STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017799	A. BUILDING: _____ B. WING _____	R-C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBERGE AT BROOKFIELD A MEMORY CARE COMM	1105 DAVIDSON RD BROOKFIELD, WI 53045

(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 09/13/2023, with information gathered through 09/18/2023, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation and verification visit of statement of deficiency (SOD) Y77R13 at Auberge At Brookfield Memory Care Community, located at 1105 Davidson Rd in Brookfield, WI. Five citations of noncompliance were issued, 3 of which were repeat violations of noncompliance. The complaint was substantiated. Census: 34 Under statuatory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 2's injuries of unknown source were investigated. This requirement is being cited for the second time. See Statement of Deficiency (SOD) Y77R12, issued 02/08/2023.	N 161		

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

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N 161	Continued From page 1 The findings include: On 08/14/2023, the department received an allegation the provider did not conduct an injury of unknown source allegation. On 09/13/2022 at 10:58 A.M., Surveyor conducted an interview with Caregiver T. Caregiver T told Surveyor Former Caregiver R and Former Caregiver S worked during the night shift, usual resident sleeping hours, from the night of 08/12/2023 through the morning of 08/13/2023. Caregiver T said when s/he arrived at the facility on the morning of 08/13/2023 to work the day shift, Former Caregiver S told Caregiver T that Former Caregiver R would not help Former Caregiver S care for Resident 2 during the night. Caregiver T said Former Caregiver S told him/her Resident 2 had a "rough" night with behaviors and Former Caregiver S was unable to get a response from Former Caregiver R and another night shift caregiver when s/he called them for help. Caregiver T told Surveyor Former Caregiver S said Resident 2 was physically aggressive and agitated. Caregiver T said Former Caregiver S said Resident 2 had swung at Former Caregiver S. Caregiver T told Surveyor Former Caregiver S was pretty "beat up" when Caregiver T saw Former Caregiver S on the morning of 08/13/2023. Caregiver T told Surveyor s/he observed Resident 2 that morning and s/he had a scratch on one of his/her ears, a scratch on his/her lip, and a big skin tear on one of Resident 2's hands. Caregiver T said Resident 2's large skin tear was not covered with a bandage. Caregiver T said Former Caregiver S told him/her Former Caregiver R was the medication passer during that night and did not provide first aid to the large skin tear on Resident 2's hand.	N 161		

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Caregiver T told Surveyor a nurse from Resident 2 hospice agency arrived at the facility later that morning of 08/13/2023. Caregiver T said s/he told Resident 2's hospice agency nurse about Resident 2's "wild" night as reported to him/her by Former Caregiver S.

On 09/13/2023, Surveyor reviewed Resident 2's record, as provided by Administrator E and Resident Care Coordinator/Licensed Practical Nurse, Facility Nurse Y.
Resident 2 was admitted to the facility on 04/05/2023 with diagnoses including dementia.
Resident 2 died at the facility on 08/20/2023.
Resident 2's "charting notes" included Caregiver T's documentation dated 08/13/2023 at 1:11 P.M. Caregiver T's documentation included, "[Resident 2] has a big skin tear on hand, small tear on elbow, fingers swollen, hospice contacted and came to do cares." Caregiver T's documentation was the only documentation describing Resident 2's injuries within Resident 2's record.
Resident 2's previous charting before 08/13/2023 was dated 08/09/2023 at 5:10 P.M. Resident 2's record, including "charting notes" did not include any documentation describing Resident 2's behavior or incidents during the night of 08/12/2023 and into the morning of 08/13/2023.
Administrator E provided Surveyor with copies of Resident 2's hospice documentation.
Administrator E told Surveyor s/he had just received the copies via fax from Resident 2's hospice agency. Resident 2's hospice documentation included a "nursing visit note" dated 08/13/2023 at 12:00 P.M. The documentation included, "Writer [Resident 2's Hospice Nurse M] in house following a call reporting an un-witnessed event that resulted in a significant L [left] hand skin tear and possible broken hand. Upon arrival, writer finds pt

