STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016347	A. BUILDING: _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY OAKS OF APPLETON	2300 EAST GLENHURST LANE APPLETON, WI 54913

(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 08/03/2023, with additional information gathered through 08/10/2023, Surveyors conducted 4 complaint investigations at Century Oaks of Appleton. Two of 4 complaints were substantiated. Two deficiencies were identified. Two of 2 deficiencies were repeat violations. See Statements of Deficiency (SOD) I0TS11 (dated 11/18/2019), SOD I0TS12 (dated 12/01/2023), SOD I0TS14 (dated 12/06/2022), and SOD I0TS15 (dated 05/17/2023). Census: 41	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident received medications as ordered for Resident 2. This requirement is being cited for a third time. See Statements of Deficiency (SOD) I0TS11, dated 12/06/2022 and SOD I0TS15, dated 05/17/2023. Findings Include: On 06/20/2023, the department received a	N 352		

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complaint alleging medications were ordered and delivered, but not administered until days later.

RESIDENT 2

On 08/04/2023 at 11:25AM, Surveyor reviewed Resident 2's physician's orders. Surveyor noted an order dated 06/16/2023 for Meloxicam 15mg take 1 tab daily for ankle pain.

On 08/04/2023 at 11:30AM, Surveyor reviewed Resident 2's observation notes and found documentation of a verbal physician's order. The note stated the following:

06/28/2023 at 8:105AM by Licensed Practical Nurse B (LPN-B): "late entry 6/16/23 seen with [physician]. New orders: Start back tonight your meloxicam 15mg daily with food then resume daily with food ..."

On 08/03/2023 at 6:02PM, Surveyor reviewed Resident 2's June Medication Administration Record (MAR). The MAR noted Meloxicam 15mg was added to the MAR on 06/19/2023. The MAR showed administration of the medication started on 06/19/2023.

On 08/07/2023 at 10:39AM, Surveyor interviewed Pharmacy Technician - D with HealthDirect. The technician confirmed the medication Meloxicam 15mg was sent to and received by the provider on 06/17/2023. Pharmacy Technician D reported the medication board included a three-day supply. Another medication board with a 30-day supply was sent to and received by the provider on 06/19/2023.

Surveyor interviewed Executive Director A (ED-A) on 08/04/2023 at 11:01AM regarding the process

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N 352	Continued From page 2 for physician's orders being placed onto the MAR. ED-A reported orders come in by a fax, the physician's office or the pharmacy. If the order was sent to the provider, they then fax it to the pharmacy. After the medication is delivered, the nurse or designee would review it. The order was then transcribed into the electronic MAR. Depending on when the medication was delivered, it would be processed the same day or the next business day. According to the late entry of the verbal physician's order, Resident 2 should have started taking Meloxicam 15mg daily beginning 06/17/2023. Review of the MAR showed the medication was not available on the MAR and was not administered until 06/19/2023.	N 352		
N 434	83.38(1)(j) Information and referral. 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: Information and referral. The CBRF shall provide information and referral to appropriate community services. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide accurate information to appropriate community services when Resident 1 experienced a medical emergency.	N 434		

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N 434	Continued From page 3 Findings include: On 07/31/2023, the department received complaint information alleging residents did not receive appropriate life sustaining measures. On 08/04/2023, Surveyor reviewed Resident 1's Patient Care Report from the ambulance service with narrative which stated: "[Resident 1] is found supine on the floor of [his/her] bedroom. [Resident 1] is unresponsive, has no pulse and is not breathing... Nursing home staff report that [Resident 1] is a DNR but they do not have any paperwork so resuscitation efforts were begun immediately by [Fire Department]. During the resuscitation, [the hospital] is contacted and report that they do not have an active DNR on file. [Resident 1's] [Power of Attorney] is also contacted and [s/he] reports that [Resident 1] is NOT a DNR." On 08/09/2023, Surveyor reviewed Resident 1's emergency room discharge documentation and noted, "There was discussion at the assisted living facility that the patient was DNR but the paperwork could not be located. [His/her] power of attorney was contacted and reported that the patient was full code." Hospital staff made contact with Power of Attorney for Health Care (POAHC) G "who confirmed [Resident 1's] status was full code." Resident 1 passed away in the hospital at 4:37 PM on 07/24/2023. Surveyor Note: According to Wisconsin Statute Ch. 154.17 DO-NOT-RESUSCITATE ORDERS, "'Do-not-resuscitate order' means a written order issued under the requirements of this subchapter that directs emergency medical services practitioners, emergency medical responders, and emergency health care facilities personnel	N 434		

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not to attempt cardiopulmonary resuscitation on a person for whom the order is issued if that person suffers cardiac or respiratory arrest."

