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SEBRING ASSISTED CARE RESIDENCE	7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719

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{N 000}	Initial Comments On 02/07/2024, Surveyors conducted 1 verification visit and 3 complaint investigations. Five deficiencies were identified. Two of 5 deficiencies were repeat violations. See Statement of Deficiency (SOD) KSK211 dated 06/02/2023, SOD WX2E12 dated 07/16/2019 and SOD Z1LL11 dated 09/22/2023. The 1 violation from SOD Z1LL11, dated 09/22/2023, was not corrected. Three of 3 complaints were substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 33	{N 000}		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on interview and record review, Executive	N 214		

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

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Director A did not provide the supervision necessary to ensure residents received proper care and treatment, that their health and safety were protected and promoted, and their rights respected.

On 12/14/2024, Resident 3 was admitted to the hospital. Resident 3 was diagnosed with metabolic encephalopathy and urinary tract infection (UTI). Per hospital records, Resident 3 had been experiencing a decline in condition for approximately 11 days before Resident 3 was sent to an emergency room. Per clinical interview, from 12/03/2023 to 12/10/2023, the provider had not contacted Resident 3's primary care clinic to report Resident 3's change in condition. Per provider's records, on 12/12/2023, Director V notified Resident 3's primary care clinic s/he had been experiencing a decline in condition for about a week or so. This report on decline in condition included the development of a pressure wound to his/her buttocks and increased weakness.

On 12/26/2024, Resident 3 was discharged from the hospital back to the facility. During Resident 3's hospital stay his/her condition and/or needs changed in the following ways: admitted to hospice service, diagnosed with 2 pressure wounds, indwelling urinary foley catheter, and new medications prescribed including a psychotropic as needed (PRN) for behaviors related to dementia.

On 01/03/2024, Nurse Practitioner R and Hospice Nurse S found Resident 3 in his/her room experiencing a decreased level of consciousness. As Nurse Practitioner R and Hospice Nurse S attempted to wake up Resident 3. They found Resident 3 to have matted hair, dried food on his/her skin/clothes/bedding, reddened skin under

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his/her breasts, his/her urinary collection bag on the floor, a metal clasp from a clothing garment causing a red indentation into his/her skin, a brief saturated with unidentifiable purulent drainage and feces, and with his/her pants only pulled partially up his/her legs. Provider's staff reported Resident 3's behaviors had made it difficult for caregivers to assist him/her with showers and/or daily grooming. Resident 3 was sent back to the hospital due to decreased level of consciousness. Resident 3 was diagnosed with acute metabolic encephalopathy, acute cystitis (bladder infection) and 5 pressure wounds. Resident 3 did not return to facility after hospitalization.

On 02/07/2024, Surveyor found the provider had not documented an assessment on Resident 3 since 09/13/2023. Resident 3's decline in condition had not been documented in his/her facility observation notes from 12/03/2023 to 12/10/2023 or from 12/19/2023 to 01/03/2024. Resident 3's individualized service plan (ISP) had not been updated since 06/15/2023. Resident 3's December 2023 medication administration record (MAR) and January 2024 MAR had not been updated with medication orders prescribed after 12/25/2023. Provider's staff did not offer Resident 3 his/her new psychotropic PRN medication for behaviors related to dementia and subsequently Resident 3 was not provided personal cares based on those behaviors.

On 02/07/2024 at 3:30 PM, Executive Director A stated s/he could not acknowledge if Resident 3 had been administered his/her medications as prescribed or not from 12/27/2023 to 01/03/2024.

On 02/13/2024 at 4:00 PM, Executive Director A stated s/he was not aware of the following related to Resident 3: location of pressure wounds,

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medications not being administered as prescribed from 12/27/2023 to 01/03/2024, and his/her physical presentation the morning of 01/03/2024.

FINDINGS INCLUDE:

According to Department facesheet the facility provides care to the following client groups: irreversible dementia, Alzheimer's, and advanced aged.