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[patient; Resident 2] in the dining room for [his/her] noon meal. [Resident 2's] L hand is wrapped. [Resident 2] is alert, confused to baseline and cooperative. Writer and [Resident 2's Power of Attorney (POA) V] took [Resident 2] to [his/her] room for treatment and assessment. [Resident 2] denies c/o [complaint of] pain and shows no s/s [signs or symptoms] of distress. Writer unwrapped [his/her] L hand and found a 5.3 cm [centimeter] x [by] 2.6 cm skin tear to top [of hand]. The wound happened during the NOC [night] and the skin had begun to shrink. [Writer] was unable to approximate [unable to bring the edges of skin tissue together] the tissue. Wound was cleansed with wound wash, Xeroform [petroleum infused dressing] applied F/B [followed by] non-adherent gauze and covered with Tegaderm. There is bruising and swelling noted to the pinky and ring finger that extends to the palm." The documentation included, "Writer updated facility caregiver [Caregiver T] and they are to administer PRN [as needed] Tylenol for pain should [Resident 2] have any."
Facility Nurse Y told Surveyor Resident 2's record did not include an incident report addressing Resident 2's left hand injury.

On 09/13/2023 at 9:00 A.M., Administrator A provided Surveyor with written caregiver statements regarding the weekend of 08/12/2023 and 08/13/2023. Former Caregiver R's written statement included, "Third shift workers [Former Caregiver R, Caregiver CC, and Former Caregiver S]." Former Caregiver R's written statement included, "[Former Caregiver S] said [s/he] wasn't [sic] getting nobody up cause [s/he] was with [Resident 2] all night." Former Caregiver R's written statement included, "[Former Caregiver S] was sleeping at the front desk and kept grabbing [Resident 2] hard and

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yelling at [him/her]." Former Caregiver S's written statement included, "To whom it may concern on [08/12/2023] after 12 am [midnight], [Former Caregiver S] insisted the med [medication] passer [Former Caregiver R] to give [Resident 2] a PRN [as needed medication] due to [him/her] getting out [of] [his/her] bed for the 2nd time within a [sic] hour. The med passer stated that its [sic] being told that they [sic] don't [sic] want to give [him/her] [his/her] PRN consistently, (to [sic] much). Within another 30 minutes to a [sic] hour [Former Caregiver S] go in and check on [Resident 2], [s/he] was on the floor on [his/her] knees with blood everywhere. [Former Caregiver S] couldn't [sic] find anybody to help assist [Former Caregiver S] with [Resident 2] . All night [Resident 2] screamed and resist [sic]. [Former Caregiver S] had to one on one [supervision] with [Resident 2] on top of covering two sections [of the facility] by [self] with two other staff members no where to be found in the building. There were other residents paging to be toileted. After the 3rd page [Former Caregiver S] hear a staff member states [sic] [Former Caregiver S's] resident was paging and [Former Caregiver S] responded [Former Caregiver S] still sitting here with [Resident 2]. [Former Caregiver S] don't [sic] want [him/her] to hurt [self] again."

On 09/13/2023 at 3:45 P.M., Surveyor conducted an interview with Administrator E. Administrator E told Surveyor s/he was out of town on leave from 08/09/2023 until 08/15/2023. Administrator E told Surveyor Hospice Nurse V informed Administrator E on 08/15/2023 about Resident 2's left hand skin tear. Administrator E told Surveyor Resident 2 fell a lot but s/he was not 100 percent aware of how Resident 2 received the skin tear on his/her left hand and other injuries. Administrator E said there was no documentation

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N 161	Continued From page 5 of when and how Resident 2's skin tear occurred in Resident 2's record and the timeframe of when the skin tear occurred was vague. Administrator E told Surveyor there was no documented incident report and no investigation of unknown source was conducted associated with Resident 2's left hand injury.	N 161		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a written report was submitted to the department within 3 workings days of when law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety, or welfare of residents or employees. On 08/14/2023, law enforcement personnel were called to the CBRF regarding allegations of caregiver misconduct. The findings include: On 08/14/2023, the department received an allegation of law enforcement being present at the facility on 08/14/2023 related to allegations of	N 164		

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caregiver misconduct.

