STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	R 06/13/2024

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 000}	Initial Comments On 06/13/2024, Surveyor conducted a verification visit at Heritage Assisted Living. One deficiency was identified. The deficiency was a repeat violation. See Statement OF Deficiency (SOD) REOQ11 dated 03/12/2024. Two of 3 deficiencies from SOD REOQ11 dated 03/23/2024 were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 41	{N 000}		
{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	{N 386}		

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

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{N 386}	Continued From page 1 provider did ensure individual service plans (ISP) addressed all resident's 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). Neither Resident 1's ISP nor the hospice care plan identified 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 alertness/lethargy, spitting and yelling out); non-pharmacological interventions for mood, behaviors, insomnia; need for psychological services; decreased cognition; need for staff to monitor carbohydrate intake; need for divided plate; or need for assist with oral care. Resident 2's hospice care plan was not available for facility staff's use in lieu of facility ISP. Resident 2 was prescribed psychotropic medications for major depressive disorder, impulsivity, insomnia, and dementia. Resident 3's ISP did not identify: risks of wandering and choking; nonpharmacological interventions for aggressive behaviors and wandering; decreased cognition (forgetfulness); need for ongoing psychological services; or mechanical soft diet. Resident 3's hospice care plan was not available for facility staff's use in lieu of facility ISP. Resident 3 was prescribed psychotropic medication for anxiety, depression, aggression, and impulsivity.	{N 386}		

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{N 386}	Continued From page 2 This is a repeat deficiency. See Statement Of Deficiency REOQ11, dated 03/12/2024 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 1 tablet daily (start date 05/29/2024) and quetiapine 50 MG take 1 tablet at bedtime (start date 05/27/2024) 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 depressive disorder, lorazepam 0.5 MG 1 tablet every 2 hours as needed (start date 05/10/2024), and memantine HCL 10 MG 1 tablet twice daily (start date 05/29/2024). Facility observation notes dated 05/01/2024-06/13/2024 included: 05/03/2024 7:30 AM by Former Assistant Director of Nursing (FADON) B- "Medications were increased due to behaviors and hospice referral was requested to [hospice name], waiting for	{N 386}		

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{N 386}	Continued From page 3 response from hospice to come out to evaluate resident." 5/22/2024 9:45 PM- After [s/he] was in bed for the night [s/he] got [him/herself] out of bed 2 times [sic]" ISP dated 03/19/2024- 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 Attitude: " ...Resident has a positive attitude with others at the community ...SERVICE PROVIDERS 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 Interaction: " ...Resident interacts will with others, establishes own goals, has contact with family and close friends,,,involved in group activities ...SERVICE PROVIDER RESPONSIBILITIES: Staff to assist with activities as needed and allowing resident to go out to community events as requests [sic]. 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	{N 386}		

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{N 386}	Continued From page 4	{N 386}		

communicate basic needs without deficits, lives in Memory Care and is safe...to effectively communicate needs and wants. 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, or communication interventions.

Example 2- Resident 2
Resident 2 was admitted 12/15/2023. Diagnoses included: unspecified dementia, unspecified severity; major depressive disorder; generalized anxiety disorder; and type 2 diabetes mellitus with hyperglycemia and type 2 diabetes with chronic kidney disease.

Physician orders included: sertraline 50 MG 1 tablet daily and 25 MG 1 tablet daily to equal 75 MG daily for major depressive disorder (start date 04/10/2024); divalproex (Depakote) 125 MG 1 capsule twice daily for impulsivity (start date 02/28/2024); Rivastigmine 3 MG 1 capsule twice daily for dementia (start date 06/13/2024); Trazadone 50 MG ½ tablet at bedtime for insomnia (start date 05/08/2024); and lorazepam 0.5 MG 1 tablet every 2 hours as needed for anxiety/nausea (start date 06/01/2024).

