STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 08/01/2023, Surveyor conducted 1 self-report review at Brookdale Madison West AL/MC. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See Statement Of Deficiency #5XF612, dated 10/08/2018. Census: 31	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan was implemented as written. Individual Service Plans (ISP) were not followed as written for 2 of 2 residents reviewed. This is a repeat violation. See Statement Of Deficiency #5XF612, dated 10/08/2018. Findings include: On 05/13/2023, the Department received a facility self-report from the provider stating reason for self -report was abuse. The self-report stated (summarized) on 05/07/2023 Resident 1 was improperly restrained, investigation was ongoing, provider would notify the Department of results of facility's investigation, and Former Med Tech E was immediately removed from the facility and placed on suspension.	N 388		

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

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N 388	Continued From page 1 On 08/01/2023, Surveyor conducted a self-report review. On 08/01/2023, Surveyor received the Incident Investigation from Executive Director A. The Incident Investigation was signed by Executive Director A and dated 05/08/2023. The investigation stated (summarized) the type of alleged incident was abuse. " ...Summary of Allegations: [Resident 1] came out of [his]her] room on Sunday, 5/7/23, wearing [his/her] pants as a shirt. [Former Med Tech E] told [Resident 1] that [s/he] needed to go back to [his/her] room and put pants on instead. [Resident 1] was refusing so [Former Med Tech E] grabbed [him/her] and they started to tussle. [Resident 1] fell to the ground and bit [Former Med Tech E] on the leg. [Former Med Tech E] then physically picked up and carried the resident to [his/her] room ...Summary of Findings ...it is determined that [Former Med Tech E] restrained [Resident 1] by hugging [him/her] from behind and lifting [him/her] off the ground and taking [him/her] to [his/her] room. Throughout the investigation, it was also alleged the [Former Med Tech E] restrained [Resident 2] by hugging [him/her] from behind and lifting [him/her] off the ground and taking [him/her] to [his/her] room. The allegation is substantiated and termination is justified ...Post Investigation Actions: Termination of [Former Med Tech E] ...Other Notifications ... Wisconsin Department of Health Services ..." On 08/01/2023, Surveyor received the Misconduct Incident Report submitted to Office of Caregiver Quality on 05/18/2023 from Executive Director A. Misconduct Incident Report dated 05/18/2023 stated on 05/07/2023 at 6:30 AM, " ...The incident	N 388		

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happened in our Memory Care unit. [Resident 1] came out of [his/her] room wearing a shirt as pants. [Former Med Tech E] told [him/her] to go back to [his/her] room to change. [Resident 1] refused so [Former Med Tech E] tried to force [him/her] by putting [his/her] arm on [his/her] back and pushing. [Resident 1] reacted by swinging [his/her] arm to push [Former Med Tech E] arm away which caused [Resident 1] to stumble to the ground between [Former Med Tech E] legs. [Resident 1] then attempted to bite [Former Med Tech E] on the leg. [Former Med Tech E] picked [Resident 1] off the ground in a bear hug type position and carried [him/her] to [his/her] room and sat [him/her] on the couch. The incident was witnessed by another resident, [Resident 2], who felt as though [Resident 1] was being attacked so [s/he] grabbed items as weapons. After [Former Med Tech E] left [Resident 1] room, [s/he] attempted to get [Resident 2] to return to [his/her] apartment. It was also witnessed that [Former Med Tech E] grabbed [Resident 2] from behind in another bear hug position and lifted [him/her] off the ground and carried [him/her] to [his/her] apartment ...DESCRIBE THE EFFECT that the incident had on the affected person ...[Resident 1] became very agitated and verbal during the interaction. [Resident 2] who witnessed the incident became agitated as well and began grabbing items as weapons ...and [Former Med Tech E] interaction with [Resident 1] disrupted other residents ..."

On 08/01/2023, Surveyor reviewed Resident 1's and Resident 2's records.

Example 1 Resident 1
Resident 1 was admitted 04/05/2023. The provider issued a 30 day discharge notice on 06/27/2023 due to behaviors and Resident 1 was

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discharged 07/04/2023. Diagnoses included dementia with agitation.