On 09/11/2023, Surveyor conducted a review of the department's facility file, including any reports received from the provider. There was no evidence the department received a written report from the provider related to any reportable incidents at the facility occurring on 08/14/2023.

On 09/13/2023 at 8:31 A.M., Surveyor conducted an interview with Administrator E. Administrator E told Surveyor there had been police intervention at the facility on 08/14/2023 as the result of Former Caregiver R's allegation of two caregivers, Caregiver P and Caregiver DD, had physically abused Resident 2. Administrator E told Surveyor no reportable incidents had been submitted to the department since June of 2023.

On 09/13/2023 at 3:45 P.M., Surveyor conducted an interview with Administrator E. Administrator E told Surveyor s/he was out of town on leave from 08/09/2023 until 08/15/2023. Administrator E said Business Office Manager O called him/her on 08/14/2023 to inform him/her law enforcement officers were in the facility. Administrator E told Surveyor Former Caregiver R dialed the police department's number on Resident 2's Power of Attorney [POA] V's telephone on the morning of 08/14/2023. Administrator E told Surveyor Former Caregiver R provided false allegations to law enforcement on 08/14/2023. Administrator E told Surveyor s/he reached out to Business Office Manager O later on 08/14/2023 and was informed Caregiver P and Caregiver DD had been arrested and taken to the police department. Administrator E told Surveyor s/he met with law enforcement at the facility on 08/15/2023 at approximately 10:00 A.M. when the officers returned Caregiver P and Caregiver DD to the

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facility after being released from custody. Administrator E told Surveyor s/he sent a summary of the situation to the facility's management company and that Former Caregiver R had been terminated from employment.

On 09/14/2023 at 10:44 A.M., Surveyor received an email from Administrator E. Administrator E's email included the summary s/he sent to the facility management company on 08/15/2023 at 1:11 P.M. The summary documentation included, "Yesterday the police were called as an employee [Former Caregiver R] had false allegations on [Resident 2's] alleged abuse claim regarding 2 other PM [evening] staff. [Former Caregiver R] also called [POA V] to let [him/her] know and sent [him/her] pictures throughout the last 2 days without letting management know of what was going on ([Former Caregiver R] was the med [medication] tech [technician] on second shift all weekend and did not document nor let hospice (which [Resident 2] was on) know anything as [Resident 2] did have skin tears that hospice was treating, however [Former Caregiver R] stated to police that the 2 PM staff "punched [Resident 2] in back, stomach and head as [Former Caregiver R] witness [sic] this event). Police found this information inaccurate throughout their investigation as there were no markings of any kind due to bruising or redness from any punch or blunt force [injury] to [Resident 2]. [POA V] is very concerned as [Former Caregiver R] had called [him/her] several times yesterday in regard to this alleged event and even at 2:13 A.M. this morning, drunk. We did suspend [Former Caregiver R] yesterday pending investigation. The police and a detective just left, stating to [Administrator E] that the investigation is concluded, and this was instigated by [Former

