STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OAK PARK PLACE WAUWATOSA	1621 RIVERS BEND WAUWATOSA, WI 53226

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{N 000}	Initial Comments On 08/21/2025, Surveyor concluded a verification visit and two complaint investigations at Oak Park Place Wauwatosa for Statement of Deficiency (SOD) W0M016 and G24S11. Six deficiencies were identified. Two deficiencies were repeat deficiencies. See SOD W0M016, dated 01/31/2025. Two deficiencies were being cited for the third time. See SOD W0M013, dated 10/25/2022, W0M015, dated 05/08/2024 and W0M016, dated 01/31/2025. One deficiency was being cited for the fourth time. See SOD W0M013, dated 10/25/2022, W0M015, dated 05/08/2024 and W0M016, dated 01/31/2025. Two complaints were substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 67	{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:	N 352		

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

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N 352	Continued From page 1 Based on record review and interviews, the provider did not ensure each resident received all prescribed medications in the dosage and at the intervals prescribed by a practitioner for 1 of 1 resident (Residents 25). Resident 25's after visit summary, dated 03/31/2025, indicated s/he was to discontinue five medications. From 03/31/2025 to 4/17/2025 Resident 25 received five medications that were discontinued for an additional seventeen days. This requirement is being cited for the third time. See Statement of Deficiency (SOD) W0M013, dated 10/25/2022 and W0M015, dated 05/08/2024. Findings include: On 04/25/2025, the department received a complaint alleging a resident was receiving medications that had been discontinued by his/her physician. On 07/21/2025 at approximately 12:15 p.m., Surveyor reviewed Resident 25's record. The following was identified: Resident 25 was admitted on 03/26/2025. Resident 25 was discharged on 04/29/2025. Resident 25's diagnoses included cancer diagnosis, Parkinson-type symptoms, history of urinary tract infections (UTI), Foley catheter, basal cell carcinoma of skin, malignant neoplasm of breast and hyperlipidemia. Resident 25's assessment, dated 03/26/2025, identified Resident 25 required assistance up to 4 times a day with medications. Resident 25 used the facility approved medication packaging	N 352		

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system.

Resident 25's Individualized Service Plan (ISP), dated 03/26/2025, stated Resident 25 was unable to self-administer all medications. Resident 25's goal was to receive medications safely and as prescribed. The ISPs interventions/tasks read, "Medications will be administered at the preferred time(s) as order by the PCP (primary care physician)." Date initiated: 03/26/2025.

Resident 25's ISP, dated 04/25/2025, stated Resident 25 was unable to self-administer all medications. Resident 25's goal was to receive medications safely and as prescribed. The ISPs interventions/tasks read, "Medications will be administered at the preferred time(s) as order by the PCP (primary care physician). PRN (as needed) medications will be administered following the parameters given by the PCP and at the resident's request." Date initiated: 04/25/2025.

Resident 25's after visit summary (AVS), dated 03/31/2025, from ProHealth Care Hospital, had a handwritten note on the top of the page, that read, "3/31-med update." The AVS provided instruction from Physician (MD) MM to, "Stop taking these medications:

- Cholecalciferol 1000-unit tablets (Commonly known as: Vitamin D3).
- Cyanocobalamin 1000 mcg (micrograms) tablets (Commonly known as: Vitamin B12).
- Multivitamin Oral Tablet.
- Rosuvastatin 10 mg tablets (Commonly known as: Crestor or Calcium).
- Thiamin 100 mg (milligrams) (Commonly known as: Vitamin B1)."

Resident 25's after visit summary from Urology

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N 352	Continued From page 3 Associate Wauwatosa, dated 04/01/2025, identified these medications were removed from Resident 25's medication list: - Cholecalciferol 1000-unit tablets (Commonly known as: Vitamin D3). - Cyanocobalamin 1000 mcg (micrograms) tablets (Commonly known as: Vitamin B12). - Multivitamin Oral Tablet. - Rosuvastatin 10 mg tablets (Commonly known as: Crestor or Calcium). - Thiamin 100 mg (milligrams) (Commonly known as: Vitamin B1). The April 2025 Medication Administration Record (MAR) indicated the following orders and staff documentation for Resident 25: - Multivitamin Oral Tablet. Give 1 tablet by mouth one time a day for supplement. Scheduled for 7:00 a.m. Start date: 03/27/2025. D/C (Discontinue) date: 04/17/2025. - Rosuvastatin Calcium Oral Tablet 10 mg (milligrams), scheduled for 7:00 p.m. Give one tablet by mouth at bedtime for hyperlipidemia. Start date: 03/26/2025. D/C date: 04/17/2025. - Vitamin B1 Oral Tablet 100 mg (milligrams), scheduled for 7:00 a.m. Start date: 03/27/2025. D/C date: 04/17/2025. - Vitamin B12 Oral Tablet Extended Release 1000 mcg (micrograms), scheduled for 7:00 a.m. Start date: 03/27/2025. D/C date: 04/17/2025. - Vitamin D3 Oral Tablets 25 mcg (micrograms) (1000 UT), scheduled for 7:00 a.m. Start date: 03/27/2025. D/C date: 04/17/2025. The Medication Pass History for Resident 25 from 04/01/2025 - 04/28/2025 at 7:00 am., indicated the following orders and staff	N 352		

