STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111056	A. BUILDING: _____ B. WING _____	R-C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN CROSSINGS AT HUNTER RIDGE	626 MONROE ST BEAVER DAM, WI 53916

(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 01/02/2024, with information obtained through 01/03/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and 2 complaint investigations at Sylvan Crossings at Hunter Ridge, a community based residential facility (CBRF) located in Beaver Dam, WI. As a result of the survey, 4 deficiencies were identified. Four deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) V0S813, dated 08/08/2023, SOD V0S812, dated 02/17/2023, SOD V0S811, dated 07/01/2022, and SOD 6W4O11, dated 02/11/2021. One complaint was substantiated, one complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 20	{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 3 of 3 residents	{N 352}		

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

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{N 352}	Continued From page 1 reviewed received all medications as prescribed by a practitioner. Resident 18 was seen on an outpatient basis by his/her medical provider for dyspnea and sinusitis concerns on 12/18/2023, where s/he was prescribed Azithromycin tablets, Guaifenesin tablets, and a saline sinus rinse kit. Resident 18 was administered only 2 of his/her 3 prescribed once-daily doses of Azithromycin. Resident 18's Guaifenesin tablets were not administered until almost 2 weeks later (on 12/31/2023) after they were prescribed. Since starting Guaifenesin on 12/31/2023, Resident 18 was only administered 1 of 5 possible doses. Resident 18 still has not received his/her saline sinus rinse kit. On 12/30/2023, Resident 18 was prescribed a fluticasone inhaler but still has not received it. Resident 18 had been taken to the emergency department twice since 12/01/2023 with dyspnea (shortness of breath) concerns, and both times s/he was hospitalized. Resident 17 was prescribed scheduled insulin that staff appeared to inconsistently hold or administer when his/her blood sugar ranged from 60-77 on 6 occasions from 12/08/2023 - 01/02/2024. Resident 17's insulin order did not provide a hold parameter value. Resident 6's Ipratropium/albuterol nebulizer treatments contained prescription instructions to complete for 14 days. Resident 6 continued to receive nebulizer treatments for 33 doses across 7 days without further instruction from his/her medical provider. Resident 6 was prescribed as needed (PRN) Quetiapine that was to be administered as needed every 12 hours, but on 12/01/2023, s/he was administered 2 doses that were approximately 2.5 hours apart.	{N 352}		

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{N 352}	Continued From page 2 This is a repeat deficiency. See Statement of Deficiency (SOD) V02813, dated 08/08/2023, SOD V0S812, dated 02/17/2023, and SOD V0S811, dated 07/01/2022. Findings include: On 01/02/2024, Surveyor conducted a complaint investigation into allegations of staff not administering medications correctly. Example 1 - Resident 18 On 01/02/2024, at approximately 9:30 a.m., Surveyor observed Caregiver F prepare Resident 18's medications at the medication cart as part of the morning medication pass. Caregiver F told Surveyor that s/he was not going to be giving the medication from one of the cards, which still contained tablets, to Resident 18 because the date for the medication had already ended. Upon entering Resident 18's room, Resident 18 reported to Caregiver F that Senior Team Lead N told him/her last night that s/he was looking into a medication concern for him/her. Resident 18 reported that s/he was supposed to be on an antibiotic for pneumonia since returning from the hospital but hasn't yet received it. Caregiver F reported that s/he was unaware of any additional antibiotic and reported that the only antibiotic medication s/he knew about had been the discontinued medication (observed earlier in the medication cart.) Upon returning to the medication cart, Surveyor observed that the medication card referenced earlier by Caregiver F as being a discontinued medication for Resident 18 contained Guaifenesin extended release 600 mg tablets.	{N 352}		

