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	0019479	A. BUILDING: _____ B. WING _____	03/12/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 03/12/2024, Surveyor conducted a standard survey and 1 self-report review at Heritage Assisted Living. Three deficiencies were identified. No findings were identified for the self-report. Census: 42	N 000		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment.	N 243		

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

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N 243	Continued From page 1 Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1of 2 employees reviewed, obtained all training as required within 90 days after starting employment. Dietary Aid C did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Dietary Aid C did not have training in required client groups within 90 days after starting employment. Findings include: On 03/12/2024, Surveyor conducted a review of 2 employees to verify compliance with all employee training requirements. Surveyor requested training records from Administrator A for Dietary Aid C.	N 243		

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N 243	Continued From page 2 Recognizing, Preventing, Managing and Responding to Challenging Behaviors On 03/12/2024 at 11:53 AM, Surveyor interviewed Administrator A who stated if Dietary Aid C's training in challenging behaviors was not listed on the online training transcript it probably was not done. The record for Dietary Aid C, hired 10/04/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 03/12/2024 at 3:06 PM, Surveyor interviewed Administrator A. Administrator A confirmed the provider did not have evidence Dietary Aid C completed or met an exemption for challenging behaviors training. Client Group The facility was licensed to provide care and services to residents within the client groups of advanced age, physically disabled, terminally ill, irreversible dementia/Alzheimer's, and traumatic brain injury. The record for Dietary Aid C, hired 10/04/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. On 03/12/2024, at 11:53 AM, Surveyor interviewed Administrator A. Administrator A stated if Dietary Aid C's training in client groups was not listed on the online training transcript it probably was not done. On 03/12/2024 at 3:06 PM, Administrator A confirmed the provider did not have evidence Dietary Aid C completed or met an exemption for client group training specific to advanced age, physically disabled, terminally ill, irreversible dementia/Alzheimer's, and traumatic brain injury.	N 243		

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N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did ensure individual service plans (ISP) addressed all resident's psychosocial needs and identified staff interventions to meet those needs for 3 of 3 residents reviewed. Resident 1's ISP did not identify aggressive verbal and physical behaviors (including repetitive calling out) or non-pharmacological interventions for behaviors, need for psychological services, or interventions to assist with communication. Resident 1 was prescribed psychotropic medications for psychosis and major depressive disorder. Resident 2's ISP did not identify specific behaviors and depressive mood symptoms (comments wanting to die, varying	N 386		

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alertness/lethargy, spitting and yelling out), non-pharmacological interventions for mood and behaviors, need for psychological services, or decreased cognition (including forgetting to request assistance with transfers which increased risk for falls). Resident 2 was prescribed psychotropic medications for major depressive disorder, impulsivity, and dementia.

Resident 3's ISP did not identify aggressive behaviors and wandering, non-pharmological interventions for mood and behaviors, decreased cognition (forgetfulness), and all fall prevention interventions. Resident 3 was prescribed psychotropic medication for anxiety and depression, aggression and impulsivity.

Findings include:

Per 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior."

On 03/12/2024, Surveyor reviewed records of Resident 1, Resident 2, and Resident 3.

Example 1- Resident 1
Resident 1 was admitted 09/22/2022. Diagnoses included dementia in other diseases classified elsewhere, unspecified severity with other behavioral disturbance and other specified anxiety disorders.

Physician orders included quetiapine 25 MG take ½ tablet (12.5 MG) in AM and quetiapine 25 MG take 1 ½ tablets at bedtime for psychosis (quetiapine was started in October 2022 with multiple dosage changes since), sertraline 50 MG 1 tablet daily (start date 09/28/2023) for major

