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N 000	Initial Comments On 08/08/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Sylvan Crossings at Hunter Ridge, a community based residential facility located in Beaver Dam, WI, for Statement of Deficiency (SOD) V0S812, dated 02/17/2023, and SOD 5MOW11, dated 03/24/2023. As a result of the survey, 5 deficiencies were identified. Three deficiencies are repeat deficiencies. See SOD 5MOW11, dated 03/24/2023, SOD V0S812, dated 02/17/2023, SOD V0S811, dated 07/01/2022, and SOD 6W4O11, dated 02/11/2021. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 17	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 that 1 of 2 residents reviewed received all medications as prescribed by a practitioner.	N 352		

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

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Resident 5's Midodrine was incorrectly administered or held on 10 occasions from 07/01/2023 - 08/08/2023.

This is a repeat deficiency. See Statement of Deficiency (SOD) V0S812, dated 02/17/2023, and SOD V0S811, dated 07/01/2022.

Findings include:

On 08/08/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 09/07/2019 with diagnoses including hypotension. Resident 5's prescriptions included Midodrine 5 mg tablets with instructions to "Take 1 tablet by mouth three times daily at 9AM, 12PM, and 5PM for hypotension (Hold if systolic [blood pressure] is >120."

Surveyor reviewed Resident 5's medication administration record (MAR) from 07/01/2023 - 08/08/2023 and observed the following 10 discrepancies:

- 07/02/2023 (8:44 a.m.): Blood pressure documented as 121/56, Midodrine documented as administered (should have been held)
- 07/02/2023 (5:24 p.m.): Blood pressure documented as 122/76, Midodrine documented as administered (should have been held)
- 07/03/2023 (8:23 a.m.): Blood pressure documented as 141/69, Midodrine documented as administered (should have been held)
- 07/07/2023 (11:54 a.m.): Blood pressure documented as 124/72, Midodrine documented as administered (should have been held)
- 07/10/2023 (12:19 p.m.): Blood pressure documented as 121/56, Midodrine documented as administered (should have been held)
- 07/12/2023 (9:09 a.m.): Blood pressure

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N 352	Continued From page 2 documented as 121/54, Midodrine documented as administered (should have been held) - 07/17/2023 (7:50 a.m.): Blood pressure documented as 121/56, Midodrine documented as administered (should have been held) - 07/30/2023 (1:12 p.m.): Blood pressure documented as 121/54, Midodrine documented as administered (should have been held) - 08/07/2023 (8:17 a.m.): Blood pressure documented as 121/85, Midodrine documented as administered (should have been held) - 08/07/2023 (11:21 a.m.): Blood pressure documented as 123/64, Midodrine documented as administered (should have been held) At approximately 3:05 p.m., Surveyor interviewed Executive Director L and Administrator M. Executive Director L reported s/he was not previously aware of issues with staff incorrectly administering Resident 5's Midodrine. Executive Director L and Administrator M reported that staff were possibly confusing the "greater than" versus "lesser than" sign in the Midodrine order and that's why they were incorrectly administering it. Administrator M reported they would do follow up training with staff to address the concern.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or	N 389		

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resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review, observation, and interview, the provider did not ensure that individual service plans (ISPs) were updated for 2 of 3 residents reviewed when there were changes in their needs, abilities, and physical condition.

Resident 13's ISP was not updated to include information about his/her behaviors and incontinence.

Resident 6's ISP contained limited information about his/her ambulation status, no information about his/her behaviors as observed by staff, and limited information about the fall prevention efforts currently being utilized by the provider. It was not updated to reflect that s/he was no longer receiving routine bowel monitoring.

This is a repeat deficiency. See Statement of Deficiency (SOD) V0S812, dated 02/17/2023, and SOD 6W4O11, dated 02/11/2021.

