see resident. New orders received ..."

05/09/2024 3:58 PM- (by Manager A)- "Writer was in kitchen taking a cake off the kitchen

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counter. Resident grabbed the box, and writer's wrist. When writer let box go [sic] resident took cake out of box and began hitting the writer with the cake box."

05/14/2024 9:25 PM- "[S/he] walked and paced through the house all night. [Resident] taking items off the shelf and carrying them around. [Resident] was talking to [him/herself] and others that werent [sic] there. [Resident] playing in water in the kitchen and had water all over the floor. [Resident] in and out of kitchen cabinets. pulling [sic] things off shelves."

05/18/2024 12:30 PM "staff [sic] was washing the dishes . [sic] [Resident 1] requested staff to move from the sink . [sic] staff [sic] told [Resident 1] no . [sic] [Resident 1] picked up a silver pan and hit staff with it across the back . [sic] staff [sic] removed [Resident 1] from kitchen area and put [him/her] in [his/her] bedroom [sic]"

05/23/2024 1:20 PM (by Manager A)- "Case Manager into see resident, [sic] and talk with writer. Writer explained residents [sic] behaviors, residents [sic] scheduled medications. Case Manager would like writer to reach out to psyche to be able to control behaviors. Writer reached out to psych NP ..."

05/24/2024 6:30 AM- "[Resident 1] got up around 4am [sic] . [sic] [S/he] began to go in the kitchen playin [sic] with water. mixing coffee . [sic] going [sic] in the fridge. Trying [sic] to his [sic] staff with a cup . [sic] throw [sic] some plates across the carpet. tried [sic] to escape out the door. Setting [sic] the alarm off. This [sic] went on until 6am [sic]"

05/24/2024 1:26 PM (by Manager A)- "Resident

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came in writer's office with a three ring binder. Resident began hitting aide that was sitting in my office multiple times with binder. Resident eventually stopped hitting aid, and writer was able to remove resident from office."

05/25/24 11:38 AM- "being [sic] combative towards me [sic] grabbing and hitting [sic] throwing trash can throwed [sic] square dining room table [sic] broke the leg to the table [sic] going into drawers [sic] taking things out [sic] throwing them [sic] fight [sic] another staff [sic]"

05/27/2024 8:53 PM- "resident [sic] poured water in the electrical shock [sic] in the kitchen where the microwave sits. Then [sic] [s/he] proceeded to plug the microwave back up into the shocket [sic]. [caregiver] had to remove the item. this [sic] [resident] pulled on door knobs [sic] trying to leave the building 3 times today on 1st shift. [Caregiver] had to redirect [him/her] to please stop due to the alarms going off. [S/he] then hit at [caregiver], pulled on [caregiver] clothes, kicked at [caregiver] bite at [caregiver] each time. [Caregiver] tried to give [resident] [his/her] meds for behaviors."

5/29/24 9:00 AM (by Manager A)- "[Resident 1] went into another room. Resident pulled [Resident 2] out of [his/her] bed threw [him/her] to the ground and began punching [him/her] in the abdomen. [Resident 1] then grabbed resident and began dragging [him/her]. When aide of unit attempted to redirect resident and get [him/her] away from the resident. [sic] Resident began hitting/punching aide. Writer was alerted to this. Writer then called [name of managed care organization] and spoke to [RN case manager]. [RN case manager] instructed writer to call the authorities. New Berlin Police Department arrived

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at facility. New Berlin Police [sic] then called crisis. Crisis did not come to facility. Crisis report being that resident has the [diagnosis] of Alzheimer's/Dementia [sic] they would not be out, and that resident was were [sic] [s/he] needed to be. Writer then updated [RN case manager] of [name of managed care organization] after New Berlin Police Department departed facility. Writer called [psychiatric nurse practitioner] and explained resident's behavior/incident new orders received, noted, and ordered ..."

05/31/2024 9:02 PM- "[Resident 1] threw a chair at me [sic] [Resident 1] also refused [his/her] meds [sic] it also took 3 of us to change [Resident 1] [s/he] [sic] was very soil [sic] [s/he] is calm for now [sic]"

06/04/2024 4:06 PM- "Resident came behind aide with a home decor ceramic lid and threw [sic] at aid of unit. Resident did not make contact with aide. Ceramic lid hit floor, [sic] and shattered."

06/12/24 7:24 PM (by Manager A)- "Writer had set up ISP meeting with [family member/POA]. [Family member/POA] was supposed to let writer know what time for today. [Family member/POA] did not call writer with a time nor did [s/he] show today."

6/13/2024 10:23 PM (by Manager A)- "Resident seen by psych. New orders received, noted and ordered ..."