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N 386	Continued From page 5 depressive disorder. Facility observation notes dated 01/02/2024-03/05/2024: 01/08/2024 5:15 AM- "Awake most of the night [sic]" 02/02/2024 9:00 PM- "Resident went to bed at 7:30 and from 7:30 until 8:45 [s/he] either yelled out for [his/her family member] or for "help". S/he was very confused and very anxious. At first [s/he] was saying things like [s/he] wanted to get out of bed and into the other bed in [his/her] room or that [s/he] wanted to go to the motel. Staff would tell [him/her] that [s/he] wasn't' leaving and the [s/he] lived here and [s/he] would tell us that [s/he] didn't believe us or we were lying or that it was a bunch of bullsh*t. At one point s/he wanted us to call the police because as [s/he] stated we were holding [him/her] against [his/her] will. After over and [sic] hour and more than [sic] a dozen trips into[his/her] room staff brought [him/her] out to the living room at 8:45pm [sic]. the [sic] behavior kept up in the living room until about 9:15 pm at which point [s/he] then stated [s/he] was going to bed and closed [his/her] eyes. 02/02/2024 9:45 PM- "Closed [his/her] eyes for about 15 minutes and then [s/he] was back to being confused and asking questions and not believe what we were saying to [him/her]. Still awake and at it at 10pm. " 02/06/2024 9:15 PM- Have been having [him/her] sleep in recliner out in living room space. only [sic] time [s/he] won't yell." 02/07/2024 3:00 PM- "Due to continuous behavioral concerns overnight, and UA being obtained and being negative; [sic] increase to HS Seroquel [sic] to 37.5 mg will be started ..." 02/17/2024 1:45 PM- "[Resident 1] was not happy this morning, [s/he] refused to get out of bed. different [sic] staff tried and a couple of different	N 386		

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times. [S/he] told us it was rude to wake [him/her] up. [s/he] [sic] told staff to get the hell out and leave [him/her] be."
02/20/2024 9:00 PM- "After resident got meds, Resident was yelling every minute and getting out of bed and chair."
02/22/2024 9:15 PM- "Resident started screaming for help around 8 [sic] RA's went in to resident room to see what [s/he] needed help with [sic] [s/he] told staff [s/he] needed help sleeping staff told [him/her] to try and relax and close eye [sic]. Resident continued to scream for help multiple times and staff went in every time [she] yelled resident kept saying the same thing that [s/he] needed help sleeping [sic] staff eventually brought resident to living room and put [him/her] in recliner resident continued to scream for help staff also explain to resident that [s/he] cannot be screaming as other residents are trying to or already asleep [sic]"
02/27/2024 9:15 PM- "Resident yelling trying to get out of bed ..."
03/05/2024 8:15 PM- "Resident continues to yell for help not even 2 minutes after staff walks out of room ..."
03/06/2024 8:00 AM- "If resident yelling for help, offer/administer PRN Tylenol (pain reliever) at [bedtime] to see if this helps/elevates the behavior. Resident has a hard time truly expressing [his/her] needs and wants due to dementia diagnosis."
03/08/2024 7:15 PM- "Resident was yelling from 2pm-bedtime, trying to get up. [S/he] said [s/he's] anxious and confused. Yelling at staff when trying to help. Staff tried food, drinks, and Tylenol."
03/11/2024 6:45 PM- "Update completed to PCP about behaviors ..."

Psychiatric Progress notes:
01/16/2024 (summarized): Follow-up due to

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dementia with physical and verbal aggression. Thought processes, judgement, insight, short- and long-term memory severely impaired. Oriented to person, disoriented to place and time. Eating less past couple of months, displays depression, anger, and verbal and physical outbursts. Taking quetiapine since October 2022 with changes in dosage since. Moderate severity aggression/impulsivity with modifying factors of medications, approach, and environment.

02/20/2024 (summarized): Resident started waking during the night and yelling during the past month. Primary care physician believes resident is having TIA's (mini strokes) causing the yelling out at night. Had negative UA, quetiapine then increased. Moderate severity aggression/impulsivity with modifying factors of medications, approach, and environment.

ISP dated 10/31/2023-
In the area of Behavior Patterns: Resident requires staff assistance to manage/redirect challenging behaviors ... SERVICE PROVIDERS RESPONSIBILITIES: RAs able to redirect resident as needed when acting out or cussing at others. MEASURABLE GOALS, OUTCOMES AND REVIEW: Staff to document all behavioral episodes, updating nursing staff with any concerns ..."

In the area of Interaction: " ...Resident has a rough and gruff demeanor at times, but gentle reminders to be nice, and resident is redirectable ...Resident to be socially appropriate at all times ...SERVICE PROVIDER RESPONSIBILITIES: Staff to assist with activities as needed and allowing resident to go out to community events as requests [sic]. Staff to remind resident that not everyone understand [his/her] sense of humor

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and demeanor and redirect as needed. MEASURABLE GOALS, OUTCOMES AND REVIEW: Staff to document any episodes of verbal anxiety or aggression, and update nursing staff with any concerns."
In the area of Communication: Resident is able to communicate all needs without deficits ...SERVICE PROVIDER RESPONSIBILITIES: Staff to monitor care needs as resident does have dementia diagnosis and forgets conversations easily. MEASURABLE GOALS, OUTCOMES AND REVIEW: Staff to monitor and update nursing staff with any needs."

