STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017668	A. BUILDING: _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MEADOWS	**1480 N 7TH ST MANITOWOC, WI 54220**

(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 08/24/2023, Surveyor investigated one complaint at Magnolia Meadows. The complaint was substantiated and one new deficiency was identified. Census 23	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they notified the resident's legal representative when there was a change in a resident's mental condition for Resident 1. Findings Include: On 04/18/2023, the department received a complaint alleging the provider did not notify the power of attorney when there was a change in mental condition. On 08/24/2023 at approximately 10:30AM, Surveyor reviewed Resident 1's Individual Support Plan (ISP) with a print date of 08/24/2023 that was printed from the provider's electronic record system. The ISP noted Resident 1 had a	N 169		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 169	Continued From page 1	N 169		

diagnosis of Wolff-Parkinson-White Syndrome and Alzheimer's, unspecified. The ISP identified Resident 1 was a potential wandering risk. There were no other behaviors documented in the ISP.

On 08/24/2023 at approximately 10:40AM, Surveyor reviewed Resident 1's record and found a fax dated 08/05/2022. The fax stated, "[Resident 1] -Up all night - takes clothes off - undresses self - severely incontinent - pacing non-stop on 3rd shift." The physician sent a follow up fax on 08/05/2022 that stated, "Quetiapine 50mg qhs [four times daily] #30 x 11." Further review of the record showed no other documentation of the behaviors.

On 08/24/2023, at approximately 10:45AM, Surveyor reviewed Resident 1's incident reports. The incident report dated 08/21/2022 noted quetiapine was not given due to the Power of Attorney (POA)'s request to stop the medication.

On 08/24/2023 at approximately 11:00AM, Surveyor interviewed Director A. Surveyor inquired if Resident 1's POA was ever notified of the behaviors or the need for a medication intervention. Director A stated there was a different director at that time so s/he could not provide that information. Director A stated a POA should be notified of any change in condition. Director A and Surveyor reviewed the record but did not find any documentation of the notification.

On 08/24/2023 at 2:21PM, Surveyor interviewed Power of Attorney B (POA-B). POA-B explained s/he was the power of attorney of healthcare for Resident 1. POA-B reported s/he was not made aware of Resident 1 exhibiting behaviors that warranted a medication intervention. POA-B stated Resident 1 was having an increase in falls,

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N 169	Continued From page 2 which lead to emergency room and physician visits. It was during one of those visits POA-B discovered Resident 1 was taking quetiapine. POA-B reported s/he asked the previous director if there were any behavioral issues, and was told, "No, [s/he] is an absolute sweetheart." POA-B then requested the provider to stop administering the medication and have it discontinued. POA-B explained s/he did not have a problem with Resident 1 being prescribed something to help him/her sleep and not be as restless but wanted to be involved with the decision. POA-B stated if s/he was informed, s/he would have suggested a supplement such as melatonin or a much lower dose of quetiapine.	N 169		