STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

(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 10/21/2024, with information gathered through 10/30/2024, Surveyors investigated 2 complaints at Terova Senior Living of Mequon. Two of 2 complaints were substantiated and 4 new deficiencies were identified. Census 22	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 residents received all prescribed medications in the dosages and at intervals prescribed by a practitioner for 3 out of 3 residents reviewed (Resident 1, Resident 2 and Resident 3). Findings Include: On 10/02/2024, the department received a complaint alleging residents did not receive medications as prescribed. On 10/21/2024, at approximately 10:00AM, Surveyors requested Resident 1, Resident 2 and Resident 3's September 2024 and October 2024 medication administration record (MAR) from Executive Director (ED-A). Review of the MARs reflected instances where medication was	N 352		

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

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documented as not given due to unavailability. Additionally, Surveyors noted instances when as needed medications were given for reasons other than what they were prescribed.

RESIDENT 1

On 10/22/2024, at approximately 10:40AM, Surveyor reviewed Resident 1's September 2024 and October 2024 MAR. The following reflected dates medications were not administered due to unavailability:

>Hydromorphone 1mg/ml LIQ - Give 1mg by mouth or under the tongue twice daily for agitation.
1st Dose: 09/20/2024, 09/23/2024, 09/25/2024 - "Medication not available"
2nd Dose: 09/21/2024, 09/23/2024, 09/24/2024, 09/25/2024 - "Medication not available"

>Lorazepam 0.5mg - Take one tablet by mouth twice daily for agitation.
1st Dose: 09/15/2024, 09/16/2024, 09/17/2024, 10/02/2024, 10/03/2024 and 10/04/2024 - "Medication not available"
2nd Dose: 09/14/2024, 09/15/2024 - "Medication not available"

>Senna Lax 8.6mg - take one tablet by mouth twice daily for constipation.
1st Dose: 09/20/2024 and 10/09/2024 - "Medication not available"

>Acetaminophen 500mg - take one tablet by mouth three times daily for pain.
3rd Dose: 10/04/2024, 10/18/2024 - "Medication not available"

Haloperidol 2mg/ml oral conc - Take 1ml (2mg)

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N 352	Continued From page 2 twice daily for agitation. 1st Dose: 10/3/2024, 10/04/2024, 10/05/2024, 10/06/2024, 10/07/2024, 10/08/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/15/2024, 10/16/2024, 10/17/2024, 10/18/2024, 10/19/2024, 10/20/2024, 10/21/2024 - "Medication not available" 2nd Dose: 10/01/2024, 10/02/2024, 10/04/2024, 10/05/2024, 10/06/2024, 10/07/2024, 10/08/2024, 10/10/2024, 10/12/2024, 10/14/2024, 10/15/2024, 10/17/2024, 10/18/2024, 10/19/2024 and 10/20/2024 RESIDENT 2 On 10/22/2024, at approximately 10:50AM, Surveyor reviewed Resident 2's September 2024 and October 2024 MAR. The following reflected dates medications were not administered due to unavailability: >Acetaminophen 325mg - Take 2 tablets (650mg) by mouth twice daily. 2nd Dose: 10/18/2024 - "Medication not available" >Atorvastatin 40mg - Take 1 tablet by mouth once daily at bedtime. 08/18/2024 - "Medication not available" >Eliquis 2.5mg - Take 1 tablet by mouth twice daily for blood clot prevention in atrial fibrillation. 2nd Dose: 10/18/2024 - - "Medication not available" >Triple Antibiotic Ointment - Apply topically to affected area twice daily with dressing changes. 1st Dose: 10/03/2024 and 10/12/2024 - - "Medication not available"	N 352		

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N 352	Continued From page 3 RESIDENT 3 On 10/22/2024, at approximately 11:10AM, Surveyor reviewed Resident 3's September 2024 and October 2024 MAR. The following reflected dates medications were not administered due to unavailability: >Diclofenac 1% Gel - Apply topically to affected area three times daily. 1st Dose: 10/19/2024 and 10/20/2024 - - "Medication not available" >Mirtazapine 7.5mg - Take one tablet by mouth once daily at bedtime. 10/07/2024 - "Medication not available" On 10/30/20244 at 3:31 PM, Surveyors interviewed VP of Operations (VPO) C. VPO C stated they are in the process of switching to another electronic record system called ECP. VPO C stated s/he will work with Director of Clinical Operations (DCO) B and will look into the concerns identified.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based record review and interview, the provider did not ensure prompt and adequate treatment was provided for one (1) out of 4 residents	N 353		