Facility Progress Notes:
05/07/2023 10:03 AM " ...LATE ENTRY Note Text: Writer received report of incident with a staff member and the resident. Writer was notified that at approximately 0630 [6:30 AM], resident came out of room with a shirt on as pants. Staff attempted to redirect resident, resident became combative with staff resulting in resident losing [his/her] balance and falling. Staff proceeded to pick resident up off of the floor in a bear hug description and carried resident back to [his/her] room. Writer and another RN went in to assess resident this am. No skin disruptions, bruising, or redness noted to resident body. Resident presents with full ROM [range of motion]. Denies any pain. Writer asked resident if [s/he] felt unsafe or if anyone had harmed [him/her]. Resident denied any of these concerns and was questioning why writer was asking [him/her] these types of questions, Investigation to follow ...POA updated along with PCP. Resident stable at this time ..."

Individual Service Plan dated 05/05/2023:
In the area of Dressing and Grooming " ... [Resident 1] is very independent and likes to care of [his/her] own needs when possible. [S/he] is able to dress [him/herself] and does not need staff assistance with dressing ..."
In the area of Reluctance to Accept Care " ...Use the Positive Physical Approach (e.g., go slow, make eye contact, get down low). Use preferred name, calm and gentle voice, and yes/no questions. Be aware that even positive interactions with visitors, residents and staff may cause reluctance to accept care due to stress or fatigue. Consider approaching resident at a

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N 388	Continued From page 4 different time or using a different staff member to provide care ...Avoid statements and/or interactions that may embarrass or shame the resident (e.g., reacting with shock, scolding or parental tone). Respect and acknowledge the resident's reality and avoid attempts to argue or reason. The resident has the right to refuse. Do not force a resident to follow an imposed schedule or routine. Be aware that discomfort may be a possible factor in a resident's responses ..." In the area of Behavior Management " ...Resident demonstrates anxious, disruptive or obsessive behaviors requiring additional attention. Approach resident with a gentle voice and expression to tell the resident that he/she is safe and cared for. Encourage repetitive manual activities (e.g., tearing coupons out of a newspaper). Use validation, respond to emotions behind anxious behavior ...Note that all repetitive behaviors are not necessarily harmful or disruptive. Redirect resident to their most familiar and comfortable area of the community if disruptive to others. Use the Positive Physical Approach (e.g., go slow, make eye contact, get down low). Use preferred name, calm and gentle voice, and yes/no questions. Respect and acknowledge the resident's reality and avoid attempts to argue or reason. Involve resident in community activities and Life Skills. Avoid statements and/or interactions that may embarrass or shame the resident (e.g., reacting with shock, scolding or parental tone). Be alert to triggers that cause the resident stress and reduce as much as possible (e.g. pain, boredom, physical and/or emotional needs, loud noises, crowded spaces, other residents, care staff approach). ...Outcome/Goal: [Resident 1] needs will receive appropriate staff approaches to address and redirect behaviors through the end of the review period ..."	N 388		

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N 388	Continued From page 5 Example 2 Resident 2 Resident 2 was admitted 11/20/2019. Diagnoses included Parkinson's disease and mild cognitive impairment of uncertain or unknown etiology. Facility Progress Notes: 05/08/2023 10:05 AM "Late Entry Note Text: On 5.8.2023 at approximately 7:30 AM writer was updated that resident had come out of [his/her] room and was experiencing some increased confusion. Resident was noted to be agitated and was trying to strike out at staff. Staff member picked resident up and placed [him/her] back in [his/her] room. Resident has no injuries noted after head to toe assessment completed. ROM intact. Will continue to monitor and update as needed. [Executive Director A] stated [s/he] would update HCPOA." ISP dated 05/09/2023: In the area of Behavior Management " ...Resident demonstrates anxious, disruptive or obsessive behaviors requiring additional attention. Approach resident with a gentle voice and expression to tell the resident that he/she is safe and cared for. Encourage repetitive manual activities (e.g., tearing coupons out of a newspaper). Use validation, respond to emotions behind anxious behavior ... Note that all repetitive behaviors are not necessarily harmful or disruptive. Redirect resident to their most familiar and comfortable area of the community if disruptive to others. Use the Positive Physical Approach (e.g., go slow, make eye contact, get down low). Use preferred name, calm and gentle voice, and yes/no questions. Respect and acknowledge the resident's reality and avoid attempts to argue or reason. Involve resident in community activities and Life Skills. Avoid statements and/or	N 388		