On 01/04/2024 & 01/23/2024, The Department received complaints related to care and services.

From 02/07/2024 to 02/20/2024, Surveyors conducted a verification visit and 3 complaint investigations at Facility. Three of 3 complaints were substantiated. Five deficiencies were identified. Two of 5 deficiencies were repeat violations. See Statement of Deficiency (SOD) KSK211 dated 06/02/2023, SOD WX2E12 dated 07/16/2019 and SOD Z1LL11 dated 09/22/2023.

Deficiencies identified which were Executive Director A's responsibility include:
1.) 83.31(1)(g) Health Monitoring
2.) 83.32(3)(h) Rights Of Residents: Receive Medication
3.) 83.35(3)(d) Service Plans Updated Annually Or On Changes
4.) 50.07(b) Prohibited Acts

On 02/07/2024, Surveyor reviewed Resident 3's facility record:

On 02/07/2024, Surveyor reviewed Resident 3's facility facesheet. Resident 3 had an activated power of attorney. Resident 3 was diagnosed with but not limited to: dementia with behavioral disturbance, psychotic disorder with delusions

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due to known physiological condition, localization-related symptomatic epilepsy, and dysuria (discomfort while urinating).

On 02/07/2024, Surveyor reviewed the facilities copy of Resident 3's hospice record. Resident 3's hospice record was dated 12/27/2023. Resident 3's hospice record included a document titled, "Routine Standing Orders Order," which stated the following, "...If oral medication held more than 24 hours, notify attending physician/designee. May give medications in applesauce/pudding...Oxygen orders: Oxygen via nasal cannula or mask at 0L - 4L per minute PRN for dyspnea (shortness of breath) or labored breathing. Humidify PRN...Indwelling urinary catheter." The hospice record included an order to administer Olanzapine 2.5 MG for behaviors related to dementia.

On 02/07/2024 at 12:00 PM, Surveyor requested Resident 3' s hospital aftercare summary for the 12/14/2023 to 12/26/2023 admission. Interim Director of Nursing J stated s/he did not have a copy of Resident 3's hospital after visit summary. Interim Director of Nursing J acknowledged the facility was to maintain documentation of resident medical visits.

On 02/07/2024, Surveyor reviewed Resident 3's facility observation notes:

-On 12/12/2023 at 5:16 PM, Director V documented the following, "Phone conversation with [Nurse KK] with [Doctor L]: we discussed residents typical/baseline behavior and habits compared to what staff have been reporting for the past week or so. Resident has some sores on [his/her] bottom and a bruise on one buttocks. Residenthas (sic.) not been getting out of [his/her]

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bed either on [his/her] own or with assistance except 2 instances. Resident has been slightly more agreeable to being changed and staff have been doing so while [s/he] lay in bed. [Nurse KK] and I discussed possible sensory cues that could help calm the resident when staff are doing cares (voice of [Family Member U's] voice, showing [him/her] what we're doing, music, and lavender soap/lotion). [Nurse KK] was going to call [Family Member U] to discuss these ideas."

-On 12/14/2023 at 9:32 AM, Director V documented the following, "[Family Member U] decided that [s/he] wanted the resident to be sent to the ER via ambulance for evaluation due to [his/her] cognitive and physical decline. [S/he] was admitted to [Name of Hospital] for UTI and observation."

-No, documentation occurred in the observation notes: from 12/01/2023 to 12/11/2023 or 12/19/2023 to 01/03/2024.