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{N 352}	Continued From page 3 On 01/02/2024, Surveyor reviewed Resident 18's record. Resident 18 was admitted to the provider on 11/06/2023 with diagnoses including acute respiratory failure. Resident 18 was documented as being his/her own legal representative. Surveyor reviewed Resident 18's medication administration record (MAR) for 12/01/2023 - 01/02/2024 and observed the following: - Azithromycin 250 mg tablets were prescribed with the following directions: "(12/19-12/21) Take 2 tablets (500 mg) by mouth once daily for 3 days." The MAR showed 2 daily administrations of the medication (as opposed to the 3 that were prescribed) - on 12/20/2023 and 12/21/2023. - Guaifenesin extended release 600 mg tablets were prescribed with the following directions: "(Pend POA auth) (12/18-12/28/23) Take 2 tablets (1200 mg) by mouth every 12 hours for 10 days." The MAR showed 1 occasion of administration, on the morning of 12/31/2023. The evening entry on 12/31/2023 was marked as "Other" with an annotation that the medication end time was over. For the 01/01/2023 morning administration, Caregiver F documented that the medication was not given due to "pill is done." For the 01/01/2024 evening administration, Senior Team Lead N documented that the medication was not given due to "Waiting for delivery." For the 01/02/2024 morning administration, Caregiver F documented that the medication was not given due to "pill is done." In reviewing Resident 18's record, Surveyor reviewed clinic visit, emergency admission, and hospital discharge notes from 12/01/2023 through the current day, and observed the following: - Hospital discharge summary dated 12/09/2023	{N 352}		

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{N 352}	Continued From page 4	{N 352}		

from Resident 18's hospitalization from 12/06/2023 - 12/09/2023, which documented under the "Hospital Course/Treatment Rendered" heading, " ...[S/he] presented to the [emergency room] at [his/her] insistence because of cough and dyspnea, initial [oxygen] saturations were in the mid 80% range ...[S/he] steadily improved and weaned off of supplemental [oxygen], but [s/he] has remained subjectively dyspneic. [S/he] also reported sinus pain/pressure ..."

- Clinic visit note dated 12/18/2023 in which Resident 18 was seen for heart failure, mild intermittent asthma, dyspnea, and chest pain. The note contained physician orders for:
1. Azithromycin 500 mg tablets with directions to, "Take 1 (one) tablet by mouth once daily for 3 days"
2. Guaifenesin extended release 600 mg tablets with directions to, "Take 2 (two) tablets by mouth every 12 hours for 10 days"
3. Sodium chloride-sodium bicarbonate 2300-700 mg kit (Neilmed Sinus Rinse) with directions to, "Flush each nostril [twice daily] for 7-10 days."

- Hospital discharge summary dated 12/30/2023 from Resident 18's hospitalization from 12/26/2023 - 12/30/2023, which contained a physician order for a fluticasone-salmeterol 115 mcg-21 mcg inhaler with directions to have 2 inhalations twice daily.

Surveyor again reviewed Resident 18's MAR from 12/01/2023 - 01/02/2023. Surveyor observed the Neilmed Sinus Rinse kit showing as starting on 12/31/2023 (almost 2 weeks after it was prescribed by his/her medical provider) but that it had not been marked as administered for 5 of 5 administrations since then due to either waiting for pharmacy delivery or "pending POA auth."

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{N 352}	Continued From page 5 Surveyor did not observe any entry for Resident 18's prescribed fluticasone inhaler from his/her 12/30/2023 hospital discharge. Surveyor reviewed Resident 18's observation notes from 12/01/2023 - 01/02/2024 but did not observe any information about his/her Azithromycin tablets, Guaifenesin tablets, Neilmed Sinus Rinse kit, or fluticasone inhaler. Regarding Resident 18's most recent hospitalization from 12/26/2023 - 12/30/2023, Surveyor observed an observation entry dated 12/26/2023 at 10:45 a.m. which documented, "resident[sic] was taken by ambulance 11 am. Had problems breathing ..." Another entry 15 minutes later, at 11:00 a.m., documented, "resident[sic] was taken by ambulance at 11am resident awoke feeling nauseous and was pale and did not eat breakfast. resident[sic] stated to staff that [s/he] was feeling ill. then[sic] resident rang to stated could not breathe. then[sic] [emergency medical services] was called." At approximately 2:00 p.m., Surveyor interviewed Executive Director S and Vice President of Training and Compliance (Vice President) R. Vice President R reviewed Resident 18's MAR during the interview and confirmed that s/he only saw 2 administrations of Resident 18's Azithromycin tablets as opposed to the 3 days s/he was prescribed to take them. Vice President R reported that the way the medication was set up on the MAR it made it appear as if the medication ended on 12/21/2023 even though Resident 18 would have still needed one additional dose in accordance with his/her prescription. Executive Director S reported that staff should have followed up with the pharmacy to discuss this further but confirmed s/he did not have any evidence that staff had done so. Vice President R	{N 352}		