Findings include:

Example 1 - Resident 13's incontinence and behaviors

On 08/08/2023, Surveyor reviewed Resident 13's record. Resident 13 was admitted to the provider on 02/02/2023 with diagnoses including history of stroke with left-sided weakness. Surveyor reviewed Resident 13's observation notes from

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N 389	Continued From page 4 07/01/2023 - 08/08/2023 and observed the following: - 07/04/2023 (9:45 a.m.): "...residents[sic] is being very button happy. resident[sic] is pressing buttons for little things like changing the channel, help look for [his/her] phone when its[sic] next to [him/her]." - 07/04/2023 (3:15 p.m.): "...Resident screamed for staff all shift Writer[sic] asked resident to please not scream and to be patient as staff was with other residents. Resident said OK but 2minutes[sic] later screamed again. Staff answered every page and as soon as they walked out the room [s/he] was screaming and paging for them." - 07/04/2023 (6:15 p.m.): "...resident was on call light repeatedly along with yelling..." - 07/07/2023 (11:15 a.m.): "resident called early in the morning, resisnt[sic] stated [s/he] was wet..." - 07/10/2023 (8:45 p.m.): "resident was paging a lot...has paged and yelled 5-10mins[sic] after staff exited room." - 07/11/2023 (2:45 p.m.): "Resident has been yelling for staff all morning and day and after they have answered [his/her] call 2 minutes after they exit [his/her] room, [s/he] yells for them. Writer asked resident to please not yell and to please be patient that staff will be with [him/her] as soon as they can resident swore at staff and stated i need [explicit] Help Now[sic]. i[sic] told resident that staff where[sic] just in their[sic] helping [him/her] that right now they where[sic] helping another resident that they would be in shortly. Writter[sic] walked out of the room and heard resident say	N 389		

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N 389	Continued From page 5 [explicit] [explicit]." - 07/11/2023 (9:00 p.m.): 'Resident paging all of shift including yelling from room repeatedly. At one point was told staff were doing shift report they'll be with you soon, resident went in they're[sic] room took top off and started yelling for help only few minutes after being told..." - 07/13/2023 (7:00 p.m.): "Resident was in room screaming for writer. Writer walked into room and reminded resident [s/he] cant be yelling for staff and that [s/he] needs to press [his/her] button and wait like everyone else...[s/he] stated that [s/he] was going to call state." - 07/15/2023 (7:45 p.m.): "Resident was paging throughout shift also calling out into hall for staff. At one point while staff were assisting another resident this resident stated to another that staff were neglecting them..." - 07/17/2023 (5:45 a.m.): "...Called staff x 1 for a change of incontinent urine..." - 07/17/2023 (8:30 p.m.): "paging constantly..." - 07/24/2023 (10:45 a.m.): "Resident was wet at this time..." - 07/28/2023 (9:45 a.m.): "Residents[sic] brief and pants were changed at this time due to resident having a urine incontinence accident." Surveyor reviewed Resident 13's ISP, which was last signed as reviewed on 04/10/2023. There was no information about Resident 13's continence status in his/her ISP. Regarding behaviors, his/her ISP documented that s/he "sees therapist monthly for mental health needs"	N 389		

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and that s/he requires staff assistance to "redirect negative attitudes." There was no other information regarding Resident 13's behaviors.

On 08/08/2023, from approximately 2:00 - 2:25 p.m., while interviewing Executive Director L, Surveyor heard Resident 13 yelling out for staff multiple times. Staff, which included Lead Caregiver N and Caregiver O, were observed attending to Resident 13 each time s/he yelled out. Surveyor asked Executive Director L if the behaviors in the above observation entries - related to making neglect allegations and frequently yelling out - were known or if they were new. Executive Director L replied that these were known behaviors for Resident 13 and had been going on for awhile. At approximately 2:25 p.m., while interviewing Executive Director L, Surveyor heard Resident 13 yell out again. Executive Director L told Surveyor that "this is an all day thing" regarding Resident 13's behavior. During the interview, Surveyor asked Executive Director L if Resident 13 was incontinent, to which Executive Director L replied that s/he was. Surveyor discussed the concern with Executive Director L that Resident 13's ISP was not updated to include his/her behaviors, including how staff were expected to manage them, or information about his/her incontinence. Executive Director L acknowledged Surveyor's concern and said staff were working on a behavioral support plan for managing Resident 13's behaviors.