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interactions that may embarrass or shame the resident (e.g., reacting with shock, scolding or parental tone). Be alert to triggers that cause the resident stress and reduce as much as possible (e.g. pain, boredom, physical and/or emotional needs, loud noises, crowded spaces, other residents, care staff approach) ...Comments: [Resident 2] has periods of hallucinations and delusions. [S/he] also has anxiety with panic attacks at times. [S/he] may require 1 on 1 during these times ...Provide reassurance and direction ..."

On 08/01/2023 at 4:45 PM, Surveyor discussed concern of ISP's not followed as written with Executive Director A, Wellness Director B, Wellness Coordinator C and Associate Executive Director D. Wellness Coordinator C stated Former Med Tech E should have followed Resident 1's and Resident 2's ISP on 05/07/2023. Wellness Coordinator C verified Resident 1's ISP dated 05/05/2023 was the ISP in effect though it had not yet been signed by Resident 1's legal representative. Wellness Coordinator C stated on 05/07/2023 ISPs were kept in binders in the kitchen area or medication room for staff to reference. Executive Director A stated s/he concluded the incident on 05/07/2023 was considered abuse due to Former Med Tech E picking Resident 1 up off the ground in a bear hug and "man-handling" him/her. Executive Director A stated s/he did not feel Former Med Tech E intended to harm Resident 1 or Resident 2.

Cross Reference:
N0408 DHS 83.37 (1)(i) PRN Psychotropic Medication

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N 408	83.37(1)(i) PRN psychotropic medication. 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 when a psychotropic medication was prescribed on an as needed basis for a resident, the resident's individual service plan included the rationale for use and a detailed description of the behaviors which indicated the need for administration of PRN psychotropic medication for 1 of 2 residents reviewed. Findings include: Per DHS 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01	N 408		

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N 408	Continued From page 8 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 08/01/2023, Surveyor reviewed Resident 1's record. S/he was admitted 04/05/2023 and discharged 07/04/2023 following 30 day discharge notice issued 06/27/2023 due to behaviors. Diagnoses included dementia with agitation. As needed physician orders included: Olanzapine 5 MG 1 tablet as needed twice daily for agitation (start date 05/22/2023, discontinue 06/19/2023), Quetiapine Fumarate 25 MG 0.5 as needed for agitation once daily (start 05/10/2022, discontinue 05/22/2023), and Risperidone 0.5 MG as needed for agitation twice daily (start date 06/19/2023). May 2023 and June 2023 Medication Administration Record (MAR) identified: Olanzapine 5 MG as needed was administered twice on 05/24/2023, once on 05/25/2023, 06/07/2023, and 06/09/2023; Quetiapine Fumarate 25 MG 0.5 as needed was not administered; and Risperidone 0.5 MG as needed was administered once on 06/27/2023 and 06/28/2023. Individual Service Plan (ISP) dated 05/05/2023: In the area of Medications- did not address as needed psychotropic medications. In the area of Cognitive/Psychosocial- did not address as needed psychotropic medications. In the area of Reluctance to Accept Care- did not address as needed psychotropic medications. As needed psychotropic medications were not addressed on Resident 1's ISP. On 08/01/2023 at 4:45 PM, Surveyor discussed concern of Resident 1's ISP not addressing as	N 408		

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N 408	Continued From page 9 needed psychotropic medications with Executive Director A, Wellness Director B, Wellness Coordinator C and Associate Executive Director D. Wellness Coordinator C stated they would not have added the as needed medications to the ISP until the ISP was due for an update, and they had just updated it 05/05/2023 prior to as needed medications starting. Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	N 408		