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N 352	Continued From page 4	N 352		

documentation:

- Multivitamin Oral Tablet. Give 1 tablet by mouth one time a day for supplement. Scheduled for 7:00 a.m. Resident 25 was administered 14 doses at 7 a.m. between 04/01/2025 and 04/15/2025, when s/he was in the facility.
- Vitamin B1 Oral Tablet. Scheduled for 7:00 a.m. Resident 25 was administered 14 doses at 7 a.m. between 04/01/2025 and 04/15/2025, when s/he was in the facility.
- Vitamin B12 Oral Tablet Extended Release. Scheduled for 7:00 a.m. Resident 25 was administered 14 doses at 7 a.m. between 04/01/2025 and 04/15/2025, when s/he was in the facility.
- Vitamin D3 Oral Tablets 25 MCG (1000 UT). Scheduled for 7:00 a.m. Resident 25 was administered 14 doses at 7 a.m. between 04/01/2025 and 04/15/2025, when s/he was in the facility.

The Medication Pass History for Resident 25 from 04/01/2025 - 04/28/2025 at 7:00 p.m., indicated the following orders and staff documentation:

- Rosuvastatin Calcium Oral Tablet. Give one tablet by mouth at bedtime for hyperlipidemia. scheduled for 7:00 p.m. Resident 25 was administered 16 doses at 7 p.m. between 04/01/2025 and 04/15/2025, when s/he was in the facility.

On 07/29/2025 at approximately 8:15 a.m., Surveyor reviewed Resident 25's Facility Progress Notes from 03/26/2025 - 03/31/2025. The following was identified:

-On 04/23/2025 at 3:21 p.m., Director of Nursing

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N 352	Continued From page 5 (DON) EE wrote, "Writer spoke with [Hospice Nurse PP] from Agrace Hospice. [Hospice Nurse PP] just got off the phone with Guardian Pharmacy and that they just 'discontinued a bunch of [Resident 25's] meds (medications), so now the pharmacy has an updated med list'. [sic] Writer will contact pharmacy to get an updated med [sic] list, as Agrace hospice was unable to provide one." -On 04/24/2025 at 12:33 p.m., DON EE wrote, "LATE ENTRY. Updated and signed med (medication) list received and uploaded in system." On 07/22/2025, at 7:35 a.m., Surveyor emailed DON EE and requested when s/he implemented the April 1st medication change from physician (MD) MM. On 07/22/2025, at 8:17 a.m., DON EE wrote, "The medication list on the AVS, unless signed by the provider are not guaranteed correct because his/her medications may not have been verified at the office. When the AVS does not say "Continue taking these medications" or "Stop taking these medications" it typically means that his/her medication list wasn't verified at the providers office. On the discharge summary from April 17, 2025, it clearly states the medication changes, which is when we made the adjustments." On 07/22/2025 at 9:50 a.m., Surveyor received and reviewed Resident 25's Hospice Documentation. Surveyor reviewed Hospice encounter history. The following was identified: - On 04/17/2025, Hospice Intake/Admission completed	N 352		

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N 352	Continued From page 6 - On 04/23/2025 at 5:42 p.m., Family OO notified Hospice Nurse (HRN) PP that medications that had been discontinued were still on Resident 25's medication list. H RN PP placed telephone call to Guardian Pharmacy, who confirmed they never received an updated medication list or were told what medications were discontinued. HRN PP's note read, "Requested Health Information Management (HIM) to fax med (medication) list to pharmcy [sic]. Called back pharmacy and requested they Dc (discontinue) the meds not on him/her list. Called [MD MM] and confirmed the DC of the incorrect meds. Updated [Family OO]." - 04/26/2025 [Resident 25] expired at home. Interviews On 07/21/2025, at 11:00 a.m., Surveyor interviewed DON EE and Director of Housing (DOH) AA, who stated Family OO was upset because Resident 25 was still getting medications that MD MM took him/her off on 3/31/2025. DOH AA believed Resident 25 saw his/her physician on 04/01/2025. However, Family OO did not provide documentation to the facility. DON EE stated, "I never received a call, I never received a fax or an order to change [Resident 25's] medications. We had no idea if there were changes." DOH AA stated the resident has the right to go out to physician's appointments independently. Surveyor questioned DON EE and DOH AA what system was in place to capture changes from physician appointments, when residents go with family or independently. DON EE and DOH AA were unable to answer the question. DOH AA stated HRN NN and HRN PP straightened out the medications for them. DOH EE stated, "We were so grateful s/he hashed the medications out for us. S/He was like a mediator between us and	N 352		