Example 2 - Resident 6's behaviors, fall interventions, ambulation, and bowel monitoring

On 08/08/2023, at approximately 8:15 a.m., Surveyor observed Resident 6 eating breakfast. Resident 6 was observed seated in a manual wheelchair with a tab alarm on. At approximately

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N 389	Continued From page 7 8:45 a.m., Surveyor observed Resident 6 seated in a recliner in the living area, with the tab alarm still on. On 08/08/2023, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/21/2023 with diagnoses including Parkinson's disease and repeated falls. Surveyor reviewed Resident 6's observation notes from 07/01/2023 - 08/08/2023 and observed the following: - 07/04/2023 (1:30 p.m.): "[as needed (PRN)] trazodone was given due to agitation, trying to destroy property." - 07/04/2023 (3:00 p.m.): "Resident was very anxious, was walking around the room, resident would not leave on [his/her] alarm was ripping it off...was very agitated..." - 07/04/2023 (6:15 p.m.): "Resident appeared agitated in afternoon..." - 07/05/2023 (1:15 p.m.): "...Antsy with [his/her] fall monitor." - 07/06/2023 (1:15 p.m.): "...[S/he] keeps messing with [his/her] fall alarm and trying to walk on [his/her] own but after lunch time [his/her] medicene[sic] makes [him/her] drousy[sic] and [s/he] shouldnt[sic] be walking independently at that point." - 07/07/2023 (11:30 a.m.): "Resident was up and walking with walker and staff..." - 07/14/2023 (10:00 a.m.): "Resident had a med review today with [physician] regarding being more aggressive, and hard to redirect..."	N 389		

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N 389	Continued From page 8 - 07/14/2023 (7:30 p.m.): "...Staff will now use the Quetiapine as the PRN and then if that don't work then it will be the Trazadone[sic], Staff will use the PRN when resident is hard to redirect. when[sic] resident is showing signs of aggression towards staff and other residents..." - 07/16/2023 (1:00 p.m.): "...Resident started to get agitated after breakfast and stated they needed to go home. Staff redirected resident multiple times. Staff changed environment, and offered water or a snack. Resident started to calm down before lunch..." - 07/21/2023 (7:45 p.m.): "Residents alarm was going off due to resident trying to get out of bed a couple times..." - 07/24/2023 (8:15 a.m.): "...Resident's alarm is on..." - 07/28/2023 (7:15 a.m.): "...Resident kept setting off [his/her] chair alarm by trying to reach down and grab a napkin..." - 07/29/2023 (8:30 p.m.): "Resident was very antsy and leaning alot[sic] today. PRN was givin[sic] to resident and appeared to help resident...Resident was slightly aggressive with writer as [s/he] was getting put into bed. Writer stated to resident that [s/he] shouldnt[sic] be grabbing staff that hard as it hurts and [s/he] could harm someone. Resident stated that [s/he] was just having a bad day..." - 08/01/2023 (10:30 a.m.): "...resident was agitated and kept trying to get out of wheelchair while at breakfast. writer prepped prn quietpaine[sic] but couldn't not get [him/her] to	N 389		

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N 389	Continued From page 9 take it..." - 08/04/2023 (7:45 a.m.): "...alarm put on wheelchair and on resident before bringing resident down..." - 08/05/2023 (1:30 p.m.): "Resident set off the chair alarm a couple of times reaching down for tissues that were dropped. Resident was reminded by staff to not bend over but to ask staff for help to prevent the risk of falling." Within Resident 6's record, between the observation notes and fall reports from 07/01/2023 - 08/08/2023, which were provided by Executive Director L, Surveyor observed 7 documented occasions in which Resident 6 fell. After 2 of those falls, 07/25/2023 and on 07/28/2023, Resident 6 was sent to the emergency department for further evaluation. A correlating observation entry for Resident 6's 07/28/2023 fall documented that Resident 6 was sent out to the emergency department for further evaluation and had received "steri strips on [his/her] left eye to stop bleeding." Surveyor then reviewed Resident 6's most recent ISP, dated 03/21/2023 but signed as reviewed on 07/10/2023. Surveyor observed the following in relation to Resident 6's behaviors, fall interventions, and ambulation status: - "Assistive device - manual wheelchair" heading: No additional information - "Recent falls" heading: No additional information - "Hi-low bed" heading: No additional information - "Hourly safety checks" heading: "Hourly safety check. High risk for falls and resident has diagnosis of Dementia[sic]...Goal is to keep resident free from falling."	N 389		