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N 353	Continued From page 4 reviewed (Resident 4). Findings Include: On 09/30/2024, the department received a complaint alleging a resident was neglected due to not receiving care overnight. On 10/22/2024, at approximately 110:15AM, Surveyor reviewed the Mequon Police Department Incident Report #24-023893, dated 09/14/2024, written by Police Officer E (PO-E). The report noted the following: "On Saturday, 09/14/2024, at approximately 6:00PM, I (PO-E) was approached by Southern Ozaukee Fire Department (SOFD) Battalion Chief (BC) ... in regards to a possible neglect case that occurred on 09/13/2024, at ... 18995 N Market Street, in the City of Mequon. The neglect case was in refence to Mequon 'Rescue Call' #24-23707, with [Resident 4] as the patient ... multiple SOFD personnel who were on the rescue call had filled out reports in regards to the neglect of [Resident 4] ..." Written Report by Paramedic H: " ... [Paramedic H] stated they had difficulty locating the patient and ended up locating two [gender] facility staff members outside the memory care entrance. Neither employee was able to direct them to the patient's room. [Paramedic H] stated [s/he] then heard another staff member call out to [him/her], recognized by [him/her] as [Caregiver F] [Caregiver F] was able to direct EMS to [Resident 4's] room, who was found to be laying on [his/her] side in bed, soaked in urine from [his/her] knees to [his/her] mid torso ... [Paramedic H] stated [Resident 4] informed [him/her] that [s/he] had been calling out for help verbally and pushing	N 353		

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[his/her] call button since approximately 9:00PM, on Thursday, 09/12/2024. [Resident 4] stated [s/he] was in excruciating pain all night and could not move due to being left on [his/her] back ... SOFD Ambulance transported [Resident 4] back to Aurora Medical Center - Grafton, after their assessment."

Written Report by Emergency Medical Technician I (EMT-I): " ...[EMT-I] ADVISED [s/he] was called to Teal Shores on Friday, 09/13/2024 for a [age] year old [gender] with severe back pain ... [EMT-I] described having difficulty finding the patient, and were eventually directed to the patient by an unknown caregiver ... [EMT-I] stated the patient, [Resident 4], appeared to be in distress and stated [s/he] had severe back pain starting last night at approximately 10:00PM. [Resident 4] described the way [s/he] was laid in bed, made it so [s/he] could not reach [his/her] call button or the phone. [Resident 4] stated after a while of trying, [s/he] was able to reach the string to pull the alarm, which [s/he] did pull ... but no one came to help [him/her]. [EMT-I] described that [Resident 4's] clothes were soaked in urine ..."

Written Report: Paramedic J: " ... [Paramedic J] stated [s/he] was dispatched to Teal Shores on 09/13/2024, for a patient with back and neck pain ... [Paramedic J] stated when they made contact with [Resident 4], [s/he] was found laying flat on [his/her] back, in obvious pain exhibited by signs of guarding, grimacing and verbalizing [his/her] neck and back pain. [Resident 4] described [his/her] pain as a 10 out of 10. [Resident 4] informed them that [s/he] was not able to reach [[his/her] call button or phone to get any help due to the way [s/he] was left in [his/her] bed. [Resident 4] clothes were wet and cold from

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urine. [Resident 4] was so weak [s/he] was unable to sit up on [his/her] own, and required the assistance of 2 EMS workers to sit up ... [Resident 4] was described as outwardly distraught ..."

Statement: Resident 4: " ... [Resident 4] advised that [s/he] arrived at Teal Shores at approximately 3:00PM on Thursday, 09/12/2024 ... and was brought to [his/her] room by an unknown staff member after being fed in the cafeteria ... [Resident 4] stated [s/he] started calling for help at about 9:00PM, the night [s/he] arrived there. [Resident 4] stated [s/he] was in excruciating pain and ended up having to go to the bathroom on [him/herself] because no staff member came to get [him/her] ready for bed. [Resident 4] stated a cleaning [gender] came into [his/her] room at approximately 3:00AM, and helped [him/her] roll onto [his/her] side at which point [s/he] was able to reach [his/her] call button, but no one came ... at 7:00AM, [s/he] was able to reach a phone to call 911."