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N 352	Continued From page 7 [Family OO]." On 07/21/2025, at 3:10 p.m., Surveyor interviewed Regional Nurse (RRN) Q and DOH AA, who stated the situation with Resident 25 was one of an overly involved family member. S/He stated, "We did the best we could for [Resident 25] and for [Family OO]. DOH AA confirmed medication discrepancy. DOH AA stated s/he could not speak to what happened and why DON EE missed the medication error. On 07/22/2025, at 10:35 a.m., Surveyor interviewed HRN NN, who stated, when s/he was doing the intake for Resident 25 on 04/17/2025, s/he discovered medication discrepancies. HRN NN stated, "There were definitely challenges with the medications." HRN NN stated s/he had to do a complete audit to be sure all the medications were correct. HRN NN stated, "[DON EE] had the 03/31/2025 after visit summary from ProHealth Care Hospital with the changes." On 08/01/2025, at 2:50 p.m., Surveyor interviewed DOH AA, who stated DON EE had been terminated. "S/He was not good at charting, and it hurt us."	N 352		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal	N 387		

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N 387	Continued From page 8 illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 1 of 1 resident record reviewed (Resident 26). This requirement is being cited for the fourth time. (See Statement of Deficiency (SOD) W0M013, dated 10/25/2022, and SOD W0M015, dated 05/08/2024 and W0M016, dated 01/31/2025). Findings include: On 07/22/2025 at 12:26 p.m., Surveyor received Resident 26's file from Director of Housing (DOH) AA via email. The following was identified: Resident 26 was admitted on 03/15/2024. Resident 26 was admitted with diagnoses including anxiety disorder and dementia. Resident 26 had an activated healthcare power of attorney (AHCPOA) QQ since 03/07/2023. Resident 26 transferred to Memory Care on 03/01/2025.	N 387		

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N 387	Continued From page 9 Resident 26's Individualized Service Plan (ISP) was revised on 05/14/2025. The ISP was not signed by Resident 26's Activated Health Care Power of Attorney (AHCPOA) QQ. On 7/22/2025 at 10:15 a.m., Surveyor requested updated assessment and ISP upon move into Memory Care. On 08/01/2025 at 9:23 a.m., Surveyor received an email from Resident 26's AHCPOA QQ, who confirmed, "I never received a care plan upon his/her move-in to memory care, nor did I receive one when s/he was originally admitted in 2024." Resident 26's ISP was not updated to reflect his/her change in condition and transfer to Memory Care on 03/01/2025. Resident 26's ISP was dated 05/14/2025, over 2½ months after his/her move and was updated after Resident 26 eloped. The ISP was not signed by Resident 26's AHCPOA QQ. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 387		
{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	{N 389}		

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{N 389}	Continued From page 10 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 and interview, the provider did not ensure each resident's individual service plan (ISP) was updated when there was a change in resident's needs, abilities or physical or mental condition for 1 of 1 resident (Resident 26). On 05/14/2025, Resident 26's ISP was revised. S/He had a fall on 05/11/2025, that resulted in a left, fractured patella (knee). On 05/14/2025, Resident 26 received a full leg/knee immobilizer. The ISP did not identify the specific interventions and approaches that Resident 26 required with his/her leg immobilizer, the specified methods for delivering care needed and the measurable goals to minimize Resident 26's fall risk. This requirement is being cited for the third time. See Statement of Deficiency W0M015 on 05/08/2024, and W0M016, dated 01/31/2025. Findings include: On 07/22/2025 at 12:26 p.m., Surveyor received Resident 26's file from Director of Housing (DOH) AA via email. The following was identified: Resident 26 was admitted on 03/15/2024. Resident 26 was admitted with diagnoses including anxiety disorder and dementia. Resident 26 had an activated healthcare power of attorney (AHCPOA) QQ since 03/07/2023. Resident 26 transferred to Memory Care (MC) on 03/01/2025.	{N 389}		

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Resident 26's admission assessment, dated 03/18/2024, identified, "Cognition. Resident is not always oriented to person, place or time. Focus. Resident has a decline in cognition. Goal. Resident will be provided a safe and secure environment. Intervention. Resident will be re-oriented as needed. Does the resident require assistance with re-direction and orientation. Yes ... Mobility needs. Resident is independent ...Does not use of an ambulatory devise ...Does not require assistive devises to transfer to bed, chair, or toilet ... Safety and risk. Is the resident at risk for elopement? No." Surveyor observed section titled, "Falls," had no markings of whether the resident was or was not a fall risk.