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{N 352}	Continued From page 6 reported that it appeared to be a similar issue with Resident 18's Guaifenesin tablets - that even though the tablets were initially prescribed on 12/18/2023 they were not input in the MAR until 12/31/2023 and since the medication date showed as ending on 12/28/2023, staff did not appear to be administering it since that date had already passed. Executive Director S reported s/he did not have any evidence to explain whether staff followed up with the pharmacy or Resident 18's medical provider to ask about his/her Guaifenesin tablet administration. Regarding Resident 18's prescribed sinus kit, Vice President R confirmed that it appeared as if the provider did not have it. Vice President R and Executive Director S reported that it was possible the provider was still waiting for insurance authorization for the kit, but confirmed they did not have any evidence that staff had reached out to Resident 18's insurance or his/her medical provider to see where they were at in the process of obtaining the kit. Regarding Resident 18's fluticasone inhaler, both Executive Director S and Vice President R both confirmed that the provider did not have this. Executive Director S reported that maybe the provider was still waiting on delivery of the inhaler but confirmed that other medications initiated on 12/30/2023 from that same hospitalization were received and being administered to Resident 18. Vice President R and Executive Director S confirmed they had no evidence of whether staff followed up with the pharmacy or Resident 18's medical provider regarding his/her fluticasone inhaler not yet being received. Example 2 - Resident 17 On 01/02/2024, at approximately 8:30 a.m., Surveyor observed Caregiver F prepare Resident	{N 352}		

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{N 352}	Continued From page 7 17's medications at the medication cart as part of the morning medication pass. Caregiver F took Resident 17's blood sugar, which was 74. Caregiver F informed Surveyor that s/he didn't think s/he should administer Resident 17 his/her morning insulin due to his/her blood sugar being low. Caregiver F reported that s/he thought there used to be a specific hold parameter within Resident 17's insulin order but there currently wasn't and so s/he wasn't sure when s/he should hold Resident 17's insulin. Caregiver F showed Surveyor on the provider's electronic record platform the order for Resident 17's insulin. The order was for Humalog KwikPen 100 units/mL, but Surveyor did not observe any hold parameters for the scheduled insulin dose documented as part of the order. Caregiver F confirmed s/he reported concerns to Senior Team Lead N about having a hold parameter for Resident 17's scheduled insulin dose when Resident 17 demonstrates low blood sugars and reported that s/he thought Senior Team Lead N was looking into the issue but that it has been several weeks since the concern was raised. Executive Director S then entered the medication area and Surveyor observed Caregiver F relaying the above concerns to him/her. At approximately 9:10 a.m., Executive Director S instructed Caregiver F to administer Resident 17 his/her scheduled dose of insulin. Executive Director S reported that the scheduled dose should only be held when Resident 17's blood sugar was below 70 due to "common sense." On 01/02/2024, Surveyor reviewed Resident 17's record. Resident 17 was admitted to the provider on 10/24/2023 with diagnoses including type 2 diabetes mellitus with diabetic neuropathy. Resident 17's prescriptions included Humalog	{N 352}		