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N 389	Continued From page 10 There was no information about Resident 6's behaviors, his/her ambulation status (whether or not s/he could self-propel his/her wheelchair versus requiring staff assistance or walk with a walker, as indicated in his/her 07/07/2023 observation note), or other fall prevention efforts utilized by the provider (such as the tab alarm observed earlier by Surveyor). In reviewing Resident 6's ISP, Surveyor also observed under the "Bowel movement monitoring" heading that staff were "to monitor and document bowel movements...If no bowel movements for 3 days, let med passer know for PRN medications." Within Resident 6's observation notes from 07/01/2023 - 08/08/2023, Surveyor observed 12 days in which staff documented Resident 6's bowel movements, including: 07/01/2023, 07/05/2023, 07/07/2023, 07/10/2023, 07/11/2023, 07/17/2023, 07/26/2023, 07/27/2023, 08/02/2023, 08/05/2023, 08/06/2023, 08/08/2023. On 08/08/2023, at approximately 1:45 p.m., Surveyor interviewed Executive Director L. In discussing fall prevention efforts, Executive Director L reported that Resident 6's tab alarm has been utilized for the last few weeks. Executive Director L reported that the provider also utilizes a floor mat alongside Resident 6's bed which is placed at bedtime and naptimes to prevent fall-related injuries. Executive Director L reported that staff sometimes will place Resident 6 in the living area within eyesight of staff so that they can better supervise him/her. Executive Director L confirmed these interventions were not documented in Resident 6's ISP. While discussing Resident 6's ambulation status, Executive Director L reported that Resident 6's presentation varied day-to-day and that s/he	N 389		

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could sometimes walk with a walker and staff assistance, could sometimes self-propel him/herself in a wheelchair, and sometimes required full staff assistance for ambulating in his/her wheelchair. Executive Director L confirmed that this information about Resident 6's ambulation was not in his/her ISP. In discussing Resident 6's behaviors, Executive Director L reported that s/he sometimes demonstrated agitation-related behaviors as well as aggression towards staff, which was why they were working with Resident 6's medical provider to explore psychotropic medication interventions. Executive Director L confirmed that there was no information about these behaviors in Resident 6's ISP. In discussing Resident 6's bowel monitoring, as directed in his/her ISP, Surveyor asked Executive Director L if Resident 6's bowel movements were being documented anywhere other than the observation notes. Executive Director L reported that staff sometimes documented them in his/her cares charting. Upon reviewing the cares charting provided by Executive Director L, Surveyor observed that staff were not routinely documenting Resident 6's bowel movements, and there were at times up to several days in between entries. Executive Director L reported that this was because Resident 6's bowel monitoring was only PRN. Surveyor asked how staff were to know if Resident 6 didn't have a bowel movement for 3 days (the parameter set in his/her ISP) if they weren't routinely monitoring his/her bowel movements. Executive Director acknowledged Surveyor's concern and reported that Resident 6 didn't require routine bowel monitoring. Executive Director L reported s/he intended to remove the bowel monitoring from Resident 6's ISP. Executive Director L reported that when s/he first started working with the provider s/he didn't have

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N 389	Continued From page 12 much to work with regarding residents' ISPs and so s/he has been working to try to update them.	N 389		
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 that Resident 6's individual service plan (ISP) included a rationale for use and a detailed description of the behaviors indicating the need for administration of his/her as-needed (PRN) Trazodone and Quetiapine. Findings include:	N 408		

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N 408	Continued From page 13 On 08/08/2023, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/21/2023 with diagnoses including major depressive disorder (severe with psychotic features) and Parkinson's disease. Resident 6's PRN psychotropic medication prescriptions included Trazodone 50 mg tablets, with instructions to "Take 1 tablet every 8 hours as needed," and Quetiapine 25 mg tablets, with instructions to "Take 1/2 tablet (12.5 mg) every 12 hours as needed." Surveyor reviewed Resident 6's observation notes from 07/01/2023 - 08/08/2023 and observed the following entries: - 07/04/2023 (1:30 p.m.): "PRN trazodone was given due to agitation, trying to destroy property." - 07/14/2023 (10:00 a.m.): "Resident had a med review today with [physician] regarding being more aggressive, and hard to redirect, [doctor] will send new medications to [pharmacy]. Will use a PRN for using helping resident when feeling irritable and not being able to settle down from the Parkinson's disease..." - 07/14/2023 (7:30 p.m.): "...Staff will now use the Quetiapine as the PRN and then if that don't work then it will be the Trazadone[sic], Staff will use the PRN when resident is hard to redirect. when[sic] resident is showing signs of aggression towards staff and other residents..." - 07/29/2023 (8:30 p.m.): "Resident was very antsy and leaning a lot[sic] today. PRN was givin[sic] to resident and appeared to help resident..." - 08/01/2023 (10:30 a.m.): "...resident was agitated and kept trying to get out of wheelchair while at breakfast. writer prepped prn quietpaine[sic] but couldn't not get [him/her] to take it..."	N 408		