On 10/23/2024, at 1:38PM, Surveyor interviewed (former) Caregiver F. Caregiver F reported on 09/12/2024, s/he was assigned to work in the area where Resident 4 was staying. Caregiver F worked the 3rd shift (overnight) on 09/12/2024 going into the morning of 09/13/2024. At approximately 11:30PM, a caregiver from the Residential Care Complex (RCAC) on the third told him/her a pendant call from Caregiver F's assigned room was alerting to the RCAC. Caregiver F reported s/he was confused as the room number reported by the RCAC staff was vacant the last time Caregiver F worked. Caregiver F explained the second shift s/he relieved did not inform him/her anyone was admitted to that room. Caregiver F stated s/he

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responded to the room and introduced his/herself to Resident 4 and apologized for the delay. Caregiver F explained s/he did not know anything about Resident 4's medical conditions, medications, needs or if s/he self-administered medication. Caregiver F reported Resident 4 said s/he was in pain and wanted medication. Resident 4 explained to Caregiver F s/he had very bad back and neck pain and was recently discharged from the hospital. Resident 4 pointed to his/her nightstand drawer and stated his/her medication was there. Caregiver F observed Resident 4 was unable to physically obtain the medication due to his/her condition. Caregiver F retrieved the medication from the drawer and handed it to Resident 4. Caregiver F observed Resident 4 take some of the medication. Resident 4 made no other requests at that time, so Caregiver F left the room. Caregiver F advised s/he checked on Resident 4 twice during the night and s/he was asleep. The following morning, Caregiver F went into Resident 4's room, and s/he asked for his/her phone. Caregiver F found Resident 4's cell phone and pendant on the floor between the nightstand and bed. Resident 4 advised s/he was calling 911 due to being in pain.

On 10/22/2024, at approximately 8:10AM, Surveyor reviewed Resident 4's pre-admission assessment dated 09/11/2024. The assessment identified Resident 4 required physical assistance for toileting and personal hygiene. It further identified Resident 4 requires assistance of 2 caregivers using a hoyer lift. The assessment specified Resident 4 administers his/her own medication.

On 10/22/2024, at approximately 8:20AM, Surveyor reviewed Resident 4's Individual Service Plan (ISP) dated 09/11/2024. The ISP noted

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Resident 4 required assistance with the following:
Ambulation: Will use wheelchair upon move in.
Toileting Assistance: Staff assistance.
Bladder Incontinence: Staff to assist with the management of the resident's bladder incontinence.
Transferring Assistance: Advanced Level of Care - Staff will offer assistance when physically transferring the resident.
Personal Hygiene: Staff will offer full assistance with personal hygiene for the entire length of the procedure.

On 10/22/2024, at approximately 8:30AM, Surveyor reviewed Resident 4's Care Instructions Updated on 09/11/2024. The care instructions were updated to identify Resident 4 required a sit-to-stand lift with assistance of 2 caregivers.

On 10/22/2024, at approximately 8:50AM, Surveyor reviewed Resident 4's face sheet. The facesheet identified Resident 4 was admitted on 09/12/2024 and had the following diagnosis: lumbar spinal stenosis (had 2 lumbar surgeries), chronic bilateral radiculopathies, peripheral neuropathy, anxiety, arthritis and vascular disease.

On 10/30/2024, Surveyor reviewed information from the Mayo Clinic found regarding chronic bilateral radiculopathies. The information stated the following:

" ... When disc material protrudes from the disc space into the spinal canal, it can compress a nerve root ... When a nerve root is compressed, people experience three general symptoms: pain, numbness and weakness ... Pain is the most common symptom, and it is usually a sharp, shooting pain along the nerve. It can vary widely,

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from a mild ache to a sharp, burning sensation or excruciating pain ...

Information retrieved on 10/30/2024 at 7:07PM from: https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/sciatica-and-radiculopathy-peculiar-names.

On 10/30/2024, Surveyor reviewed information from the Mayo Clinic found regarding peripheral neuropathy. The information stated the following:

"Peripheral neuropathy happens when the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged. This condition often causes weakness, numbness and pain, usually in the hands and feet ... Symptoms of peripheral neuropathy might include: Gradual onset of numbness, prickling, or tingling in your feet or hands. These sensations can spread upward into your legs and arms. Sharp, jabbing, throbbing or burning pain. Extreme sensitivity to touch. Pain during activities that shouldn't cause pain, such as pain in your feet when putting weight on them or when they're under a blanket. Lack of coordination and falling ..."