On 02/07/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) signed on 06/15/2023. Under the subsection "ADL Needs: Bathing," the following is documented "I may RESIST bathing activities. Per [Family Member U]- [Resident 3] has not taken a bath/shower in a while but will wash up in the sink. Since admission staff from [Name of Facility] and [Previous Hospice Facility] have been unsuccessful in having [Resident 3] take a shower or bath...My caregivers will observe for any changes in my ability to participate in my care and report any changes in ADL function/need to the nurse and coordinator." Under the subsection "ADL Needs: Dressing," the following is documented "I need physical assistance with dressing. I will be able to participate in some of

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dressing activities. I need frequent clothing changes. I need application of stockings...I may RESIST care...I require more than one change of clothing per day, i.e., morning and pm care." Under the subsection related to medication Resident 3's ISP states facility staff are to assist Resident 3 with medication administration. Under the subsection "I have potential/actual impairment to integrity," the following is documented, "My caregivers will observe/document/report location, size and treatment of skin injury and/or any new or worsened alterations in skin integrity. Resident 3's ISP documented the following, "I am/have the potential to be verbally aggressive or to demonstrate behaviors. Has thrown items at staff including silverware utensils." Resident 3's ISP hadn't been updated with new concerns and/or needs since 06/15/2023. Resident 3's ISP does not mention Resident 3's pressure wound to his/her heel, pressure wound to his/her buttocks, admission to hospice/hospice orders, and his/her psychotropic PRN.

On 02/07/2024 at 10:15 AM, Surveyor discussed Resident 3 with Caregiver I. Caregiver I stated s/he administered medications and provided caregiving services to Resident 3. Caregiver I stated when Resident 3 returned from the hospital. The pharmacy sent a bunch of medications in blister packs for Resident 3; but the facility MAR didn't have the medications listed so s/he did not administer them. Caregiver I stated Resident 3 had a couple medications listed on his/her MAR and those medications were administered to Resident 3. Caregiver I stated s/he reported Resident 3's incomplete MAR to Former Resident Care Director Q. Caregiver I stated pharmacy would only deliver medications from 9:00 AM to 12:00 PM and at 8:00 PM. Caregiver I stated s/he cared about Resident 3.

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N 214	Continued From page 7 Caregiver I stated Resident 3 needed a much higher level of care then the facility could provide. Caregiver I stated his/her life partner works at [Name of Psychiatric Hospital] and Resident 3 seem more like that type of resident. Caregiver I reported Resident 3 would not allow staff to assist him/her with showers and s/he would steal things from around the unit to hide in their room. Caregiver I stated Resident 3 would become verbally aggressive and at times attempt to hit staff if s/he had not been approached in the correct manner. Caregiver I stated Resident 3 would refuse to be showered to the point Resident 3's body odor could be detected in the hallways outside of his/her room. Caregiver I stated s/he would report Resident 3's behaviors to Former Resident Care Director Q. Caregiver I stated Resident 3 would require multiple re-approaches a day to complete personal cares. On 02/07/2024, Surveyor reviewed Resident 3's December 2023 MAR. The following medication orders were transcribed to Resident 3's December 2023 MAR: 1.) Lamotrigine Tablet 300 MG ER - Once daily (This order is listed as discontinued as of 12/26/2023) 2.) Quetiapine Tablet 25 MG - Once daily (This order is listed as discontinued as of 12/06/2023) 3.) Fentanyl 25 MCG/HR - Apply patch once every 3 days 4.) Olanzapine 2.5 MG Tablet - Once daily 5.) Polyethylene Glycol - Once daily 6.) Quetiapine Tablet 50 MG - As Needed (PRN) (This order is listed as discontinued as of 12/06/2023) 7.) Polyethylene Glycol - PRN 8.) Naloxone 4 MG/0.1 ML Nasal Spray - PRN 9.) Olanzapine 2.5 MG - PRN 10.) Bisacodyl 10 MG Suppository - PRN	N 214		