On 07/22/2025 at 10:15 a.m., Surveyor requested all assessments completed after Resident 26 moved into MC and fall with injury on 05/11/2025. Director of Housing (DOH) AA provided Surveyor with the following assessments:

On 05/12/2025, a pain tool assessment was completed for Resident 26. For each pain location site listed there was also a description of the pain. The following was identified, "Right knee (front), abrasion. Left knee (front), bruising. Face, abrasion on forehead, left cheek, upper lip and below nose. Left shoulder (front), bruising ... What makes pain better. Rest and ice on left knee. What makes pain worse. Putting weight on left knee ...Describe all methods of alleviating pain and their effectiveness. Ice, rest, medication, and leg immobilizer."

On 05/14/2025, Director of Nursing (DON) EE conducted Resident 26's wandering assessment. The following was identified, "Orientation, disoriented (x3 ...). Behavior/mood, does not understand surroundings. Recent experiences,

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{N 389}	Continued From page 12	{N 389}		

room change. Mobility, independent (no assist). Diagnosis, early dementia ... History of wandering, known wanderer/hx (history) of wandering."

On 05/14/2025, DON EE conducted Resident 26's Morse Fall Assessment. It read, "History of Falling. Has the Resident ever fallen before? Yes. Secondary Diagnosis. Does the resident have more than one diagnosis on the chart? Yes. Ambulatory Aid. What ambulatory aides, if any, does the resident use? Uses crutches, cane or walker. Gait. What type of gait does resident exhibit? Impaired. (Defined as difficulty rising from chair, uses chair armes to get up, bounces to rise, keeps head down when walking, watches the ground, grasps furniture, person or aid when ambulating. Cannot walk unattended.) Mental Status. Does resident's response to, 'Are you able to go to the bathroom alone or do you need assistance' indicate they know the limits of their abilities to ambulate safely? Overestimates or forgets limits."

Surveyor did not receive an assessment for change in condition when transferred to Memory Care (MC) on 03/01/2025.

ISP

Resident 26's ISP, revised on 05/14/2025, identified Resident 26 required the use of a walker and left leg immobilizer to maximize independence with mobility. Resident 26 was identified as having a decline in cognition and being at risk of falls. Resident 26's ISP did not include information on his/her level of supervision. Resident 26's ISP did not include information on Resident 26 requiring any staff assistance with leg immobilizer; how to put it on,

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{N 389}	Continued From page 13 how to take it off, when s/he should and should not wear it or what interventions staff needed to assist Resident 26 with to reduce the risk of falling. There was no information or instructions on when Resident 26 needed to use the walker. Resident 26's ISP identified him/her as an elopement risk. "[Resident 26] will not leave community unattended." On 05/12/2025, The ISP was updated with interventions: "Distract [Resident 26] from wandering by offering pleasant diversions (gardening and watercolors), structured activities, food, conversation, television, and books." On 07/02/2025, Surveyor reviewed a self-report submitted by the director of Housing (DOH) AA to the Department on 05/16/2025 regarding fall. The report stated, "Incident description: [Resident 26] was assisted to bathroom by [Director of Nursing (DON) EE] and [Medical Assistant B]. [Resident 26] demanded privacy and staff stood at doorway when resident stood up and fell hitting his/her head on door stop [sic] causing a laceration. EMS notified, Bluestone notified and [AHCPOA QQ]). Incident Outcome: [Resident 26] was sent via EMS to Froedtert (hospital) for eval (evaluation). Action taken to ensure residents health, safety, and wellbeing: [Resident 26] Had knee immobilizer but was insistent that staff not be in the bathroom. When resident returns from hospital will reassess and implement supervision for toileting needs." Fall Report On 05/16/2025 at 11:15 a.m., DON EE completed a witnessed fall report. The nursing description indicated Resident 26 attempted to get up from the toilet and lost his/her balance and fell. Resident 26 hit his/her head on the doorstop.	{N 389}		

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{N 389}	Continued From page 14 DON EE addressed the headwound/laceration on the top of Resident 26's scalp and contacted AHCPOA QQ, who agreed to send Resident 26 out for additional evaluation. DON EE indicated Resident 26 had no injuries observed post incident, s/he was oriented to person, confused, had gait imbalance and transferred without assist. Progress Notes On 05/16/2025 at 12:30 p.m., DON EE wrote, "LATE ENTRY. [Resident 26] had fall today from the toilet onto the floor, with two caregivers present. Laceration on forehead from hitting doorstop..[sic] it appears the entire impact was to his/her left side. [AHCPOA QQ] notified, writer requested resident be sent to ER (emergency room) for evaluation. While waiting for Bell ambulance to arrive, [Resident 26] became much more disoriented and weak [sic] and was leaning to left side and not able to move his/her left arm. While waiting on the ambulance s/he became very pale, his/her breaths were very shallow, and his/her eyes kept rolling back. S/He was unable to stay alert and wasn't responding to pain stimuli. At that time writer called 911, while on the phone with EMS, Bell arrived with two paramedics [sic] so writer canceled the 911 and they felt it was best to transport to Froedtert due to his/her condition at the time. PCP (primary care physician) notified." Interviews On 07/22/2025, at 9:50 a.m., Surveyor interviewed Director of Housing (DOH) AA. Surveyor inquired what fall interventions were in place with Resident 26. DOH AA reported Resident 26 was ambulatory and independent. Resident 26 had two back-to-back incidents. The	{N 389}		