Resident 1's ISP did not identify aggressive verbal and physical behaviors (including repetitive calling out), non-pharmacological interventions for behaviors, communication interventions, or need for psyche services.

Example 2- Resident 2
Resident 2 was admitted 12/15/2023. Diagnoses included: unspecified dementia, unspecified severity; major depressive disorder; and generalized anxiety disorder.

Preadmission History and Physical dated 12/07/2023 (summarized): History includes dementia and mood disorder. Oscillates between high anxiety and periods of lethargy. Scored 16/30 indicating dementia on the Saint Louis University Mental Status (SLUMS) cognitive assessment. Moving from a memory care unit to different facility. Medications included escitalopram, Rexulti and trazadone. Recommended psychological follow up.

Physician orders included: sertraline 50 MG 1 tablet daily for major depressive disorder (start date 02/13/2024); divalproex (Depakote) 125 MG

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1 capsule twice daily for impulsivity; Rivastigmine 3 MG 1 capsule twice daily for dementia. Trazadone 50 MG 1 tablet at bedtime was discontinued on 02/20/2024.

Facility progress notes dated 02/01/2024-03/02/2024-
02/01/2024 3:00 PM- Update completed to [nurse practitioner] about anxiety/depression from resident and behaviors ...medication changes continue to happen."
02/04/2024 1:00 PM- "was [sic] yelling in the dinning [sic] becasue [sic] [s/he] was cold ..."
02/05/2024 9:45 PM- "Spitting in the bathroom and on the floor in [his/her] bedroom ...and calling both r.a [sic] names ..."
02/05/2024 11:15 AM- "Update about recent behaviors to [nurse practitioner] medication changes to be completed ..."
02/10/2024 3:11 PM- "Incident Report (Fall-Unwitnessed) created for [Resident 2]."
02/10/2024 3:15 PM- "It was reported [Resident 2] self-transferred ...is not using [his/her] pendant. [S/he] is yelling out for help to anyone who walks by."
02/12/2024 8:00 AM- "Psych updated about behavioral changes over the weekend ...continues to have an alert day followed by a day or two of days where [s/he] appears lethargic. Increase to Sertraline on 02/13/2023, resident has been off Rexulti now for a few weeks. However, when on Rexulti resident appeared with flat affect. Continue to monitor behaviors, and update nursing."
Note: "Rexulti is a prescription antipsychotic medication used in the treatment of major depressive disorder, schizophrenia, and agitation associated with dementia due to Alzheimer's disease." (Source: https:www.Drugs.com/rexulti/html (retrieval date

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03/15/2024)).
02/21/2024 11:00 AM- "Seen by [nurse practitioner] on 02/20/2024; decrease Trazadone ...then discontinue."
02/28/2024 1:45 PM- "Resident told writer after lunch that [s/he] wanted to die and wanted to get out. Writer tried to calm resident down and get [him/her] feeling better."
03/02/2024 9:30 PM- "Staff was getting resident ready for bed, resident stated [s/he] wanted to die."

Facility Scheduled Psychotropic Review dated 01/26/2024-
"Names of scheduled psychotropic medication(s) reviewed Rexulti 2 MG, Escitalopram 20 MG, Trazadone 50 MG. Did resident have desired response to the medications? No. If no, explain. Resident admitted to facility with medications in place. Resident with flat affect and increased lethargy. Resident with increased confusion and difficulty completing ADLs and transfers. Resident would become anxious at night or tell staff that [s/he] would want to die. Per family reports resident was put on Rexulti as a 'last result' [sic] ...Resident has transitioned to see in house psych services ..."

Psychiatric Progress note dated 02/20/2024 (summarized): Follow-up dementia, major depressive disorder, insomnia, and anxiety. Oriented to person, disoriented to time and place. Judgement, thought processes, and short-term memory severely impaired. Long term memory moderately impaired. Moderate severity anxiety and impulsivity with modifying factors of medications, approach, and environment. Resident was self-transferring leading to falls. Depakote was started with no falls since.