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N 214	Continued From page 8 On 02/07/2024, Surveyor reviewed Resident 3's January 2024 MAR. The following medication orders were transcribed to Resident 3's January 2024 MAR: 1.) Lamotrigine Tablet 300 MG ER - Once daily (This order is listed as discontinued as of 12/26/2023) 2.) Fentanyl 25 MCG/HR - Apply patch once every 3 days 3.) Polyethylene Glycol - Once daily 4.) Naloxone 4 MG/0.1 ML Nasal Spray - PRN 5.) Bisacodyl 10 MG Suppository - PRN On 02/07/2024, Surveyor reviewed the facilities list of Resident 3's medication orders. The following medication orders were listed as follows: 1.) Zeasorb-AF Powder 2% - Apply topically twice daily - Order was initiated on 12/25/2023 2.) Acetaminophen 650 MG Tablet - PRN every 6 hours for pain - Order was initiated on 12/27/2023 3.) Melatonin 3 MG Tablet - PRN at bedtime for insomnia - Order was initiated on 12/25/2023 4.) Olanzapine 2.5 MG Tablet - PRN once daily for aggressive behavior - Order was initiated on 12/27/2023 5.) Ondansetron 4 MG Tablet - PRN every 8 hours for nausea - Order was initiated on 12/27/2023 On 02/07/2024 at 3:30 PM, Surveyor discussed the above concerns with Executive Director A, Interim Director of Nursing J and Interim Executive Director K. Executive Director A stated s/he could not acknowledge if Resident 3 had been administered his/her medications as prescribed or not. Executive Director A produced the hospital after visit summary dated 12/26/2023 for Resident 3. This hospital after visit summary	N 214		

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documented all prescription medications besides the Lamotrigine had been discontinued. Executive Director A stated s/he did not understand what Caregiver I was referring to in relation to having physical pills in the medication cart that were not administered to Resident 3. Executive Director A stated there had been instances where discontinued medications had been left in the medication cart until the next cycle fill. Executive Director A stated s/he believed Caregiver I had mistaken discontinued medications for newly delivered medication. Surveyor asked Executive Director A if the list of medication orders the facility had on file for Resident 3 was correct. Executive Director A stated the medication orders list was sent to him/her that day from an outside pharmacy. Executive Director A stated Resident 3 was no longer his/her resident so s/he didn't know exactly what the pharmacy was doing for Resident 3 at that time.

On 02/07/2024, Surveyor reviewed the medication orders the facility had on file for Resident 3. The fax cover sheet states Resident 3's medication list was faxed from the pharmacy to the facility on 02/07/2024 to Interim Director of Nursing J.

On 02/08/2024 at 8:24 AM, Surveyor emailed Executive Director A requesting all 2023 and 2024 assessments completed on Resident 3 by the facility.

On 02/09/2024, Surveyor reviewed an email sent from Executive Director A on 02/08/2024 at 4:27 PM. Executive Director A stated all requested documents were attached to the email. The last assessment completed on Resident 3 was on 09/13/2023.

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N 214	Continued From page 10 On 02/09/2024, Surveyor reviewed Resident 3's hospice record. On 01/03/2024 at 5:31 PM, Hospice Nurse S documented the following, "RN performed comprehensive assessment, medication reconciliation, and plan of care review. Symptoms addressed and recommendations: Upon arrival, writer was stopped by lead nursing staff [Former Resident Care Director Q] at facility. [Former Resident Care Director Q] asks writer to meet with [him/her] and [Director V] in [his/her] office. [Former Resident Care Director Q] tells writer that they do not have updated medication list for patient and they have not known what to give patient since start of January. [Former Resident Care Director Q] and [Director V] report last medications were given on 12/31. Writer inquired about Fentanyl patch; [Director V] states new patch would not have been placed since prior to 1/1 as no medications have been given. Writer reviewed importance of giving medications and noted that [Name of Hospice] could have been called with any questions about medication orders 24/7. [Former Resident Care Director Q] gave writer faxed documents and a December MAR for patient stating, "this is all we have, it's so confusing." Writer reviewed documents and found updated faxed copy of patient's medication list from hospice attending office. Writer gave this to [Former Resident Care Director Q]. [Former Resident Care Director Q] and [Director V] then questioning if they have all medications available in facility. Writer and [Director V] reviewed med cart - all medications available aside from PRN Bisacodyl supps. Writer to f/u on this. [Director V] denies needing any further follow up for ordered medications to be given. [Nurse Practitioner R] then arrived and stated [s/he] is here to see patient. Writer and [Nurse Practitioner R]	N 214		