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N 164	Continued From page 8 Caregiver R] due to false allegations and they did not have any finding in regard to alleged abuse. Statements were given to the police as well as completing their own investigation yesterday. However, all original documents were then given to the police as [Administrator E] was not here to assist the community (we always make copies for our records), due to being on PTO [personal time off]. Today, [Administrator E's] day back from PTO, [Administrator E] did have the police here, family of [Resident 2] and [Resident 2's funding agency nurse] to also look over [Resident 2] due to not having a nurse in-house at this time and [Resident 2's funding agency nurse] had no findings and reported to family and [Administrator E] after [his/her] assessment. Can [Administrator E] proceed to term [terminate] [Former Caregiver R] due to being in [his/her] probationary period? [POA V] is scared for [Former Caregiver E] to come back and so am I [Administrator E] due to [his/her] involvement in this case, lying to police, and disruptions to the community as a whole." On 09/14/2023 at 10:14 A.M., Surveyor conducted an interview with Administrator E. Administrator E told Surveyor s/he was not aware of the requirement to submit a written report to the department within 3 working days of when law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety, or welfare of residents or employees.	N 164		
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	N 352		

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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 Resident 9 received his/her prescribed Fentanyl 12 mcg/hour patches on 6 occasions that it would have been due from 08/27/2023 - 09/13/2023.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) Y77R11, issued on 09/01/2022.

Findings include:

On 09/13/2023, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 06/07/2023 with diagnoses including depression and cognitive impairment. Surveyor reviewed Resident 9's prescriptions, which included Fentanyl 12 mcg/hour patches, active from 07/24/2023 - 09/11/2023 and 09/11/2023 through current, with instructions to "Apply 1 patch topically every 72 hours (remove old patch before applying new one)." Surveyor reviewed Resident 9's medication administration record (MAR) from 08/01/2023 - 09/13/2023 and observed the following 5 occasions that Resident 9's patches were marked as being unavailable:

- 08/27/2023
- 08/30/2023
- 09/02/2023
- 09/05/2023
- 09/08/2023

After 09/08/2023, the MAR entries for Resident

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9's Fentanyl patches (documenting 2 entries for the 2 different order timeframes documented above) were blank.

On 09/13/2023, at approximately 1:13 p.m., Surveyor observed the medication cart with Caregiver X. Surveyor observed a bag containing Resident 9's Fentanyl patches (12 mcg/hour) with a pharmacy label on the bag indicating as such. The pharmacy label indicated that 5 patches were dispensed on 09/11/2023. The bag contained all 5 patches.

At approximately 1:35 p.m., Surveyor interviewed Resident 9. Resident 9 reported that s/he had received pain patches in the past but hasn't received them lately and wasn't sure why. Resident 9 showed Surveyor his/her back and said that was where his/her pain patches were usually placed but that there wasn't one there. Resident 9 reported that the pain s/he had was at his/her left foot due to having a heel wound and toe wounds. Resident 9 reported that the pain didn't bother him/her at rest but that it hurt when s/he walked on that foot. While interviewing Resident 9, Surveyor observed an orthopedic-type boot on Resident 9's left foot.

At approximately 3:15 p.m., Surveyor interviewed Nurse Y about Resident 9's Fentanyl patches. Nurse Y reported s/he was unaware that Resident 9's patches had been out since staff never informed him/her. Nurse Y reported that medication technicians were expected to re-order non-cycled medications (which would have included Resident 9's Fentanyl patches) when the medications required refill. After looking at Resident 9's MARs with Surveyor, Nurse Y identified that the first staff to mark Resident 9's Fentanyl patches being out, on 08/27/2023, was

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N 352	Continued From page 11 Caregiver W, who was in the room during the interview. Caregiver W then reviewed the MAR and confirmed that s/he marked the patches as being out because s/he did not observe them in the narcotic medication box within the medication cart. Caregiver W could not confirm whether s/he attempted to request a refill of Resident 9's Fentanyl patches. At approximately 3:45 p.m., Surveyor interviewed Administrator E. Administrator E acknowledged Surveyor's concern that Resident 9 did not receive his/her Fentanyl patches as prescribed on 6 total occasions, including 08/27/2023, 08/30/2023, 09/02/2023, 09/05/2023, 09/08/2023, and either on 09/11/2023 or 09/12/2023 (depending on what time the patches were dispensed on 09/11/2023). Administrator E confirmed that it seemed like a re-ordering issue. Administrator E reported that Caregiver W, who first would have documented the patches being unavailable, "should know how to do his/her job." Upon Surveyor reporting that Resident 9 still did not receive any of his/her patches since being dispensed on 09/11/2023 as observed by 5 of 5 patches being in the medication cart, Administrator E stated, "That's really sad." On 09/15/2023, at approximately 1:30 p.m., Surveyor interviewed Pharmacy Technician Z, from the pharmacy that refilled Resident 9's prescriptions. Pharmacy Technician Z reported that a refill request was made on 08/09/2023 for Resident 9's Fentanyl patches, and 5 patches were dispensed on that day. Pharmacy Technician Z reported that a new prescription was received on 09/09/2023 and that 5 patches were then dispensed on 09/11/2023.	N 352		