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{N 352}	Continued From page 8 KwikPen 100 units/mL with instructions to, "Inject 25 units subcutaneously 3 times daily with sliding scale for diabetes mellitus ..." There was no hold parameter documented as part of the prescription directions. Surveyor reviewed Resident 17's MAR from 12/01/2023 - 01/02/2024 in conjunction with his/her vitals history document, where Resident 17's blood sugars appeared to be recorded, and observed the following 6 occasions of staff inconsistently handling Resident 17's scheduled insulin administration when his/her blood sugars were between 60 and 77: - 12/07/2023 8:00 a.m. dose marked as administered, blood sugar documented as 69 - 12/08/2023 8:00 a.m. dose marked as administered, blood sugar documented as 65 - 12/08/2023 12:00 p.m. dose marked as administered, blood sugar documented as 73 - 12/09/2023 12:00 p.m. dose with the annotation, "Holding per nurse due to [blood sugar] being 72" - 12/22/2023 8:00 a.m. dose marked as "No pass per vitals" with the annotation "[blood sugar] 77" - 01/01/2024 8:00 a.m. dose marked as "No pass per vitals" with the annotation "[blood sugar] 60" At approximately 2:00 p.m., Surveyor interviewed Executive Director S and Vice President R. Both confirmed Surveyor's observations of the inconsistent holding versus administration of Resident 17's scheduled insulin dose when his/her blood sugars were in the 60-77 range. Vice President R confirmed s/he did not see a hold parameter in Resident 17's insulin prescription. Vice President R reported remembering having a previous conversation about hold parameters related to insulin administration for residents demonstrating low blood sugar, but wasn't sure why Resident 17 didn't have a hold parameter for staff to follow.	{N 352}		

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{N 352}	Continued From page 9 Example 3 - Resident 6 On 01/02/2024, at approximately 9:15 a.m., Surveyor observed Caregiver F prepare Resident 6's medications at the medication cart as part of the morning medication pass. Caregiver F pulled out a vial from the medication cart and explained that it was for Resident 6's nebulizer treatment. Caregiver F then set up the nebulizing treatment for Resident 6 in his/her room and put his/her mask over his/her face. Caregiver F turned on the machine and left the room. On 01/02/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/21/2023 with diagnoses including Parkinson's disease. Resident 6 was documented as receiving hospice services. Resident 6's prescriptions included the following: - "Ipratropium / Sol[ution] Albuter[ol]" with directions to, "Use 1 vial via nebulizer 4 times daily for 14 days" - Quetiapine 25 mg tablet with directions to, "Take 1/2 tablet (12.5 mg) every 12 hours as needed (Do not crush)" Surveyor reviewed Resident 6's MAR from 12/01/2023 - 01/02/2024. Regarding Resident 6's nebulizer treatment, Surveyor observed administration entries at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Surveyor observed that Resident 6's nebulizer treatment was first administered at 12:00 p.m. on 12/09/2023. Resident 6 was documented as receiving every scheduled dose from 8:00 a.m. on 12/10/2023 through 12/23/2023 (14 days of every administration, in accordance with his/her order.) Resident 6 was also documented as receiving the	{N 352}		

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{N 352}	Continued From page 10 following 33 doses across 7 days (in addition to the 14 days s/he initially received his/her nebulizer treatment): - 12/24/2023: 8:00 a.m. and 8:00 p.m. doses - 12/25/2023 through 12/26/2023: 4 doses each day (8 total) - 12/27/2023: 8:00 a.m., 4:00 p.m., and 8:00 p.m. doses - 12/28/2023 through 12/30/2023: 4 doses each day (12 total) - 12/31/2023: 8:00 a.m., 12:00 p.m., and 4:00 p.m. doses - 01/01/2024: 4 doses - 01/02/2024: 8:00 a.m. dose (in accordance with Surveyor's observation above of the administration) Surveyor reviewed Resident 6's observation notes from 12/01/2023 - 01/03/2024 but did not find any evidence of information regarding the continuation of his/her nebulizer treatment. At approximately 2:00 p.m., Surveyor interviewed Executive Director S and Vice President R. Vice President R confirmed Surveyor's observation that Resident 6's nebulizer treatment order was written for 14 days of treatment. Both Vice President R and Executive Director S reported they were unaware that staff were still administering the nebulizer treatment to Resident 6. Executive Director S reported that it's possible Resident 6's Ipratropium/albuterol vials were delivered in excess than what was prescribed and staff did not pay attention to the 14 days of administration directions in the order. Both confirmed they had no evidence that Resident 6's medical provider ordered his/her nebulizer treatments past 14 days of administration. Vice President R reported s/he put a discontinue order	{N 352}		