Facility observation notes dated 05/01/2024-06/13/2024 included:
05/01/2024 3:30 AM- "was [sic] awake on his pendant most of shift [sic] all [sic] needs were met [sic] [S/he] still was pushing [his/her] pendant

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{N 386}	Continued From page 5 Prn [sic] melatonin was given [sic] it [sic] was not effective [sic] [s/he] goings [sic] stated [s/he] could not sleep [sic] [s/he] was yelling out just kill me I want to die [sic] and was pushing [his/her] pendant yelling help me [sic] to were [sic] other residents were asking what was going on and then [s/he] was hot and cold [sic] staff covered and uncovered [him/her] [sic] 5/04/2024 4:15 PM- " ...yelling help me. Wouldn't stay in [his/her] recliner. we [sic] would find [him/her] sitting forward and trying to stand. [S/He] threw cups on the floor when finished.... due to the yelling [s/he] has kitchen staff, family members, and other residents coming to find Ra's [sic] to let them know that [Resident 2] needs help. When we as RA's were in there and just met [his/her] needs.... [S/He] wants to die, it [sic] repeated over and over. Today we decided to bring [him/her] to the living room. when [sic] that didn't work we had [him/her] visit memory care where others were. Behaviors continued but [s/he] was around others and visible to staff at all times." 05/05/2024 4:15 PM- "[Resident 2] said [s/he] needed to spit ...went to get [him/her] something to spit in, on [his/her] way back to [Resident 2], [s/he] spit on the floor already." 05/06/2024 6:00 AM- "Resident was restless from beginning of NOC shift about being cold, hot, wanting to die, asking for someone to shoot him. Called on call and was given the OK to pass PRN melatonin along with PRN Tylenol. Settled down around 2:30 AM." 05/06/2024 6:45 AM by FADON-B - "Updates about behavioral episodes throughout the weekend made to PCP."	{N 386}		

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{N 386}	Continued From page 6 05/07/2024 3:00 AM- "resident [sic] literally calling every 5-10 minutes since I came in at 6:00pm [sic], saying [s/he] wants to die, doesn't know what [s/he] is doing, wants water, needs to spit. Resident is yelling out for help all night, residents swearing and mocking staff, spitting on floor, calling staff in to tell them to let [him/her] die. Resident saying things like[s/ he] hopes [his/her] c-pap [sic] suffocates [him/her], asking staff to kill [him/her], telling staff to just leave [him/her] here to die. Resident saying [s/he] wants to sleep but continues calling every 5 minutes. Calling multiple times to ask about [his/her] teeth, or hearing aid, or glasses, ra [sic] reminded resident all this stuff was done before bed and at this point it is 3:00am [sic] and[s/he] needs to try and get some sleep." 05/09/2024 8:30 AM by FADON-B - "Resident started on Trazodone [sic] 25mg [sic] to assist with behavioral disturbances, and insomnia as well as palliative referral sent over to [name of agency] on this date." 05/14/2024 12:00 PM- "Had a follow up meeting with [his/her] endocrinologist ....Please be sure we are monitoring [his/her] meals, if we are having a lot of carbs in one meal, please only give [him/her] half portions of the carbs or sweets ...if you notice resident is not eating more than 50% of [his/her] meals, please let nursing staff know so we can adjust the dose or the time [his/her] insulin is given." 05/15/2024 8:45 AM- "Seen on 05/13/2024 by [name] psych, NNO [no new orders]." 05/16/2024 3:45 PM- "Went to dentist today. Needs to have better brushing, suggesting a tri-brush toothbrush for caretakers to use for	{N 386}		