6/14/2024 1:26 PM (by Manager A)- "Writer reached out to resident case manager for any updates on resident discharged [sic]. Writer did leave voicemail for return call. Writer then called residents [sic] [RN case manager]. Writer spoke with [RN case manager] and updated [him/her]

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that resident was seen yesterday by psych. [His/her] depakote, and Geodon [sic] was increased ..." (Note: Depakote is a non-antipsychotic medication and Geodon is an atypical antipsychotic medication used to treat behaviors.)

06/17/2024 10:33 AM (by Manager A)- "Writer was with aide when aide attempted to admin [sic] residents [sic] medication. Resident became angry, [sic] and started yelling obscenities to aide. Resident did say to aid that [s/he] was going to kill [him/her] when aide on unit attempted to redirect resident. [sic] Resident began swinging and hitting aide."

06/27/2024 11:27 AM- "As im [sic] sitting on the couch watching [Resident 1] [s/he] decided to take this metal thing up out [sic] the floor. When I [sic] told [him/her] to leave it alone [s/he] said [s/he] had to get it up first. So before [s/he] could get it all the way out I told [Manager A] to come over. By the time [s/he] came over [s/he] got it got [sic] the floor and started pulling on it. [S/he] going [sic] get electrocuted if [s/he] keep [sic] pulling at them cords. I was able to put it back in the floor and put the couch over it. But how long will that last before [s/he] try again. [sic]"

07/01/2024 10:45 AM- "as [sic] myself and another staff were cleaning [Resident 1] up for the day [s/he] began to fight us both kicking [sic] punching [sic] scratching [sic] screaming [sic] yelling [sic] cursing [sic] etc. [s/he] [sic] scratches my right wrist drawing blood."

07/01/2024 1:17 PM (by Manager A)- "Writer seen [sic] resident to remove stitches from chin. Resident chin noted to be shaved, with stitches removed. One stitch noted to remain in chin.

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Resident quite agitated for writer to attempt to remove stitch at this time." (Note: Resident sustained chin laceration during elopement to park across street from facility on 06/21/2024.)

07/16/2024 9:44 PM- "I assist [sic] [Resident 1] with the shower and [s/he] hit me because I wanted to help [him/her] [sic] i [sic] finish [him/her] anyway [sic]"

07/16/2024 4:36 PM (summarized)- Manager A called POA in attempt to set another ISP meeting. POA requested Manager A leave ISP t the unit for his/her signature.

7/26/24 - 07/29/2024 (summarized) Resident evaluated at and admitted to hospital due to no interest in foods or fluids, no intake, and swollen feet. Diagnoses with urinary tract infection. Facility refused to readmit Resident 1 stating a 30-day discharge notice was issued in May 2024. Resident discharged from facility.

Observation notes dated 05/07/2024 - 07/25/2024 with behaviors listed by time (all notes except 06/22/2024, 06/25/2024, and 07/13/2024 also identified walking, wandering, or pacing on unit) (summarized):

5/27/2024 9:02 PM - in bedroom playing in water; pushing chair; pacing; tampering with windows, window blinds, cords and lamps.

05/29/2024 - wandered unit; cussed, repetitively yelled "Shut up!", yelled at caregiver "Whip me!" and talked to self; played in water trying to wash dishes; pulled pots and pans out of kitchenette cupboard; pushed dining room tables and chairs, pulled on hallway rail; tampered with kitchenette stove and electrical sockets; pulled on

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N 433	Continued From page 37 kitchenette's overhead hanging lights; poured juice onto kitchenette counter; attempted to elope out back doors; hit and kicked staff; and attempted to rip footboard off his/her bed while sitting on bed. 05/30/2024- in other resident rooms and their garbage; threw items; removed items from kitchenette refrigerator; hallucinating; turning chairs over and stating s/he will cut them; refused to be changed and swinging at staff; and name calling. 06/10/2024 - spit out medications; touched and yelled at staff; touched books; pushed living room chairs; tampered with the fireplace screen; shook doorknobs; and refused medications. 6/12/24 - made faces; shouted; pushed chairs, tables, and dresser; wandered with his/her bed sheets, pushed on exit doors; and tampered with fire extinguisher; attempted to pull blind off window. At 7:30 PM, Resident 1 noted to get upset and yell a staff for coughing then hit, kicked and tried to bite staff. Staff tried to calm Resident 1 down and s/he again hit, kicked, and tried to bite staff. 6/16/24 - refused PM medications, wandering setting off door alarms, placed clothes and sheets all over own room. 06/17/2024 - tampered with paper and took things apart in fax room; tampered with pots and pans; folded and unfolded his/her clothes in his/her room; and yelled and cussed at staff. 06/19/2024 - talked to staff about leaving, knocked on doors and attempted to leave out exit doors.	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019677	A. BUILDING: _____ B. WING _____	C 09/11/2024