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completed joint visit. Patient found lethargic in [his/her] room. Patient able to deny pain, but otherwise unresponsive with eyes closed throughout remainder of visit. Patient's catheter bag dragging on floor, no securement device in place. Writer found medline box of supplies ordered last week upstairs and arranged them. [Nurse Practitioner R] expressing concern to writer that patient may have UTI and requests to complete a UA (urinary analysis). [Nurse Practitioner R] called [Family Member U], VM left asking to do UA. [Family Member U] returned call and stated [s/he] would join visit. Writer and [Nurse Practitioner R] completed cares - Significant purulent white/yellow discharge present around catheter and vaginal area. Old catheter removed. Incontinence cares performed as stool also present. Patient wearing [undergarment] with metal clasps and pants halfway on. Writer removed pants and [undergarment] d/t risk of pressure injuries from metal clasps. Clean shirt placed on patient. Old food in bed around patient - writer and [Nurse Practioner R] cleaned area. Skin under breasts is fragile and pink. Antifungal powder applied. [Family Member U] then arrived. updated on patient's condition (unresponsiveness and concerns of UTI) and [Family Member U] requests patient be taken to the ED (emergency department). Writer provided education on option of testing for UTI and treating at facility with oral antibiotics if UA does indicate UTI. [Family Member U] states, "Would they even give [him/her] the antibiotics here?" Writer validated [Family Member U's] concerns and frustrations."

On 02/13/2024 at 4:00 PM, Surveyor completed an exit interview with the TEAMS conference system with Executive Director A, Interim Director of Nursing J and Interim Executive Director K.

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Surveyor asked Executive Director A if the Department's facility facesheet was correct in listing him/her as the facility's administrator. Executive Director A stated s/he has been the facility administrator since August 2023. Executive Director A acknowledged s/he was not aware of Resident 3's pressure wounds. Executive Director A acknowledged s/he was not aware of Resident 3 not being administered his/her medications as prescribed from 12/27/2023 to 01/03/2024. Executive Director A stated s/he knew staff and nurses found Resident 3 unresponsive the morning of 01/03/2024 but was not aware of other details related to Resident 3's physical presentation. Executive Director A acknowledged s/he was not aware Resident 3's physician had ordered a psychotropic PRN to manage behaviors related to dementia. Executive Director A acknowledged the facility did not assess Resident 3 upon return from the hospital on 12/26/2024; and Resident 2's care plan was not updated with his/her new concerns/needs. Executive Director A, Interim Director of Nursing J and Interim Executive Director K did not have any questions related to Surveyor's findings. Interim Executive Director K stated s/he would work with staff to be sure issues like this are reported to administrators in the future.

On 02/22/2024 at 8:25 AM, Surveyor discussed Resident 3's care with Nurse MM. Nurse MM stated s/he worked with Resident 3's primary care physician Doctor LL. Nurse MM stated s/he had access to Resident 3's EHR (electronic health record). Nurse MM stated the facility did not contact Resident 3's primary care clinic from 12/03/2023 to 12/10/2023 to report changes in condition. Nurse MM stated facility called primary care clinic on 12/11/2023 and 12/12/2023 to discuss open sore on buttocks and decline in