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{N 386}	Continued From page 7 brushing more effective ...and dentures should be coming out EVERY NIGHT!" 05/19/2024 5:30 AM- "Awake all night, on and off [his/her] pendant. Nothing helped calm [him/her] enough to sleep." 05/23/2024 4:00 AM- "resident [sic] was up all night, calling staff into [his/her] room like every 10 mins. Staff asked what was wrong and resident ither [sic] didn't know or wanted to know the time. Staff [sic] tried redirection but [sic] didn't work." 05/23/2024 5:45 AM- "Resident was trying to spit at staff this morning." 05/29/2024 5:30 AM- "was [sic] up all night saying help [sic] me help me I want to die [sic] [s/he] [sic] was pressing[his/her] pendant every 3 minutes [sic] all [sic] needs where [sic] met [sic] also [sic] saying I'm [sic] cold [sic] I don't know what I'm doing [sic] this s[sic] has been going on every night [sic] could we see about getting a prn to help [him/her] rest [sic]" 05/29/2024 2:00 PM- "Please use a divided plate at all times." 05/31/2024 5:30 AM- "resident [sic] was pushing [his/her] pendant on and off all night long stating I [sic] want to die! Please let me die! Help me die!" 05/31/2024 11:30 PM "throughout [sic] my shift [s/he] was calling a lot and asking me to kill [him/her]." 06/03/2024 10:00 AM- " ...The resident was repeatedly saying 'I [sic] don't know what I am doing". [sic] I heard the resident saying this before I entered the room, and upon arriving in	{N 386}		

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{N 386}	Continued From page 8 the room the resident continued to repeat this phrase almost in a frantic, repeated way. I assured the resident that I was helping [him/her], and [s/he] would be OK ..." 06/04/2024 9:45 AM- "When resident was done eating breakfast resident kept repeating that [s/he] wanted to die, over and over. RA called hospice and hospice told us to give [him/her] lorazepam. Loraz [sic] didn't seem to help. Wife is now here taking resident for a haircut." Psychiatric Progress note dated 05/13/2024. Most recent previous visit was 03/18/2024. " ...According to staff, dementia and confusion have been worsening and may be admitted to hospice in the near future ..." ISP dated 01/11/2024- In the area of Oral Cares: "Resident is independent with oral cares ...Maintain proper oral health and hygiene and independence with oral care. SERVICE PROVIDER RESPONSIBILITIES: Resident will maintain oral health hygiene independently for one year. MEASURABLE GOALS, OUTCOMES AND REVIEW: ...Resident will complete oral health hygiene daily independently." In the area of Eating: "Resident requires staff to monitor food consumption ...to consume adequate food/proper nutrition ...Is independent with eating, uses built up utensils. Does better with finger foods and cues while eating ...To maintain adequate food and nutrition intake and independence with eating. SERVICE PROVIDER RESPONSIBILITIES: Resident will continue to eat independently and maintain adequate nutrition for one year ... MEASURABLE GOALS, OUTCOMES AND REVIEW: ...will feed	{N 386}		

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{N 386}	Continued From page 9 [him/herself]. Care staff will monitor ..." In the area of Meal Preparation: "Resident requires the community to prepare all meals ...To have nutritious meals that resident enjoys. Resident will receive three nutritious meals day provided by the community ...the community with [sic] prepare and offer three nutritious meals a day." In the area of Diabetes Management: "Resident requires staff to manage diabetes per physician orders ...Maintain controlled blood sugar levels. SERVICE PROVIDER RESPONSIBILITIES: Staff to assist with checking blood sugar levels ...and sliding scale insulin ... MEASURABLE GOALS, OUTCOMES AND REVIEW Residents [sic] blood glucose levels will remain within normal range, and care staff to update nursing staff with any concerns." 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."	{N 386}		

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{N 386}	Continued From page 10 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, depressive mood symptoms (comments wanting to die/asking staff to kill him, yelling out, and spitting,) decreased cognition; insomnia; non-pharmacological interventions for mood, behaviors, and insomnia; need for psychological services; need for assistance with oral cares; or need for a divided plate. 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 (start date 11/27/2023) and 25 MG ½ tablet (12.5 MG) every morning (start date 04/10/2024) for aggression; divalproex (Depakote) 125 MG 2 capsules (to equal 250 MG) 3 times daily for impulsivity (start date 06/12/2024) increased from previous dose; and lorazepam 0.5 MG 1 tablet every 2 hours as needed for anxiety, insomnia or agitation (start date 08/18/2023). Facility observation notes dated 04/01/2024-06/13/2024 included:	{N 386}		