Information was retrieved on 10/30/2024 at 7:10PM from: https://www.mayoclinic.org/diseases-conditions/peripheral-neuropathy/symptoms-causes/syc-20352061#:~:text=Peripheral%20neuropathy%20happens%20when%20the,functions%20including%20digestion%20and%20urination

On 10/23/2024 at 11:03AM, Surveyor interviewed Adult Protective Services G (APS-G). APS-G reported s/he confirmed the allegation of neglect regarding Resident 4. APS-G stated s/he

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N 353	Continued From page 10 reviewed police reports, EMS reports and interviewed Resident 4. Additionally, APS-G stated Resident 4 provided "consistent" information to EMS personnel, law enforcement, family and APS-G. On 10/30/2024, at approximately 3:30PM, Surveyor interviewed Vice President of Operations D (VPO-D). VPO-D reported s/he is aware of the disconnect in communication that was experienced in the past. VPO-D stated the provider will improve communication between shifts moving forward. Resident 4 was admitted on 09/12/2024 with diagnosis consisting of lumbar spinal stenosis, chronic bilateral radiculopathies, peripheral neuropathy. The diagnosis limit movement due to symptoms of pain and numbness in back and extremities. Resident 4 exhibited symptoms of pain during the overnight hours on 09/12/2024 through the morning of 09/13/2024. During the beginning of Caregiver F's overnight shift, Resident 4's pendant notifications were being received by the RCAC located on a separate floor. Caregiver F addressed Resident 4's immediate needs but did not have any information on Resident 4's cares or level of assistance. EMS responded to Resident 4's 911 call and found s/he was saturated in cold urine from the knees to the torso. Subsequently, the interview with APS-G identified they confirmed on the allegation.	N 353		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s	N 406		

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medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure expired medications were separated from other medications in current use for 1 out of 3 residents reviewed (Resident 1).

Findings include:

On 10/21/2024 at approximately 10:45 AM, Surveyors observed Resident 1's medications with Caregiver C. Surveyors noted an expired bubble packed card of Acetaminophen 500MG - Take one tablet by mouth three times daily. The expiration date on the bubble pack was 10/11/2024.

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N 406	Continued From page 12 On 10/21/2024 at approximately 11:00 AM, Surveyors interviewed Caregiver C regarding the expired medication. S/he stated the nurse was supposed to remove the expired medication from the med cart. On 10/30/2024 at 3:45 PM, Surveyors interviewed Vice President of Operations (VPO) D. VPO D stated s/he would follow up with Director of Clinical Operations (DCO) B. On 10/31/2024 at 1:30 PM, Surveyors received email correspondence from VOP D. The email explained there was a pharmacy review in early October, and the expired acetaminophen was missed.	N 406		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation of the resident's response to the administration of an as needed medication for 1 of 3 residents reviewed	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

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N 415	Continued From page 13 (Resident 1). Findings include: On 10/22/2024, at approximately 10:40AM, Surveyor reviewed Resident 1's September 2024 and October 2024 MAR and noted several instances when Resident 1 was administered an as needed medication and his/her response to the medication was not documented. The medications and dates were as follows: >Haloperidol 2mg/ml Oral Conc - Take 0.5ml to 1ml (1-2MG) by mouth every two hours as needed for agitation/restlessness. 09/13/2024 at 7:41PM, 09/17/2024 at 7:35PM, 09/18/2024 at 7:08PM, 09/19/2024 at 6:57PM, 09/23/2024 at 9:56PM, 09/25/2024 at 9:01PM, and 09/27/2024 6:38PM >Hydromorphone 1mg/ml Liquid - Take 1ml-4ml by mouth or under the tongue every hour as needed for pain/shortness of breath. 09/13/2024 at 7:41PM, 09/17/2024 at 7:35PM, 09/18/2024 at 7:08PM and 09/19/2024 at 6:57PM >Lorazepam 0.5mg - Take one to two tablets by mouth every two hours as needed (1 Tab = Moderate, 2 Tabs = Severe symptoms for anxiety). 09/13 7:41 PM - No outcome documented >Lorazepam 1mg - Take one tablet by mouth every two hours as needed for agitation/restlessness. 10/02/2024 at 9:00AM, 10/03/20241 at 8:32AM, 10/03/2024 at 12:52PM, 10/13/2024 at 11:48AM, 10/17/2024 at 11:33AM, and 10/18/2024 at 11:25 AM.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018247	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEROVA SENIOR LIVING OF MEQUON	10995 N MARKET STREET MEQUON, WI 53092

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N 415	Continued From page 14 On 10/21/2024 at approximately 11:00 AM, Surveyors interviewed Caregiver C and asked if outcomes are supposed to be documented for PRN medications. S/he stated sometimes a screen pops up to document outcomes, but s/he does not know how to go back into the chart to document outcomes when the screen does not pop up. On 10/30/20244 at 3:31 PM, Surveyors interviewed VP of Operations (VPO) C. VPO C stated they are in the process of switching to another electronic record system called ECP. VPO C stated s/he will work with Director of Clinical Operations (DCO) B and will look into the concerns identified.	N 415		