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N 214	Continued From page 13 condition. On 02/23/2024, Surveyor reviewed Resident 3's hospital record for admission on 12/14/2023 and discharge on 12/26/2023: On 12/14/2023 at 8:22 PM, Doctor DD documented the following, " Chief Diagnosis: Acute on Chronic Encephalopathy likely due to UTI...[Resident 3]...was brought in from [his/her] facility on 12/14/23 with an 11-day history of weakness and worsened confusion. [S/he] has decreased mental status with infections but usually [s/he] rebounds after a few days but hasn't this time. [S/he] decompensated to the point that now [s/he] using a wheelchair to get around (typically can ambulate)." On 12/18/2024 at 2:06 PM, Nurse AA documented the following related to Resident 3's skin integrity needs, "Lots of dry/flaky skin noted to peri wound skin likely due to use of barrier cream versus hydrating lotion/moisture barrier...On further assessment a DTPI (deep tissue pressure injury) was noted to [Resident 3's] right heel. Unclear when it first began to develop as [Resident 3] is oriented x1 and [Family Member U] has not looked at [his/her] feet in a while. [S/he] does report that for the past 2 weeks [s/he's] been much more confused and deconditioned so [s/he] has been essentially bed bound since then, plan for heel mepilex and prevalon boots to prevent any further damage, although the heel is likely to continue breaking down before it begins to heal....Recommendation: Q2 turns (reposition every 2 hours), -Mepilex on buttocks unless patient begins to have frequent incontinent stools, HOB <30 (head of bed less than 30 degrees) if possible at all times." On 12/21/2023 at 5:12 PM, Social Worker FF documented the following, "Writer spoke with [Interim Executive Director K] and [s/he] stated that they unable to accept [Resident 3] back since [s/he] is requiring too	N 214		

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much assistance from them even with hospice. Writer informed [Interim Executive Director K] that per [Director V], memory care director at [Name of Facility], [Resident 3] has been like this for 2 weeks before getting admitted to [Name of Hospital] therefore [s/he] is at [his/her] baseline of when [s/he] left there. If they are unable to meet [his/her] needs, they would need to accept [him/her] back and give a 30 days noticed to POA (power of attorney)." The after visit discharge summary dated 12/26/2023 documented the following, "Your medications have changed...START taking: acetaminophen, lamotrigine, melatonin, miconazole (MICOTIN), moi-stir, ondansetron (ZOFRAN-ODT), senna-docusate...Upcoming Appointments Follow up with [Name of Clinic] UROLOGY." Attached to the hospital aftercare summary is an education packet titled, "Learning About Indwelling Catheter care To Prevent Infection Overview." The subsection titled, "How can you help prevent infection?" states, "when you clean around the catheter, check the surrounding skin for signs of infection. Look for things like pus and irritated, swollen, red, or tender skin around the catheter." The education packet also explain how to appropriately empty and secure the urinary collection bag."

On 02/27/2024, Surveyor reviewed Resident 3's hospital record for admission on 01/03/2024 with discharge on 01/04/2024. On 01/03/2024, Resident 3 was diagnosed with the following: acute cystitis, metabolic encephalopathy, pressure wound to left heel, pressure wound to right heel, pressure wound to left buttock, pressure wound to right buttock and pressure wound to area unspecified. On 01/03/2024 at 2:14 PM, Nurse HH documented the following, "While rolling pt, blister noted to right lateral

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N 214	Continued From page 15 ribcage, [Family Member U] at side states that [s/he] had wounds develop due to care at facility [s/he] was at. Pt has bilateral heel ulcers as well, dressings in place over wounds and heels elevated off of bed." CROSS REFERENCE N0352 DHS Chapter 83.32(3)(h) Rights of Residents: Receive Medication CROSS REFERENCE N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or On Changes CROSS REFERENCE N0431 DHS Chapter 83.38(1)(g) Health Monitoring CROSS REFERENCE Y3180 DHS Chapter 50.07(b) Prohibited Acts	N 214		
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 the resident's right to receive all medications in the dosage and at intervals prescribed by the practitioner for 2 of 2 residents reviewed. Resident 2: Summary No physician ordered as needed (prn) lorazepam for anxiety was available for Resident 2 from 9:00	N 352		