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{N 408}	Continued From page 12	{N 408}		
{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 the individual service plans (ISPs) for 3 residents reviewed included the rationale for use and detailed description of the behaviors indicating the need for administration of their prescribed as-needed (PRN) psychotropic medication. Resident 7's ISP did not include a rationale for use and detailed description of behaviors which distinguished between the need for administration of his/her PRN Quetiapine versus PRN Olanzapine.	{N 408}		

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{N 408}	Continued From page 13 Resident 8's ISP did not clarify which of his/her listed anxiety behaviors indicated the need for his/her PRN Clonazepam, when it was active, and did not contain information about his/her PRN Olanzapine use. Resident 8 received his/her PRN Clonazepam and Olanzapine on 10 occasions in July and August 2023. Resident 9's ISP did not include a detailed description of the behaviors indicating the need for his/her PRN Lorazepam. This requirement is being cited for the third time. See Statement of Deficiency (SOD) Y77R13, issued on 06/28/2023, and SOD Y77R12, issued 02/08/2023. Findings include: Example 1: Resident 7 On 09/13/2023, at approximately 9:55 a.m., Surveyor observed the medication carts with Caregiver X. Surveyor observed the following PRN psychotropic medication cards: - 1 card of 30 PRN Olanzapine 5 mg tablets, prescribed to Resident 7 with a dispensed date of 07/27/2023. All 30 tablets were observed in the card. - 1 card of 15 PRN Quetiapine 50 mg tablets, prescribed to Resident 7 with a dispensed date of 07/27/2023. The tablets were divided in half, in accordance with the administration instructions, and each half tablet was individually bubble-packed, with all 30 half-tablets observed in the card. On 09/13/2023, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider	{N 408}		

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{N 408}	Continued From page 14 on 07/26/2023 with diagnoses including Parkinson's disease and dementia. Surveyor reviewed the following PRN psychotropic medications prescribed to Resident 7: - Olanzapine 5 mg tablets, with a start date of 07/26/2023 and instructions to "Take one tablet by mouth once a day as needed for severe agitation." - Quetiapine 50 mg tablets, with a start date of 07/26/2023 and instructions to "Take 1/2 tablet (25 mg) by mouth every six hours as needed for agitation or anxiety (1st choice)." Surveyor reviewed Resident 7's ISP, dated 07/26/2023, and observed the following in relation to his/her PRN psychotropic medication use: - Under the "ANTIPSYCHOTICS' heading: "Quetiapine 12.5 mg daily. Quetiapine 12.5mg [every 6 hours] prn for agitation / Anxiety daily as needed for Agitation. Olanzapine 5m." Under that line was documented: "What symptoms or behaviors does this Resident exhibit that support the usage of this medication? Anxiety & agitation as seen by sarcastic criticism, yelling, threats, and demanding behaviors in an elevate manner to minor frustrations." There was no information in the ISP detailing for what specific behaviors Resident 7 was to be administered his/her Quetiapine versus his/her Olanzapine and whether the behaviors documented indicated use of his/her Quetiapine or his/her Olanzapine. On 09/13/2023, at approximately 3:45 p.m., Surveyors interviewed Administrator E. Administrator E acknowledged Surveyor's concern that there were no behavioral indications	{N 408}		

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

detailed for staff in Resident 7's ISP for knowing when they were to administer his/her Quetiapine versus his/her Olanzapine. Administrator E reported s/he would look further into it.