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{N 386}	Continued From page 11 04/01/2024 3:45 PM- "Resident stopped staff in the hallway with [his/her] box of popcorn, stated that staff are stealing [his/her] popcorn, and told [initials] that over the weekend [s/he] put [his/her] hand around one of the girls neck and gave it a squeeze because the girls wouldn't leave [his/her] room when [s/he] had ask them to.... Resident started asking for the Chief [sic] sheriff's number and wanted to call them because everyone here is "stealing [his/her] things"... Resident told [initials] that it's [his/her] room and [his/her] floor if [s/he] wants to make a mess then they should let [him/her]. [Initials] tried to calm resident down but the more [initials] talked to resident the more worked up [s/he] became ..." 04/15/2024 7:45 AM- " ...Resident with increased behaviors at times with staff, follow residents [sic] lead and do not engage in behavioral outbursts. Resident is confused at baseline at times ..." 04/21/2024 9:30 PM- " ...[s/he] believes people stole from [him/her] and [s/he] thinks its [sic] the young girls. [Resident 3] becomes upset when young girls assist [him/her] with cares and [s/he] does not trust them and if the wrong approached [sic] is used, not allowing [him/her] to do things [his/her] way, [his/her] behavior will increase ..." 04/26/2024 12:45 PM- "Resident started aspirating during lunch while [s/he] was with his/her social worker. Resident continued to cough afterwards. Hospice was notified by [his/her] shower aid that came in." 04/29/2024 7:30 PM- " ...[Resident 3] said [s/he] was leaving out the door before dinner as [s/he] believed someone in the parking lot took out three cars and [s/he] was waiting for the police to	{N 386}		

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{N 386}	Continued From page 12 come so [s/he] could report it ...we guided [him/her] back to the dining room, and when ready the recliner and tv. we [sic] would have called for PRN however, it was close to [Resident 3] getting [his/her] regular medication which usually deems [him/her] sleepy." 05/04/2024 1:30 PM- "Resident started choking on the meatballs at lunch time today. Staff had [him/her] spit it out. [S/he] continued to cough for a good 20 minutes after the incident. Staff has noticed that resident has been doing a lot of coughing while taking pills as well. Hospice was called ..." 06/01/2024 9:45 PM- "went [sic] for the door. I told [him/her] [his/her] cars were with family. [S/he] was sad because [s/he] feels family doesn't share things with [him/her]. [S/he] thanked me and asked me to take [him/her] back to [his/her] room. [S/he] almost went outside but I saw [him/her] ..." ISP dated 01/22/2024: In the area of Behavior Patterns- "Wandering Risk: Not Applicable" "Choking: Not Applicable" "Other: 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. MEASURABLE GOALS, OUTCOMES AND REVIEW: Resident to display minimized instances of behavior that affect care process." In the area of Nursing Procedures- "Resident is safe in the facility. Safety checks 4x Every Day	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	R 06/13/2024

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 And As Needed Minimize risk of being in an unsafe environment. SERVICE PROVIDER RESPONSIBILITIES: Ensure safety & address resident needs MEASURABLE GOALS, OUTCOMES AND REVIEW: Ensure resident safety and needs met every two hours." Resident 3's ISP did not identify: risks of wandering and choking; nonpharmacological interventions for aggressive behaviors and wandering; decreased cognition (forgetfulness); or need for psyche services. On 06/13/2024 at 1:46 PM, Surveyor interviewed Resident Aid D who stated Resident 1 yelled a lot, swore and was verbally aggressive especially toward him/herself stating things like "Damn it [Resident 1's name]!" when upset with self. Resident Aid D stated Resident 1 had exhibited those behaviors since his/her hire date in January 2023. On 06/13/2024 at 1:56 PM, Surveyor interviewed Resident Aid E who stated Resident 2 pressed his/her call light often, yelled out daily and often stated "Please let me die." Resident Aid E stated Resident 3 was aggressive toward staff when s/he did not understand why staff were asking him/her to do something. Resident Aid E stated Resident 3 was sometimes easily redirected and sometimes not when wandering in his/her wheelchair and Resident 3 required reminders and cues due to varying short term memory loss. On 06/13/2024 at 3:26 PM, Surveyor discussed concern of ISPs not updated with Administrator A who stated Resident 2 was not independent with toothbrushing. Administrator A stated it was FDON-B's responsibility to update ISPs and after Administrator A tried to guide FDON-B to do so	{N 386}		