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N 352	Continued From page 16 AM on 12/12/2024 to 11:55 PM 12/14/2023 due to staff's failure to request a refill prior to or after administering the last tablet on 12/12/2023 at 9:00 AM. On 12/13/2023 at approximately 7:30 PM, Resident 2 was very anxious and crying. Family Member N requested a refill of prn lorazepam on 12/14/2023 AM, which pharmacy delivered to facility at 11:55 PM on 12/14/2023. Resident 3: Summary On 12/26/2024, Resident 3 was discharged from the hospital back to the provider. Resident 3 was also admitted to outpatient hospice service. Resident 3's practitioners ordered new medications including a psychotorpic PRN for behaviors related to dementia. On 12/27/2023, Resident 3's new medications were delivered to the provider by pharmacy. Former Resident Care Director Q did not transcribe the new medication orders to Resident 3's December 2023 medication administration record (MAR) or January 2024 MAR. This resulted in Resident 3 not receiving the following medications as prescribed: -From 12/27/2023 to 01/03/2024, Resident 3 did not receive his/her Lamotrigine 25 mg tablets and Senna-Docusate 8.6-50 mg tablets as prescribed. -From 12/27/2023 to 12/30/2023, Resident 3 did not receive his/her Miconazole Nitrate external powder 2% as prescribed. -From 12/27/2023 to 01/03/2024, The provider did not make the following PRN medications available to Resident 3: Acetaminophen 650 mg for pain, Melatonin 3 mg for insomnia, and Ondansetron 4 mg for nausea.	N 352		

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N 352	Continued From page 17 -On 01/03/2024, Hospice Nurse S assessed Resident 3 and could not find Resident 3's Fentanyl 25 MCG/HR. Hospice Nurse S documented that following, "[Former Resident Care Director Q] and [Director V] report last medications were given on 12/31. Writer inquired about Fentanyl patch; [Director V] states new patch would not have been placed since prior to 1/1 as no medications have been given." This is a repeat violation. See Statement of Deficiency (SOD) KSK211 dated 06/02/2023 and SOD WX2E12 dated 07/16/2019. FINDINGS INCLUDE: On 12/15/2023, the Department received a complaint regarding Resident 1's medication and on 01/04/2024, the Department received a complaint regarding Resident 2's medications. Example 1- Resident 2 From 02/07/2024 - 02/14/2024 Surveyor received and reviewed Resident 2's record. Resident 1 was admitted 06/30/2023. Diagnoses included generalized anxiety disorder. Admission orders dated 06/30/2023 (received 02/13/2024 at 2:19 PM from Executive Director A) included lorazepam 0.5 MG 1 tablet every 6 hours as needed for anxiety. Individual Resident Controlled Substance Record (narcotic count log)- The log dated 08/09/2023 identified the pharmacy dispensed 30 tablets of prn lorazepam 0.5 MG on 08/09/2023, and on 12/12/2023 staff documented	N 352		

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N 352	Continued From page 18 the 30th tablet was administered at 9:00 AM on 12/12/2023. The log dated 12/14/2023 identified the pharmacy dispensed 30 tablets of prn lorazepam 0.5 MG on 12/14/2023. Resident 2's record did not contain facility progress notes prior to 2/2/2024, when staff could have documented pharmacy refill requests during December 2023. Neither Resident 2's record or facility records contained December 2023 pharmacy delivery receipts or evidence the facility faxed the pharmacy a refill request for Resident 2's prn lorazepam during December 2023. Individual Service Plan (ISP) dated 08/02/2023- In the area of Medication Administration- " ...I will receive medications safely and as prescribed ..." On 02/07/2023 at 10:57 AM, Surveyor interviewed Med Tech L who stated staff ordered prn medications from pharmacy when a couple of days' worth of medications remained so they would not run out. On 02/07/2023 at 1:10 PM, Surveyor interviewed Resident 2 (in person) and Family Member N (on speaker phone). Family member N stated in December 2023, facility ran out of prn Ativan (lorazepam) so s/he called the pharmacy and requested a refill. On 02/07/2023 at 1:43 PM, Surveyor interviewed Med Tech I who stated they re-ordered prn medications when 7 days' worth of medication remained.	N 352		