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{N 389}	Continued From page 15 first incident, s/he eloped and fell on the concrete, breaking his/her left knee. S/He had a full leg immobilizer after that. (DOH) AA stated, "[Resident 26] kept trying to take it on and off. S/he was confused, and s/he didn't understand." The second incident happened a week later. DOH AA stated, "[Resident 26] was in the bathroom, with the door open and the leg immobilizer on, and s/he fell. Staff reported they were in the hallway because s/he insisted." On 07/29/2025, at 10:23 a.m., Surveyor interviewed Medical Assistant VV, who described Resident 26 as anxious. Medical Assistant VV stated, "It's safe to say that Memory Care is considered 24-hour supervision. [Resident 26] displayed elopement behaviors way before s/he came into Memory Care. One night s/he left, and we couldn't find him/her. We got a call from a motel in Brookfield saying s/he was there asking if it was his/her home. [DON EE] knew s/he had elopement issues. [Resident 26] also went down to the police station often, complaining how someone stole his/her car." On 07/29/2025, at 1:40 p.m., Surveyor interviewed Caregiver RR, who explained Resident 26 had moments of exit seeking behaviors. Caregiver RR stated, "Most of the time, s/he would try to leave. S/He would pace back and forth. Immediately when s/he moved into Memory Care, s/he was trying to elope. That time s/he got up to the theme park and feel in the street, that wasn't his/her first time." Caregiver was unable to identify other dates of elopements. Caregiver RR stated, "We would try to redirect him/her, talk with him/her, keep him/her busy. We always told [DON EE]."	{N 389}		

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{N 426}	Continued From page 16	{N 426}		
{N 426}	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the community based residential facility (CBRF) did not provide supervision appropriate for resident needs to prevent elopement for 1 of 1 resident (Resident 26). On 05/11/2025, Resident 26 eloped, had a fall, which resulted in a left, fractured patella (knee). Resident 26 was admitted on 03/15/2024. Resident 26 transferred to Memory Care on 03/01/2025. On 5/11/2025, Resident 26 eloped from a secured and alarmed Memory Care unit and was found at the end of the street, on the ground with a left, fractured patella (knee). This is a repeat deficiency. See Statement of Deficiency (SOD) W0M016, dated 01/31/2025. Findings include: On 05/29/2025, the department received a complaint alleging concerns regarding supervision for residents.	{N 426}		

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{N 426}	Continued From page 17 Observation On 07/21/2025, at 12:33 p.m., Surveyor parked at area business where Resident 26 was found after elopement on 05/11/2025. Surveyor conducted an address search from 1435 N 113th St, Wauwatosa to 1621 Rivers Bend, Wauwatosa. Resident 26 was 0.3 miles and a 7-minute walk away from the facility. On 07/21/2025, at 1:00 p.m., Surveyor toured the facility. The facility was comprised of 3 floors. The memory care was located on the 2nd floor. Record Review On 07/22/2025 at 12:26 p.m., Surveyor received Resident 26's file from Director of Housing (DOH) via email. The following was identified: Resident 26 was admitted on 03/15/2024. Resident 26 was admitted with diagnoses including anxiety disorder and dementia. Resident 26 had an activated healthcare power of attorney (AHCPOA) since 03/07/2023. Resident 26 transferred to Memory Care on 03/01/2025. On 07/22/2025, Surveyor reviewed a self-report submitted by the DOH AA to the Department on 05/12/2025 regarding Resident 26's elopement. The report stated, "Incident description: At approximately 08:30a [Caregiver FF] and [Caregiver BB] were assisting residents with breakfast. [Medical Assistant B] was administerring [sic] morning meds (medications) to MC (memory care) residents. All staff were in the MC dining room providing assistance. [Caregiver FF] walked to the nurses	{N 426}		

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station to grab gloves and heard the south stairwell door alarm sounding. S/He and the other staff present began conducting a head count and found [Resident 26] was not in the MC unit. AL (assisted living) staff notified the front reception desk and began an exterior search. [Resident 26] was located at the end of the street by [Activity Assistant LL] as s/he saw resident on the ground while driving by. EMS (emergency medical services) was contacted. Incident Outcome: [Resident 26] was evaluated by EMS. Abrasions to face and skinned knees due to fall on pavement. EMS contacted POA (power of attorney [AHCPOA QQ]) and declined to have resident evaluated at hospital. [Resident 26] was transported back to community and was evaluated and assessed by Director of Nursing (DON) EE. [Physician ZZ] notified and will evaluate as well. Action taken to ensure residents health, safety, and wellbeing: Secondary alarm placed on South Stairwell with a louder alarm to be heard. Frequent checks on residence by care staff. Outcome: Elopement. Resident return to facility, reassessed and interventions put in place."