On 08/04/2023, Surveyor reviewed Resident 1's record.
Surveyor reviewed Resident 1's facility face sheet dated 01/27/2021, and noted Resident 1 was admitted to the facility on 09/21/2020. Resident 1 was advanced aged with diagnoses of chronic systolic heart failure, chronic obstructive lung disease, hypertensive disorder, bipolar disorder, chronic kidney disease, and atrial fibrillation. Surveyor noted this face sheet did not include Resident 1's code status related to life sustaining measures.

Surveyor reviewed Resident 1's facility face sheet with print date 08/03/2023 and noted "DO NOT RESUSCITATE' listed under his/her name on the top of the face sheet.
No DNR order paperwork was found in Resident 1's record.

On 08/03/2023 at approximately 11:01 AM, Surveyor interviewed Caregiver H who found Resident 1 unresponsive on 07/24/2023. S/he had called over the walkie to his/her coworkers that Resident 1 was unresponsive in his/her bathroom. Caregiver H indicated multiple staff arrived to the room and 911 was called. Caregiver E checked the computer for Resident 1's face sheet to see if s/he was a DNR or full code. Caregiver I stated Resident 1's face sheet said s/he was a DNR. Caregiver E, Caregiver H, and LPN B assisted Resident 1 to the floor and did not initiate CPR. Caregiver H stated when EMT's arrived they had asked for Resident 1's DNR orders or DNR bracelet. S/he stated generally there are folders with all of the

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resident's information in it to indicate if they were full code or DNR. Caregiver H stated there was no paperwork. Caregiver H indicated CPR would have been initiated by provider staff if they would have known Resident 1 was full code. "If we had the right paperwork and direction, you know [maybe] we could have saved a life."

On 08/03/2023 at approximately 10:07 AM, Surveyor interviewed LPN B who responded to Caregiver H's call over the walkie-talkie on 07/24/2023. LPN B inquired about Resident 1's resuscitation/code status, in which s/he was told by Caregiver E, his/her face sheet on the computer listed him/her as "DO NOT RESUSCITATE." LPN B stated s/he wiped Resident 1's mouth and EMT's arrived. LPN shared the following staff were present in Resident 1's room: LPN B, Caregiver H, Caregiver E, Director of Wellness RN -B, and VP of Quality RN - F. S/he stated when EMT's arrived they had asked for Resident 1's DNR bracelet or papers. Staff reported not being able to locate any DNR orders, so EMT's initiated CPR. Resident 1's hospital and POAHC-G was contacted and reported not having a DNR order on file. EMTs reported accepting verbal DNR from the POAHC, so Director of Wellness RN-F contacted POAHC-G to obtain approval, in which POAHC-G declined consent and indicated Resident 1 was a full code. LPN B stated, "I would have initiated CPR if I would have known [Resident 1] was full code."

On 08/04/2023, Surveyor reviewed written information from POAHC-G reporting when s/he talked with facility staff, they had thought Resident 1 was a DNR. POAHC-G stated Resident 1 had never been a DNR and was always a full code, so s/he didn't know where they

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N 434	Continued From page 6 got this information. On 08/09/2023, Surveyor reviewed provider's "RESPONDING TO EMERGENCIES" policy dated 04/14/2023 which stated: "1) 911 PROCEDURES ... v) The nature of the emergency ... c) Information to give EMS [emergency medical services] when they arrive i) Vital signs, information regarding illness, and injury ii) Copy of emergency packet (located at the care station) which should include: (1) Advanced Directives (2) Copy of MAR [medication administration record] (3) Emergency information sheet" On 08/03/2023 at approximately 9:40 AM, Surveyor inquired about their protocol for resident emergencies. Executive Director A stated resident emergency packets were kept in each hall's medication rooms. Included in each emergency packet was the resident's face sheet, treatment records, and advance directives (which would include DNR orders if applicable). Executive Director A stated Resident 1's face sheet identifying Resident 1 as a DNR was a discrepancy. In conclusion, inaccurate healthcare directive information was provided to LPN B and EMS when Resident 1 experienced a medical emergency at the facility, which impacted the nurse's decision to initiate CPR.	N 434		