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N 408	Continued From page 14 Surveyor reviewed Resident 6's individual service plan (ISP), showing a creation date of 03/21/2023 and last signed as reviewed on 07/10/2023. There was no information regarding Resident 6's Trazodone and Quetiapine use. Surveyor reviewed Resident 6's medication administration record (MAR) from 07/01/2023 - 08/08/2023 and observed the following 8 occasions in which Resident 6 was administered his/her PRN Trazodone and Quetiapine: - 07/04/2023 (1:29 p.m.): Trazodone administered - 07/06/2023 (4:01 p.m.): Trazodone administered - 07/09/2023 (2:44 p.m.): Trazodone administered - 07/21/2023 (7:37 p.m.): Quetiapine administered - 07/23/2023 (2:52 p.m.): Quetiapine administered - 07/27/2023 (3:56 p.m.): Quetiapine administered - 07/29/2023 (3:32 p.m.): Quetiapine administered - 07/31/2023 (1:13 p.m.): Quetiapine administered At approximately 1:45 p.m., Surveyor interviewed Executive Director L. Executive Director L confirmed that Resident 6's ISP did not address his/her Trazodone or Quetiapine use. Executive Director L reported s/he was unaware of the regulation requiring a rationale for use and a detailed description of the behaviors indicating the need for PRN psychotropic medication administration in residents' ISPs.	N 408		
N 431	83.38(1)(g) Health monitoring.	N 431		

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N 431	Continued From page 15 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 6's health was monitored when s/he experienced an episode of feeling unwell with elevated blood pressure on	N 431		

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N 431	Continued From page 16 07/01/2023, and when s/he experienced a fall on 07/04/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 5MOW11, dated 03/24/2023, and SOD V0S812, dated 07/17/2023. Findings include: On 08/08/2023, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/21/2023 with diagnoses including Parkinson's disease and repeated falls. Surveyor reviewed Resident 6's observation notes from 07/01/2023 - 08/08/2023 and observed the following: - 07/01/2023 (3:15 p.m.) by Caregiver Q: "Writer was in kitchen when [other resident] came to writer and stated that resident told [other resident] [s/he] wasn't feeling well. Writer went to check on resident, Resident[sic] stated to writer that resident was feeling off. Writer asked what was wrong that resident felt off. Resident stated resident just wasn't feeling well. Writer took residents[sic] [blood pressure] 150/79, which was normal." - 07/01/2023 (7:45 p.m.): "...Writer asked how resident was feeling, resident stated resident was feeling a little better..." There was no evidence of staff following up further with Resident 1 or re-assessing his/her blood pressure. According to the American Heart Association, the following guidelines are provided regarding blood pressure:	N 431		

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- Normal = less than 120/80
- Elevated = 120-129 systolic and <80 diastolic
- High blood pressure (hypertension) stage 1 = 130-139 systolic and 80-89 diastolic
- High blood pressure (hypertension) stage 2 = 140 or higher systolic and 90 or higher diastolic
- Hypertensive crisis = >180 systolic and/or >120 diastolic

(Source: American Heart Association, Understanding Blood Pressure Readings, May 30, 2023, https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings (retrieval date - August 10, 2023).).

Surveyor reviewed Resident 6's medication administration record (MAR) from 07/01/2023 - 08/08/2023, where staff appeared to document weekly vitals that they were taking for him/her. Surveyor observed the following:

- 07/06/2023: Blood pressure was 115/60
- 07/12/2023: Blood pressure was 128/64
- 07/19/2023: Blood pressure was 121/68
- 07/26/2023: Blood pressure was 125/68
- 08/02/2023: Blood pressure was 125/61

While reviewing Resident 6's record, Surveyor also reviewed a fall report dated 07/04/2023 at 1:50 p.m. The report, documented by Caregiver P, indicated that Resident 6 had a fall while s/he was trying to get up off a loveseat "and slid off." In the report, the following was documented:

- "Resident inspected for any injuries?" The "No" box was checked.
- "Range of motion and all extremities performed?" The "No" box was checked.
- "Mental status performed?" The "No" box was checked.