Example 2: Resident 8

On 09/13/2023, at approximately 9:55 a.m., Surveyor observed the medication carts with Caregiver X. Surveyor observed the following PRN psychotropic medication card:

- 1 card of 15 PRN Olanzapine 5 mg tablets, prescribed to Resident 8, with a disepensed date of 07/14/2023. The tablets were divided in half, in accordance with the administration instructions, and each half tablet was individually bubble-packed for a total of 30 half-tablets. Surveyor observed 7 half-tablets punched out from the card, with 23 remaining.

On 09/13/2023, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 04/03/2023 with diagnoses including early onset Alzheimer's disease and anxiety. Surveyor reviewed the following PRN psychotropic medications prescribed to Resident 8:

- Clonazepam 0.5 mg tablets, active from 01/20/2023 - 07/14/2023, with instructions to "Take 1/2 tablet (0.25 mg) by mouth every eight hours as needed for anxiety."
- Olanzapine 0.5 mg tablets, with a start date of 07/14/2023 and instructions to "Take 1/2 tablet (2.5 mg) by mouth every four hours as needed for anxiety/agitation."

Surveyor reviewed Resident 8's medication administration records (MARs) from 07/01/2023 - 09/13/2023 and observed the following 10 PRN

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{N 408}	Continued From page 16 pyschotropic medication administrations: - 07/03/2023 (5:15 p.m.): Clonazepam administered for "agitation" - 07/04/2023 (12:33 p.m.): Clonazepam administered for "anxiety" - 07/04/2023 (5:27 p.m.): Clonazepam administered for "agitation" - 07/08/2023 (7:13 p.m.): Clonazepam administered for "agitation" - 07/09/2023 (11:58 a.m.): Clonazepam administered for "terminal restlessness" - 08/20/2023 (12:35 p.m.): Olanzapine administered for "terminal restlessness" - 08/21/2023 (8:39 a.m.): Olanzapine administered for "terminal restlessness" - 08/23/2023 (7:40 a.m.): Olanzapine administered for "terminal restlessness" - 08/24/2023 (8:17 a.m.): Olanzapine administered for "terminal restlessness" - 08/31/2023 (9:30 p.m.): Olanzapine administered for "terminal restlessness" Surveyor reviewed Resident 8's initial comprehensive ISP, dated 04/27/2023, and observed the following in relation to his/her PRN psychotropic medication use (when only his/her Clonazapam was in use): - Under the "Anti-Anxiety" heading: "Clonazepam 0.25 mg [oral] PRN; buspirone daily." Under that was documented, "What are common signs and symptoms of anxiety exhibited by the Resident? restlessness, rapid speech, racing thoughts. Have alternative measures or interventions been utilized prior to the initiation of medication? resident is given quiet time in [his/her] room with [his/her] cat when feeling overwhelmed or anxious."	{N 408}		

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{N 408}	Continued From page 17 There was no clarification on whether the behaviors documented as Resident 8's "common signs and symptoms of anxiety" were indications of his/her PRN Clonazepam use. Surveyor reviewed Resident 8's most recent ISP, dated 09/11/2023, and observed no information about his/her PRN Olanzapine use (which would have been initiated with his/her medical provider order on 07/14/2023.) On 09/13/2023, at approximately 3:45 p.m., Surveyors interviewed Administrator E. Administrator E acknowledged Surveyor's concern that there were no detailed behaviors documented in Resident 8's ISP indicating the use for his/her Clonazepam previously or his/her Olanzapine currently. Administrator E reported s/he would look further into it. Example 3: Resident 9 On 09/13/2023, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 06/07/2023 with diagnoses including depression and cognitive impairment. Surveyor reviewed Resident 9's prescriptions, which included Lorazepam 0.5 mg tablets, with a start date of 07/24/2023 and orders to "Take one tablet by mouth every hour as needed for anxiety or restlessness." In reviewing Resident 9's MARs for 08/01/2023 - 09/13/2023, Surveyor observed that Resident 9's Lorazepam was not documented as being administered. Surveyor then reviewed Resident 9's most recent ISP, dated 07/06/2023, and observed the following in relation to his/her PRN psychotropic medication use: - Under the "Anti-Anxiety" heading: "Lorazepam 0.5 mg [every hour] prn for Anxiety/restlessness.	{N 408}		