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{N 352}	Continued From page 11 in for the medication during the interview with Surveyor. On 01/03/2024, Surveyor again reviewed Resident 6's MAR and observed that on 12/01/2023, Resident 6 was administered his/her PRN Quetiapine at 1:15 p.m. and at 3:40 p.m. (approximately 2.5 hours in between doses.) On 01/03/2024, at approximately 3:47 p.m., Surveyor interviewed Vice President R. Vice President R confirmed Surveyor's observation that it seemed Resident 6 was administered 2 doses of PRN Quetiapine approximately 2.5 hours apart instead of in accordance with his/her prescription, which directed for it to be administered every 12 hours as needed. Vice President R reported that typically there was a red flag in the provider's electronic record system that alerts staff if they were try to administer a medication out of compliance with the prescription. Vice President R reported s/he would look further into this.	{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 resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement	{N 389}		

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{N 389}	Continued From page 12 with the individual service plan. 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) was updated when there was a change in his/her skin care needs. This is a repeat deficiency. See Statement of Deficiency (SOD) V0S813, dated 08/08/2023, SOD V0S812, dated 02/17/2023, and SOD 6W4O11, dated 02/11/2021. Findings include: On 01/02/2024, at approximately 9:01 a.m., Surveyor observed a dry erase board in the staff/med cart room (see Photo 1). The following was documented on the board: "[Resident 6] has a bed sore that popped. Reposition every hour. [Resident 6] also weight blanket goes on top of [him/her] if [s/he] wants it not underneath [him/her]." At this time, Surveyor interviewed Caregiver F about the board. Caregiver F reported that it was where resident updates were sometimes documented by staff. Caregiver F reported that s/he sometimes referenced the board. On 01/02/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/21/2023 with diagnoses including Parkinson's disease. Resident 6 was documented as receiving hospice services. Resident 6's current ISP documented the following in relation to hospice and skin care needs: - Under the "Skin Evaluation" heading: "Observe	{N 389}		

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	111056	A. BUILDING: _____ B. WING _____	R-C 01/03/2024

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{N 389}	Continued From page 13 skin condition with daily dressing and toileting. Full body skin check with showers weekly ... [Resident 6] desires to keep skin intact and free of open areas ...Staff will insure[sic] to complete weekly skin checks and report any concerns to the supervisor." - Under the "Miscellaneous - Nursing Procedures" heading: "Resident is on hospice and has 2 nursing visits per week." There was no evidence of information regarding a current wound or wound care management (including any repositioning needs) in his/her ISP. Surveyor reviewed Resident 6's observation notes from 12/01/2023 - 01/02/2024 and observed the following entries: - 12/10/2023 (1:30 p.m.): "Resident was repositioned at this time ..." - 12/11/2023 (6:30 a.m.): "Resident was checked and repositioned every 2 hours ..." - 12/20/2023 (9:45 p.m.): " ...residents[sic] bed sore did pop, there was no blood. staff[sic] cleaned the area and notified facility director." - 12/21/2023 (1:30 p.m.): "resident used toilet and was rested in [his/her] bed on left side then on [his/her] right side for the bed soar[sic] has popped. cream has been applied to area ..." - 12/26/2023 (5:15 a.m.): " ...Resident was repositioned every 2 hours ..." - 12/27/2023 (6:30 a.m.): "Resident was checked on and repositioned every 2 hours ..."	{N 389}		