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N 431	Continued From page 18 - "Resident sent to [emergency room]?" The "No" box was checked. - "Vitals that were taken:" This section was blank. Surveyor then reviewed Resident 6's observation notes for the same day to see if any post-fall assessment had been completed for Resident 6. There was no information about this fall in the notes. At approximately 1:45 p.m., Surveyor interviewed Executive Director L. Surveyor asked if there was any parameters from Resident 6's medical provider regarding a systolic blood pressure of 150 being "normal" (as documented by Caregiver Q). Executive Director L reported s/he was unaware of any. Executive Director L confirmed Surveyor's observation that Resident 6's blood pressure of 150/79 did not seem to be within his/her typical range as evidenced by his/her vitals monitoring in June and August 2023. Executive Director L reported that Caregiver Q should have informed him/her of the 07/01/2023 blood pressure reading, since it was outside of a normal range for Resident 6, so that s/he could further assess Resident 6. Surveyor then reviewed Resident 6's 07/04/2023 fall report with Executive Director L. Executive Director L confirmed there was no evidence that Resident 6 was assessed for injury after the fall. Executive Director L reported that Caregiver P no longer worked with the provider. Executive Director L reported that Caregiver P did not have previous experience in healthcare and so maybe that was why s/he didn't know what should have been assessed after Resident 6's fall.	N 431		
N 441	83.39(3) Hand washing.	N 441		

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N 441	Continued From page 19 Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that employees followed hand washing procedures in accordance with the Centers for Disease Control and Prevention (CDC) standards. Caregiver F was not observed to conduct hand hygiene during the morning medication pass, from approximately 7:20 - 8:38 a.m., which included administering medications to 11 residents. Findings include: The CDC instructs healthcare providers to complete hand hygiene after touching a patient or the patient's immediate environment as well as after glove removal (Source: CDC, Healthcare Providers Introduction to Hand Hygiene, January 8, 2021, https://www.cdc.gov/handhygiene/providers/index.html#:~:text=Alcohol%2Dbased%20hand%20sanitizers%20are%20the%20preferred%20method%20for%20cleaning,and%20after%20using%20the%20restroom (retrieval date - August 9, 2023)). On 08/08/2023, at approximately 7:20 a.m., Surveyor began observing Caregiver F during the morning medication pass. Between then and approximately 8:38 a.m., Surveyor observed Caregiver F administer medications from the medication cart to 11 residents, including Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 15.	N 441		

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N 441	Continued From page 20	N 441		

This was observed to include grabbing medication cups from the stack, using keys to lock/unlock the medication cart, retrieve medication cards from the cart drawers, pop medications into medication cups, and hand the cups to residents for administration. Caregiver F was observed to apply a blood pressure cuff to Resident 10's left arm and take his/her blood pressure while administering his/her medications. Caregiver F was also observed crushing medication for Resident 11. As part of this, s/he was observed grabbing a spoon from a container of plastic spoons by the spoon bowl (the part that touches a resident's lips/mouth) before mixing Resident 11's medications in applesauce for administration. As part of the medication pass, Caregiver F was observed donning gloves and applying a foot ointment to Resident 13's left foot. After doffing the gloves, Caregiver F moved onto administering Resident 14's medications. The last resident to receive his/her morning medications, Resident 5, had his/her blood pressure taken by Caregiver F. Throughout this entire observation period, Caregiver F was not observed to conduct hand hygiene.

At approximately 8:38 a.m., Surveyor interviewed Caregiver F. Caregiver F reported s/he was nervous to have Surveyor watching during his/her medication pass. When asked how often Caregiver F is supposed to conduct hand hygiene, Caregiver F replied s/he knew s/he was supposed to do it in between each resident's medication administration.

At approximately 3:05 p.m., Surveyor interviewed Executive Director L and Administrator M. Both reported they were informed earlier by Caregiver F's of his/her lack of hand hygiene during the morning medication pass. Both reported they

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N 441	Continued From page 21 expected medication passers to conduct hand hygiene between each resident's medication administration.	N 441		