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N 386	Continued From page 11 ISP dated 01/11/2024- In the area of Behavior Patterns: "Resident has anxiety and depression behaviors. Behavior monitoring twice daily and as needed. SERVICE PROVIDER RESPONSIBILITIES: Care staff to monitor and document all episodes of behaviors ... MEASURABLE GOALS, OUTCOMES AND REVIEW: Resident to be managed with medication and care staff to update nursing staff with concerns." In the area of Attitude: "Resident has a positive attitude with other at the community ... SERVICE PROVIDER RESPONSIBILITIES: Resident will maintain having a positive attitude with others at the community for one year. MEASURABLE GOALS, OUTCOMES AND REVIEW: Care staff to monitor and notify nursing staff with changes or concerns." In the area of Mental Illness: "Resident with anxiety, depression and advancing dementia. Resident to express a pleased mood. SERVICE PROVIDER RESPONSIBILITIES: Staff to document any behaviors and administer medications per PCP orders. MEASURABLE GOALS, OUTCOMES AND REVIEW: Resident to have a pleasant mood, without any behavior disturbances, care staff to update nursing with any concerns." Resident 2's ISP did not identify specific behaviors and depressive mood symptoms (comments wanting to die, varying alertness/lethargy, spitting and yelling out), decreased cognition (including forgetting to request assistance with transfers which increased risk for falls), non-pharmacological interventions for mood and behaviors, and need for psyche services.	N 386		

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N 386	Continued From page 12 Example 3 Resident 3 Resident 3 was admitted 06/17/2023. Diagnoses included major depressive disorder, recurrent, moderate and Alzheimer's disease. Physician orders included: Sertraline 100 MG 1 tablet daily for anxiety and depression (start date 12/20/2023); quetiapine (Seroquel) 25 MG 1 ½ tablets daily at bedtime for aggression (start date 11/27/2023); divalproex (Depakote) 125 MG capsule 3 times daily for impulsivity (start date 01/24/2024); and lorazepam 0.5 MG 1 tablet every 2 hours as needed for anxiety, insomnia or agitation (start date 08/18/2023). Scheduled Psychotropic Review dated 01/25/2024- "Name(s) of scheduled psychotropic medication(s) reviewed Sertraline, Seroquel Did resident have desired responses to the medications(s)? Yes ...Resident started on Depakote to assist with wandering behaviors with good results. As well as adjustment of [his/her] Seroquel 37.5 at bedtime to assist with [his/her] aggression with staff ..." Monthly PRN Psychotropic Review dated 02/28/2024- " ...Name(s) of PRN psychotropic medication(s) reviewed Lorazepam 0.6 MG ...Resident signed onto hospice services and medication is part of the hospice comfort pack, 0 PRN doses have been administered. Resident has been signed on with psych services to assist with medication management and Depakote has been ordered to assist with wandering with positive effect ..." Fall Reports/Investigations (summarized): 01/17/2024 4:33 PM- Found on floor in resident room, no injury. 01/17/2024 8:09 PM- Found on floor next to toilet in resident's bathroom, no injury.	N 386		

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	0019479	A. BUILDING: _____ B. WING _____	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

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N 386	Continued From page 13 01/18/2024 2:10 PM- Found on floor in resident's bathroom, no injury. 01/21/2024 10:30 AM- Found on floor in resident's bathroom, self-transferred from toilet to wheelchair. No injury. 01/24/2024 1:03 PM- Found on floor, rolled out of bed, no injury. 01/25/2024 4:28 PM- Found on floor under table in resident's room, slid out of wheelchair, no injury. 02/01/2024 9:30 AM- Found on floor sitting on floor mat next to bed, no injury. 02/07/2024 1:37 PM- Found on floor between recliner and wheelchair, no injury. 02/11/2024 3:00 AM- Rolled out of bed when legs were hanging off bed, no injury. 02/16/2024 4:00 AM- Rolled out of bed, no injury. Negotiated Risk Agreement dated 11/26/2023 and dated including by MD- "[Resident 1] has advanced Alzheimer's Disease. Despite a multidisciplinary attempt with every recommended intervention to prevent falls, [s/he] continues to fall frequently. My recommendtation [sic] is to continue to monitor [his/her] safety with the current interventions in place, and to continue to investigate each fall per facility protocol, but also recognize that these falls will very likely continue and maybe unavoidable ..." ISP dated 01/22/2024: In the area of Mobility and Transferring- "Independent with mobility and use of wheelchair. Resident is a high fall risk ...Resident requires staff assistance to complete transfers; however often forgets to call for help and will transfer self ...SERVICE PROVIDER RESPONSIBILITIES: Nursing staff to evaluate falls semi-annually and after each fall, monitor psychotropic medications monthly and quarterly; staff to report fall(s) to	N 386		

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N 386	Continued From page 14	N 386		

supervisor promptly, assist with proper footwear daily, ensure resident wears proper footwear daily, chair/bed alarm in place. Staff to give [bedtime] medications as early as possible to aide in behaviors that may occur later in the shift. Resident will maintain independence with positioning for one year. Staff to provide 1 A for all transfers as resident allows ..."