Facility Fall Report

On 05/11/2025 at 8:30 a.m., Caregiver BB completed an unwitnessed fall report. The report read, "Incident location: Outside. Incident description. Nurse called, unwitnessed fall. Level of Pain: 10. Level of Consciousness: Lethargic (drowsy). Predisposing physiological factors. Impaired memory. Predisposing situation factors. Active exit seeker. Predisposing situation factors. Wanderer."

On 05/11/2025 at 8:30 a.m., [Medical Assistant B] completed an unwitnessed fall report. The report

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read, "Incident location: Outside." Medical Assistant B wrote as s/he was passing medications in the memory care dining room; another caregiver notified him/her that the alarm for back door in memory care was going off, and they were unable to locate Resident 26. Caregivers searched inside of entire building. Medical Assistant B searched outside and around the facility. Medical Assistant B wrote, " ... was informed by [Activity Assistant LL] that while driving into work they saw [sic] what appeared to be an old wo/man laying [sic] in the street by Spin City (Action Park). Writer drove to location. Upon arrival [sic] writers saw another caregiver, [Resident 26], fire department and two unknown pedestrians. Predisposing physiological factors. Impaired memory, gait imbalance, incontinence and confused. Predisposing situation factors. Active exit seeker, ambulating without assistance. Predisposing situation factors. Wanderer." Medical Assistant B also indicated Resident 26 sustained lacerations to face.

On 05/12/2025, Resident 26's X-ray patient report from Rapid Radiology, read, "Swelling and bruising after fall, pain ... Findings: Significant Findings. Left Knee ...There is an acute-appearing fracture of the patella. There is a mild displacement of the distal fragment."

On 05/13/2025, DON EE sent an order to Bluestone Physicians, and requested immediate orthopedic referral due to, "Left patella fracture, fall on concrete on 5/11/2025 and left patella- mild displacement of the distal fragment."

On 05/14/2025, Bluestone notes indicated Resident 26 was taken to urgent orthopedic clinic for evaluation.

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{N 426}	Continued From page 20 Interviews On 07/29/2025, at 10:23 a.m., Surveyor interviewed Medical Assistant VV, who described Resident 26 as anxious. Medical Assistant VV stated, "It's safe to say that Memory Care is considered 24-hour supervision. [Resident 26] displayed elopement behaviors way before s/he came into Memory Care. One night s/he left, and we couldn't find him/her. We got a call from a motel in Brookfield saying s/he was there, asking if it was his/her home. [DON EE] knew s/he had elopement issues. [Resident 26] also went down to the police station often, complaining how someone stole his/her car." Medical Assistant VV stated s/he was working the day Resident 26 eloped. Staff was serving breakfast, and s/he was giving medication. Resident 26 utilized the back stairwells to elope. Staff did not know where s/he went. An activity aid came in to work and told staff s/he saw an older adult in the road. Medical Assistant VV stated DON EE told staff to watch him/her more, but did not change his/her care plan. On 07/29/2025, at 1:40 p.m., Surveyor interviewed Caregiver RR, who explained Resident 26 had moments of exit seeking behaviors. Caregiver RR stated, "Most of the time, s/he would try to leave. S/He would pace back and forth. Immediately when s/he moved into Memory Care, s/he was trying to elope. That time s/he got up to the theme park and fell in the street, that wasn't his/her fist time." Caregiver was unable to identify other dates of elopements. Caregiver RR stated, "We would try to redirect him/her, talk with him/her, keep him/her busy. We always told [DON EE]." Caregiver RR confirmed they did not put information in database, they just provided verbal reports to leadership.	{N 426}		

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{N 426}	Continued From page 21 On 08/01/2025 at 9:23 a.m., Surveyor received an email from Resident 26's AHCPOA QQ, who stated, "I was never informed of any elopement issues after [Resident 26] was moved into memory care." On 08/14/2025 at 11:13 a.m., Surveyor interviewed DOH AA and Regional Nurse (Regional RN) Q, who explained the staff followed the elopement policy after Resident 26 eloped. A bystander found Resident 26 lying in the road. Resident 26 was bruised and bloody. Regional RN Q, stated, "The policy was not amended after the incident. The policy is solid." DOH AA and Regional RN Q explained that after the incident, they re-educated the staff and explained the strict adherence to the policy. They explained that there were other interventions that could have been in place. However, DON EE was no longer at the facility, and DOH AA stated s/he could not speak to the interventions. Surveyor questioned if interventions would have been in the service plan. DOH AA stated, "I suppose."	{N 426}		
N 438	83.38(2)(c) Terminally ill: coordinated plan of care The primary care provider and the CBRF shall develop a written, coordinated plan of care before the initiation of palliative or supportive care. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not develop a written, coordinated plan of care before the initiation of skilled nursing services or supportive companion care with 2 of 2 agencies for 1 of 1 resident reviewed (Residents 25).	N 438		