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{N 386}	Continued From page 14 on 05/07/2024, FDON-B was terminated approximately 2 weeks later for not updating the ISPs. Administrator A stated s/he him/herself did not really understand how to update the ISPs in the electronic medical record. Administrator A stated a new nurse started approximately 06/06/2024 and would be updating all ISPs next week. On 06/14/2024 at 9:36 AM, Surveyor interviewed Administrator A who stated Resident 1, Resident 2 and Resident 3 were on hospice service. Administrator A stated hospice care plans were available to staff and staff were to follow the hospice care plan. Administrator A stated any updates from hospice are documented in the facility observation notes since staff are to read the observation notes daily for changes. Administrator A stated s/he would send Surveyor the hospice care plans. On 06/14/2024 at 11:12 AM, Administrator A emailed Surveyor stating ..."[Name of hospice agency] just met with [Resident 2's] family this week to finalize [his/her] care plan since [s/he] just signed onto hospice recently and I got that sent to me this morning...[Resident 3] is on a different hospice company than what we typically see being used by residents. They had been keeping [his/her] care plan in a binder in [his/her] apartment. When I went to the binder there were only progress notes/visit summaries of cares or changes, and the most recent care plan was not there. So, I also requested [his/her] current care plan and going forward requested they send it directly to us to keep with the rest of our hospice ISPs. We did find the diet change order that was made on 5/6/24 [Resident 3 to mechanical soft diet] that our nurse signed off/implemented at that time ...Again, when hospice updates the care	{N 386}		

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{N 386}	Continued From page 15 plans we are adding them as observations (or orders sent by hospice MD, as applicable) so that all staff are notified/see them as soon as they log into ECP [electronic medical record] and are aware of the changes. Going forward, I will ensure our ISP is updated when we are adding an observation note as well ..." Resident 1's hospice care plan was attached to the email. Hospice Care Plan dated 05/10/2024: In the area of Grief and Emotional Support Need due to Terminal Illness- "Goal: For Patient/Family/Friend(s). [Resident 1] and [his/her] family will express feeling supported in grieving process as [s/he] continues with hospice services. Ongoing. Intervention: [Hospice name] social services to encourage the expression of feelings and provide emotional support at each visit to [Resident 1] and [his/her] family ...[name of hospice] SW [social worker] to explore level of acceptance of disease process at every visit ...SW will allow for opportunity to express anticipated loss during visits." In the area of Symptom Management Need due to AGITATION: "Goal: patient/family/facility to report agitation being controlled AEB [as evidenced by] pt not having outlashes to either staff/residents/family while on [name of hospice] services. Intervention: [Name of hospice] nurse to be aware pt at times does yell at other residents/staff if [s/he] is upset. Staff most recently report [s/he] will yell out if [s/he] has any lights on in [his/her] room thinking it is [his/her] TV. Intervention: Pt may need re-approach for visits." Resident 1's hospice care plan did not identify interventions for facility staff to prevent/manage aggressive verbal and physical behaviors, non-pharmacological interventions for behaviors,	{N 386}		

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{N 386}	Continued From page 16 or communication interventions. Physician order dated 05/06/2024 to change Resident 3's diet to mechanical soft was also attached to the email.	{N 386}		