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{N 389}	Continued From page 14 At approximately 2:00 p.m., Surveyor interviewed Executive Director S and Vice President of Training and Compliance (Vice President) R. Executive Director S reported that Resident 6's wound seemed to be more of a blister. Both confirmed Surveyor's observations that Resident 6's repositioning needs and information about his/her wound care were not included in his/her ISP. Executive Director S reported that staff are instructed to call hospice for further guidance if Resident 6's wound looks like it's opening more. On 01/03/2024, at approximately 9:17 a.m., Surveyor interviewed Executive Director T, from Resident 6's hospice agency. Executive Director T reported that Resident 6 has a stage 2 pressure ulcer at his/her coccyx and that cares for this were active and provided by a hospice nurse 2 days each week. Executive Director T reported that the care consisted of dressing changes. Executive Director T reported that the provider's staff are expected to call hospice for any changes in Resident 6's wound or if a dressing falls off and needs to be replaced in between nursing visits.	{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	{N 408}		

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{N 408}	Continued From page 15	{N 408}		

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 the individual service plans (ISP) for 2 of 2 residents reviewed included a rationale for use and a detailed description of the behaviors indicating the need for administration of their as-needed (PRN) psychotropic medication.

Resident 16's ISP did not include rationales for use or detailed descriptions of behaviors indicating the need for his/her prescribed PRN Lorazepam or his/her PRN Quetiapine tablets.

Resident 6's ISP did not include rationales for use or detailed descriptions of behaviors indicating the need for his/her prescribed PRN Lorazepam or his/her PRN Quetiapine tablets.

This is a repeat deficiency. See Statement of Deficiency (SOD) V0S813, dated 08/08/2023.

Findings include:

Example 1 - Resident 16

On 01/02/2024, at approximately 10:07 a.m., Surveyor observed the medication cart with Vice President of Training and Compliance (Vice

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{N 408}	Continued From page 16	{N 408}		

President) R. Surveyor observed that Resident 16 had a medication card for PRN Quetiapine 25 mg tablets.

On 01/02/2024, Surveyor reviewed Resident 16's record. Resident 16 was admitted to the provider on 10/06/2023 with diagnoses including vascular dementia and history of cerebral infarction. Resident 16's prescriptions included the following:

- Lorazepam 1 mg tablet: "May take 1 tablet by mouth every 4 hours as needed for anxiety or agitation *hospice patient*"
- Quetiapine 25 mg tablet: "Take 1 tablet by mouth every 8 hours as needed for restlessness & agitation"

Surveyor reviewed Resident 16's current ISP, which, under a "Psychotropic Medication" heading, contained a list of Resident 16's PRN and scheduled psychotropic medications with their corresponding prescription directions (as described above.) There was no evidence of detailed descriptions of behaviors indicating the need for administration of his/her Lorazepam or his/her Quetiapine.

At approximately 2:00 p.m., Surveyor interviewed Executive Director S and Vice President R. Both confirmed that Resident 16's ISP did not contain detailed descriptions of behaviors indicating the need for administration of his/her Lorazepam or his/her Quetiapine. Vice President R reported that s/he had previously documented behaviors in the ISPs of residents who had PRN psychotropic medication but was told by someone else to take them out.

Example 2 - Resident 6

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{N 408}	Continued From page 17 On 01/02/2024, at approximately 10:07 a.m., Surveyor observed the medication cart with Vice President R. Surveyor observed that Resident 6 had a medication card for PRN Quetiapine 25 mg tablets. On 01/02/2024, 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 prescriptions included the following: - Lorazepam 0.5 mg tablet: "Take 1 tablet by mouth every 3 hours as needed for anxiety / agitation / restlessness *hospice patient*" - Quetiapine 25 mg tablet: "Take 1/2 tablet (12.5 mg) every 12 hours as needed." Surveyor reviewed Resident 6's medication administration record (MAR), dated 12/01/2023 - 01/02/2023, and observed 3 administrations of his/her PRN Quetiapine - 2 on 12/01/2023 (1:15 p.m. and 3:40 p.m.) and 1 on 12/24/2023 (8:51 a.m.) Surveyor reviewed Resident 6's ISP, which, under "Psychotropic Medication Management" and "Psychotropic Medications" headings, contained a list of Resident 6's PRN and scheduled psychotropic medications with their corresponding directions (as described above.) There was no evidence of detailed descriptions of behaviors indicating the need for administration of his/her Lorazepam or his/her Quetiapine. At approximately 2:00 p.m., Surveyor interviewed Executive Director S and Vice President R. Both	{N 408}		