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N 438	Continued From page 22 Resident 25 received Always Best Care (ABC) companion services between the dates of 03/31/2025 to 04/26/2025. Resident 25 received (Preceptor) Home Health and Hospice skilled nursing, physical therapy, occupational therapy and medical social work services from 03/30/2025 to 04/17/2025. The provider did not develop a written, coordinated plan of care before the initiation of supportive care with ABC companion services or Preceptor Home Health Care while Resident 25 resided at facility. Findings include: On 07/21/2025 at approximately 12:15 p.m., Surveyor reviewed Resident 25's record. The following was identified: Resident 25 was admitted on 03/26/2025. Resident 25 was discharged on 04/29/2025. Resident 25's diagnoses included recent cancer diagnosis, Parkinson-type symptoms, history of urinary tract infections (UTI), Foley catheter, basial cell carcinoma of skin, malignant neoplasm of breast and hyperlipidemia. Resident 25's assessment, dated 03/26/2025, identified Resident 25 required supervision and/or assistance with bathing, dressing, oral care, nail care, foot care and toileting. Resident 25's assessment identified s/he had a catheter and required staff assistance. Resident 25's assessment did not identify additional supportive companion care services or skilled nursing services being planned for him/her upon admission. Resident 25's Individualized Service Plan (ISP), dated 03/26/2025, did not include a coordinated plan of care with (ABC) companion services or	N 438		

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N 438	Continued From page 23 (Preceptor) Home Health and Hospice skilled nursing, physical therapy, occupational therapy and medical social work services. Resident 25's ISP, dated 04/25/2025, did not include a coordinated plan of care with (ABC) companion services. Resident 25's record did not include a developed, written and coordinated plan of care between the CBRF and ABC companion services or Preceptor before the initiation of Resident 25's skilled nursing services or companion care. On 07/23/2025 at 11:15 a.m., Surveyor reviewed Resident 25's Preceptor documentation. The following was identified: On 03/30/2025, Resident 25 signed the patient acknowledgement and consent with Preceptor services. Resident 25 received services from 03/30/2025 to 04/17/2025. Resident 25's home heath certification and plan of care stated Resident 25 would receive, "Frequency/Duration of Visits: SN 1WK2,1Q2WK6,1WK1, PT 1WK1. 2WK2,1WK3. OT 1WK5. ST 1WK1. MSW 1WK1,1Q2WK4." On 08/19/2025 at 8:59 a.m., Surveyor received an email from Preceptor Clinical Services Manager (PCSM) TT. S/He defined the 'Frequency/Duration of Visits' found on Resident 25's plan of care, "Skilled nursing to see patient once weekly for two weeks then every other week for six weeks. Physical therapy to see patient once weekly for one week, twice weekly for two weeks and then once weekly for three weeks. Occupational therapy to see patient once weekly for five weeks. Speech therapy to see patient once weekly for one week. Social work to see	N 438		

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N 438	Continued From page 24 patient once weekly for one week then every other week for four weeks." On 07/29/2025 at 10:30 a.m., Surveyor reviewed Resident 25's ABC companion services documentation. The following was identified: On 03/28/2025, Resident 25 signed a client service agreement with ABC companion services. Resident 25 received services between the dates of 03/31/2025 to 04/26/2025. On 03/28/2025, Resident 25's ABC assessment and care plan indicated Resident 25 needed assistance in the following areas, "Continence. Self-control of urination and defecation. Task: change adult undergarments. Check and change every two hours, or as needed. All shifts. All days. Dressing/Grooming. Picking clothes, managing fasteners, combing hair, shaving, toothbrushing. Task: Assist with dressing, brush hair, brush teeth. All shifts. All days. Eating. Feeding self, buttering bread, cutting food. Task: Assist client with meal. All shifts. All days. All shifts. All days. Comfort. Provide comfort and emotional support to loved ones. Companionship. Playing games, watching tv, reading newspaper. Laundry. Cleaning, ironing, folding, and putting away clothes. Notes: Offer to do laundry as needed. Task: Do laundry. All shifts. All days. Preparing Meals. Opening containers, cooking and serving. Task: Clear dishes, prepare meal, prepare snack. All shifts. All days. On 08/07/2025 at 12:45 p.m., Surveyor reviewed Resident 25's care tracking sheets from ABC companion services. Resident 25 received a total of 33 companion shifts between the dates of 03/31/2025 to 04/26/2025. The services rendered were dressing: 33 times, brushing hair: 33 times,	N 438		

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	0014395	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

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N 438	Continued From page 25	N 438		

brushing teeth: 33 times, changing adult undergarments: 31 times, doing laundry: 33 times, clearing dishes: 34 times, preparing snacks: 30 times, and preparing meals: 33 times.