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N 433	Continued From page 38 06/21/2024 - tampered with doors and blinds. 06/22/2024 - walked around with sheets and blankets; sat on living room floor from 3:30 PM-5:00 PM; resistive to eating; knocked on resident's doors and attempted to elope. 06/25/2024 - played with water in bathroom. 06/26/2024 - knocked on resident's doors and refused dinner. 6/29/2024 - pushed tables and chairs and attempted to get out "yard door". 07/02/2024 - pushed big recliner chair over; tried to open windows; tampered with bookshelf and cable box in living room; knocked on glass door to back yard and pushed on doors. 07/04/2024 - pushed on doors to get out. 07/05/2024, 07/07/2024 and 07/09/2024 - Tampered with drawers in kitchenette. 07/10/2024 - tampered with drawers, dishes, coffee, and refrigerator in kitchenette and crawled on floor at 4:00 PM and 8:00 PM. 07/13/24 - crawled on floor, played in water in kitchenette and tampered with bookshelves. 07/14/2024 - crawled on floor, was aggressive toward staff and tampered with front and back doors. 07/22/2024 7:38 PM - pushed on doors. 7/25/24 7:07 PM - pulled pants down and urinated	N 433		

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N 433	Continued From page 39 and defecated on carpet. Incident Report dated 06/21/2024 (by Manager A): " ...Resident found on path to park across the street from facility. Resident was laying on [right] side on grass/path. Resident noted to have laceration under chin. 911 called for ambulance transport to hospital ...Resident seen post elopement/fall walking around unit. Resident noted to have stitches to chin ..." Psychiatry Follow Up dated 07/15/2024: " ...Per staff, has mixup [sic]of days and nights at times. [S/he] is ambulatory, has a wander guard in place. Per staff, [s/he] is in [his/her] own unit when [s/he] is agitated, not safe to be around other residents ..." Provider Order Form dated 06/24/2024: " ...15 minute safety checks to be performed due to recent elpoment [sic] ..." Individual Service Plan (ISP) dated 05/02/2024: In the area of Psychotropic Medication: " ... (Interventions) Resident is utilizing Psychotropic [sic] medications for aggressive behaviors ..." In the area of Reluctance To Accept Care: " ... (Interventions) If you meet reluctance with ADLs [activities of daily living]: stop, ensure safety, and resume/re-approach at a later time." In the area of Behaviors: "(Goal) Will not act out in a way that is harmful to self or others by hitting, punching, kicking, and throwing objects. (Interventions) Exhibits inappropriate behaviors: taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse or other extreme or erratic behavior patterns. Receives mental health services through: [Name of psychiatric service]. Report changes from baseline behaviors to Nurse.	N 433		

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N 433	Continued From page 40	N 433		

WANDERS aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased. Not a disturbance to others."
In the area of Cognition: " ...(Interventions) Has disorientation or difficulty recalling/retaining information. Needs cueing. Is on safety checks every 2-3 hours at night."
In the area of Elopement Risk: "(Goal) Safety will be maintained. (Interventions) Resides within a locked unit. Wears a monitoring device wonder [sic] guard, as ordered by health care practitioner.

On 09/05/2024 at 10:56 AM, Surveyor interviewed Caregiver C who stated Resident 1 was very aggressive, combative with other residents and hard to redirect. Caregiver C stated all other residents who lived on the same unit as Resident 1 were moved to a different unit.

On 09/06/2024 at 11:26 AM, Manager A stated because Resident 1 was "snowed" on admission medications for behaviors were stopped and gradually restarted. Manager A stated Resident 1 was very hard to redirect and became instantly combative so s/he was basically left to do his/her own thing. Manager A stated on 05/30/2024, the day after Resident 1 pulled Resident 2 out of bed and punched him/her in the abdomen, the 4 other residents residing on Resident 1's unit were moved to different unit(s). Manager A stated after the other 4 residents were moved Resident 1 resided on the unit him/herself and had one-to-one supervision of staff. Manager A stated s/he issued Resident 1' involuntary discharge notice in early May due to behaviors.

On 09/09/2024 at 9:03 AM, Surveyor received Resident 1's involuntary discharge notice from

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N 433	Continued From page 41 Manager A dated 05/06/2024 and stated: "Re: Notification of 30 day discharge -[Resident 1] ... LindenCourts [sic] New Berlin is giving [Resident 1] a 30-day written advance notice to vacate on or before June 6th, 2024 due to [his/her] care level being higher and more specialized than our CBRF is set up for. Four times the police have been out and Waukesha County Crisis Unit worked with to address [Resident 1] outburst. [S/he] is threating and hitting other residents. [S/he] is a danger to others to [sic] reside here at LindenCourts [sic] ..." Cross Reference: N0382 DHS 83.35(1)(b) Sources Used For Assessment Information N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0328 DHS 83.31(4)(c) Involuntary Notice Discharge Requirements	N 433		