In the area of Behavior Patterns- "Resident is restless at times, accusatory occasionally, and forgetful. Document any behaviors ...2x Every Day And As Needed. Minimal instances of significant behaviors that influence cares. SERVICE PROVIDER RESPONSIBILITIES: Monitor and document ALL behaviors and mood. Resident to display minimized instances of behavior that affect care process."

Resident 3's ISP did not identify aggressive behaviors and wandering, decreased cognition (forgetfulness), and all fall prevention interventions utilized.

On 03/12/2024 at 1:07 PM, Surveyor interviewed Director of Nursing (DON) B who stated Resident 3 did not usually use a call light due to forgetfulness but would occasionally use when reminded. DON B stated Resident 3 would bend down from a sitting position to pick up something out then slide out of chair. DON B stated Resident 3 had a dementia diagnosis and activated Power of Attorney for Health Care document. DON B stated Resident 3's fall interventions included chair and bed alarm, reminder signs posted in resident room, toileting schedule for bowel movements (had urinary catheter), taken outside for walks, given small tasks to do in room, enjoyed agricultural tv shows, had a hi-low bed and removable foam

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N 386	Continued From page 15 wedge, bed was pushed up against wall, encouraged use of proper footwear and as much independence as possible to decrease frustration with self. On 03/12/2024 at 3:06 PM, Surveyor discussed concern of ISP's not including interventions for behaviors, decreased cognition and mood with Administrator A and DON B. DON B stated Resident 1 had yelled out since his/her admission but recently his/her yelling out was more repetitive and aggressive due to worsening dementia. DON B stated when s/he assessed Resident 2, s/he did not display behaviors and every day was different with Resident 2. DON B stated s/he agreed with Surveyor that the ISPs did not accurately reflect the resident's mood and cognition or provide interventions to prevent behaviors or mood symptoms. DON B stated since the facility transferred to a different electronic medical record in September 2022 the assessments did not capture mood and cognition or trigger mood and cognition to be addressed on the ISPs. DON B stated they would update the ISPs. Cross Reference: N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	N 386		
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	N 408		

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N 408	Continued From page 16 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 resident was prescribed an as needed (PRN) psychotropic medication, the 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. Resident 3's ISP did not include rational for use and detailed description indicating the need for PRN lorazepam. Findings include: Per 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 03/12/2024, Surveyor reviewed Resident 3's record. S/he was admitted 06/17/2023. Diagnoses included major depressive disorder, recurrent, moderate and Alzheimer's disease.	N 408		

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N 408	Continued From page 17 Physician orders included lorazepam 0.5 MG 1 tablet every 2 hours as needed for anxiety, insomnia, or agitation (start date 08/18/2023). ISP dated 01/22/2024: In the area of Medication Administration- Resident requires staff to manage/administer medications ...To receive medications as prescribed by PCP. Care staff to manage and administer all medications in accordance with PCP orders, facility to receive medications from [name of pharmacy], and medications to be stored in medication cart ..." In the area of Behavior Patterns- "Resident is restless at times, accusatory occasionally, and forgetful. Document any behaviors ...2x Every Day And As Needed. Minimal instances of significant behaviors that influence cares ...Monitor and document ALL behaviors and mood. Resident to display minimized instances of behavior that affect care process." Resident 3's ISP did not include rational for use and detailed description indicating the need for PRN lorazepam. On 03/12/2024 at 1:07 PM, Surveyor interviewed and reviewed Resident 3's ISP with Director of Nursing (DON) B. DON B stated their electronic medical record was new since September 2022 and they were still figuring it out. On 03/12/2024 at 3:06 PM, Surveyor discussed concern of ISP not including rational for use and detailed description indicating the need for Resident 3's PRN lorazepam with Administrator A and DON B. DON B stated s/he had now added it to the ISP.	N 408		

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N 408	Continued From page 18 Cross Reference: N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan	N 408		