Interviews

On 07/21/2025 at 11:00 a.m., Surveyor interviewed Director of Nursing (DON) EE, who stated Resident 25 moved in with Preceptor already in place. DON EE acknowledged Preceptor was not in Resident 25's initial ISP.

On 07/21/2025 at 1:05 p.m., Surveyor interviewed DON EE, who confirmed Resident 25's file did not contain a care plan for ABC companion services or a care plan for Preceptor.

On 07/22/2025, Surveyor interviewed Caregiver RR, who stated facility caregivers used Resident 25's care plan as a guide to provide care. Caregiver RR stated, "Sometimes it was confusing. The cross-over between us and the companion agency."

On 08/14/2025 at 9:45 a.m., Surveyor interviewed Owner Always Best Care (OABC) VV, who stated Resident 25's Family (FA) OO hired the company to provide companion care. "When we started, we introduced ourselves to [DON EE]. I also spoke with [Director of Housing (DOH) AA]. However, no one ever initiated a coordinated care plan. We had challenges from the start. No one ever knew what to do or who did what. The first time we were in there, the facility caregivers told our caregivers they had to do everything. There was little to no collaboration."

On 08/14/2025 at 11:25 a.m., Surveyor interviewed Regional Nurse (Regional RN) Q and

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N 438	Continued From page 26 DOH AA, who stated Preceptor Home Health Care and ABC companion agency were initiated before Resident 25 moved in. DOH AA stated s/he understood Resident 25's care plan was not implemented according to the code. DOH AA stated, "We need to figure out a better system for coordinating all of care plans in the future." On 08/19/2025 at 8:30 a.m., Surveyor interviewed Preceptor Clinical Service Manager (PCSM) TT and Nurse Clinical Services Manager (RNCSM) UU from Preceptor. On 03/25/2025, Resident 25 was in transition from the hospital emergency room to the facility. Physician (MD) YY sent a referral to Preceptor for short term catheter care upon move-in at facility. Nurse Clinical Services Manager (RNCSM) UU stated, "I see in my notes that we called the facility on 03/26/2025 at 3:57 p.m., to advise we would be starting care." RNCSM UU confirmed facility did not return call or attempt to coordinate care for Resident 25.	N 438		
{N 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 3 of 3 areas. This is a repeat deficiency. See Statement of Deficiency (SOD) W0M016, dated 01/31/2025. Findings include:	{N 499}		

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{N 499}	Continued From page 27 The facility was licensed on 11/01/2013 to serve up to 75 residents in client groups of advanced aged, physically disabled, and irreversible dementia/Alzheimer's. On 07/29/2025, at approximately 3:40 p.m., Surveyor toured the facility and observed the following: Memory Care Staff Desk At 3:48 p.m., Surveyor observed on the staff desk, 1 container of Sani-Cloth germicidal wipes and a bottle of Clorox toilet bowl cleaner with bleach. Caregiver JJ, who sat behind the staff desk, told Surveyor it had been there since s/he started his/her shift at 2:30p.m. Caregiver JJ stated it was supposed to be in the spa room, locked up. Memory Care Bathroom At 3:50 p.m., Caregiver II informed Surveyor, the bathroom in the middle of the memory care hallway was a public bathroom. Surveyor entered the bathroom and observed a 19-ounce spray can of Kaboom with OxiClean on the bathroom counter. Caregiver II stated, "That's not supposed to be there." Memory Care Activity Room At 3:52 p.m., Surveyor observed Activity Assistant KK, Activity Assistant LL and one resident, working on a puzzle in the memory care activity room. Surveyor observed a cabinet over the activity room sink, with a lock. Surveyor opened the cabinet door and observed a spray bottle of Clorox cleaner with bleach. At 3:54 p.m., Surveyor interviewed Activity Assistant KK, who stated, "That should be locked	{N 499}		

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{N 499}	Continued From page 28 up. I don't know why it is not." Surveyor observed residents moving freely through the facility. On 07/29/2025, at 4:20 p.m., Surveyor interviewed Director of Housing (DOH) AA. DOH AA confirmed s/he was aware of the code requirement. DOH AA stated, "I have had so many in services on this. I walk the floor. The residents in Memory Care are so vulnerable. This is so disappointing." DOH AA reported s/he would ensure staff were ensuring all chemicals were securely stored.	{N 499}		