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{N 408}	Continued From page 18 confirmed that Resident 6's ISP did not contain detailed descriptions of behaviors indicating the need for administration of his/her Lorazepam or his/her Quetiapine. Vice President R reported that s/he had previously documented behaviors in the ISPs of residents who had PRN psychotropic medication but was told by someone else to take them out.	{N 408}		
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 that at the time of medication administration, the person administering the medication documented the dosage administered. The sliding scale insulin dosage (number of units) administered to Resident 17 was not recorded in his/her medication administration record (MAR) on 56 occasions across 29 days between 12/01/2023 - 01/02/2024 when it would have	N 415		

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N 415	Continued From page 19 been indicated for administration. This is a repeat deficiency. See Statement of Deficiency (SOD) V0S812, dated 02/17/2023. Findings include: On 01/02/2024, Surveyor reviewed Resident 17's record. Resident 17 was admitted to the provider on 10/24/2023 with diagnoses including type 2 diabetes mellitus with diabetic neuropathy. Resident 17's prescriptions included Humalog KwikPen 100 unit/mL with instructions to "Inject 25 units subcutaneously 3 times daily with sliding scale for diabetes mellitus." The corresponding sliding scale was documented as follows: 150 - 185 = 1 unit 186 - 200 = 2 units 201 - 249 = 3 units 250 - 300 = 4 units 301 - 349 = 5 units 350 - 400 = 6 units >400 = Call provider Surveyor reviewed Resident 17's MAR from 12/01/2023 - 01/02/2024 along with his/her vitals history report, where staff appeared to document his/her blood sugar levels. Surveyor observed the following 56 occasions across 29 days in which Resident 17's blood sugar level was within parameters for administration of his/her sliding scale insulin, which was initialed off as administered by staff, but the number of units administered to him/her was not documented: - 12/02/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/03/2023 (8:00 p.m. administration) - 12/04/2023 (12:00 p.m. and 8:00 p.m.	N 415		

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N 415	Continued From page 20 administrations) - 12/05/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/06/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/07/2023 (8:00 p.m. administration) - 12/08/2023 (8:00 p.m. administration) - 12/09/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/10/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/11/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/12/2023 (8:00 a.m. and 8:00 p.m. administrations) - 12/13/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/14/2023 (8:00 a.m., 12:00 p.m., and 8:00 p.m. administrations) - 12/15/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/16/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/17/2023 (8:00 a.m., 12:00 p.m., and 8:00 p.m. administrations) - 12/18/2023 (8:00 a.m., 12:00 p.m., and 8:00 p.m. administrations) - 12/19/2023 (8:00 a.m., 12:00 p.m., and 8:00 p.m. administrations) - 12/20/2023 (8:00 a.m. and 8:00 p.m. administrations) - 12/21/2023 (8:00 p.m. administration) - 12/22/2023 (8:00 p.m. administration) - 12/24/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/25/2023 (12:00 p.m. and 8:00 p.m. administrations) - 12/27/2023 (8:00 p.m. administration) - 12/28/2023 (12:00 p.m. and 8:00 p.m. administrations)	N 415		

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N 415	Continued From page 21 - 12/29/2023 (8:00 a.m., 12:00 p.m., and 8:00 p.m. administrations) - 12/30/2023 (8:00 a.m., 12:00 p.m., and 8:00 p.m. administrations) - 12/31/2023 (8:00 p.m. administration) - 01/02/2024 (12:00 p.m. administration) At approximately 2:00 p.m., Surveyor interviewed Executive Director S and Vice President of Training and Compliance (Vice President) R. Vice President R reported that s/he remembered discussing having the number of sliding scale insulin units documented in applicable residents' charts in the past, but wasn't sure why this didn't happen for Resident 17's MAR. Vice President R reported during the interview with Surveyor that s/he had just changed Resident 17's MAR to prompt staff to document the number of sliding scale units administered going forward.	N 415		