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{N 408}	Continued From page 18 [Hospice agency] services." There was no information detailing the specific behaviors indicating his/her Lorazepam use. On 09/13/2023, at approximately 1:15 p.m., Surveyor observed the medication carts with Caregiver X. Surveyor observed Resident 9's 2 PRN Lorazepam 0.5 mg tablet cards, which showed the following: - Card 1: Dispensed date of 06/24/2023, 1 tablet punched out - Card 2: Dispensed date of 07/27/2023, contained all 30 of 30 dispensed tablets. Surveyor asked Caregiver X if s/he knew when Resident 9's Lorazepam was supposed to be administered. Caregiver X replied that it was to be given for pain. Surveyor asked Caregiver X to confirm if Resident 9's Lorazepam was supposed to be administered for pain. Caregiver X replied, "Yes."	{N 408}		
N 431	83.38(1)(g) Health monitoring. 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	N 431		

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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 that Resident 7's health was monitored after s/he experienced a fall on 08/16/2023.

Findings include:

On 09/13/2023, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 07/26/2023 with diagnoses including Parkinson's disease and dementia. In reviewing Resident 7's charting notes from 07/27/2023 - 09/13/2023, Surveyor observed the following entry:

- 08/16/2023 (at 8:45 p.m.) by Caregiver AA: "Resident had a fail[sic] tonight walking to

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[his/her] room very fast and stumbled into the wall where [s/he] slipped down the wall resident was assist completed range of motion and got vitals will be checked on frequently family notified incident report completed."

The next entry was dated 08/24/2023 about an unrelated communication with family. There was no other information in the charting notes about Resident 7 being assessed for pain or injuries after this fall, clarifying how Resident 7 was going to be "checked on frequently" (as indicated in the note) and whether that occurred, what Resident's 7 vitals values were, and whether the range of motion and vitals assessments revealed any concerns.

Surveyor reviewed "Twenty-Four Hour" reporting documents, provided by Nurse Y, which documented resident updates. The report for 08/16/2023 documented, "[Resident 7] - Resident had a fall tonight." No other information was documented on this day, or throughout the rest of the month's notes, regarding Resident 7's fall.

Surveyor reviewed Resident 7's individual service plan (ISP), dated 07/26/2023, which documented the following in relation to Resident 7's fall risk:

- Under the "Mobility" heading: "Does the Resident have a history of falls with injury prior to admission? Yes"
- Under the "Falls Risk" heading: "average risk due to Parkinson's and unsteady gait."

On 09/13/2023, at approximately 2:45 p.m., Surveyor interviewed Administrator E. Surveyor asked for the incident or fall report for Resident 7's fall on 08/16/2023. Administrator E reported that s/he couldn't find any. Administrator E

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N 431	Continued From page 21 reported that the caregiver would typically fill out a report which contained Resident 7's post-fall assessment information, which would then be given to Nurse BB. Nurse BB would then upload the information to the provider's online system and would shred the original document. Surveyor asked Administrator E if the original document was maintained in this case since s/he could not find it on the online system. Administrator E replied that it likely wasn't. Administrator E confirmed s/he could also not find anything in the online system showing Resident 7 being assessed for pain or injuries after his/her fall.	N 431		