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N 352	Continued From page 19 On 02/07/2024 at 2:37 PM, Surveyor interviewed Med Tech M who stated they ran out of Resident 2's prn Lorazepam prior to December 2023 but s/he could not recall when that was. Med Tech M stated when they ran out of a medication, they called pharmacy or the nurse right away to request a refill. On 02/07/2024 at 3:22 PM, Surveyors discussed concern of facility running out of Resident 2's prn lorazepam with Interim Director of Nursing J, Interim Executive Director K and Executive Director A. Interim Director of Nursing J stated his/her expecation was staff would request a refill 7 days prior to the medication running out but s/he did not work at the facility in December 2023. Executive Director A stated s/he agreed staff should request a refill 7 days prior to the medication running out. On 02/08/2023 at 3:25 PM, Surveyors received signed packing slip/delivery receipt via email from the pharmacy dated 12/14/2023 identifying 30 tablets of Resident 2's prn lorazepam was delivered to facility on 12/14/2023 at 11:55 PM. On 02/08/2024 at 4:34 PM, Surveyor interviewed Family Member N who stated on 12/13/2023 at approximately 7:30 PM, Resident 2 called him/her. Resident 2 was very anxious and crying and a caregiver was trying to comfort him/her. Family Member N stated s/he was told during that phone call no prn lorazepam available. Family Member N stated on 12/14/2023 AM, s/he called the pharmacy and requested a refill of Resident 2's prn lorazepam. On 02/13/2024 at 4:00 PM Surveyors discussed concern of facility running out of Resident 2's prn lorazepam with Interim Director of Nursing J,	N 352		

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N 352	Continued From page 20 Interim Executive Director K and Executive Director A. Interim Director of Nursing J stated it was possible the pharmacy did not have a physician order for the prn lorazepam refill until 12/14/2023. On 02/14/2023 at 11:39 AM, Surveyor interviewed Pharmacist O who stated on 08/09/2023 pharmacy received a refill order for prn lorazepam from Resident 2's prior out of state physician used to refill prn lorazepam in August 2023, and on 08/12/2023 pharmacy received a refill order for prn lorazepam from Resident 2's new local physician used to refill prn lorazepam on 12/14/2023. Example 2 - Resident 3 On 02/07/2024, Surveyor reviewed Resident 3's facility facesheet. Resident 3 had an activated power of attorney. Resident 3 was admitted to the facility on 08/30/2022. Resident 3 was diagnosed with but not limited to: dementia with behavioral disturbance, psychotic disorder with delusions due to known physiological condition, localization-related symptomatic epilepsy, and dysuria (discomfort while urinating). On 02/07/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) signed on 06/15/2023. Under the subsection "ADL Needs: Bathing," the following is documented "I may RESIST bathing activities. Per {Family Member U]- [Resident 3] has not taken a bath/shower in a while but will wash up in the sink. Since admission staff from [Name of Facility] and [Previous Hospice Facility] have been unsuccessful in having [Resident 3] take a shower or bath...My caregivers will observe for any changes in my ability to participate in my care and report any changes in ADL function/need to	N 352		

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N 352	Continued From page 21 the nurse and coordinator." Under the subsection "ADL Needs: Dressing," the following is documented "I need physical assistance with dressing. I will be able to participate in some of dressing activities. I need frequent clothing changes. I need application of stockings...I may RESIST care...I require more than one change of clothing per day, i.e., morning and pm care." Under the subsection related to medication Resident 3's ISP states facility staff are to assist Resident 3 with medication administration. Under the subsection "I have potential/actual impairment to integrity," the following is documented, "My caregivers will observe/document/report location, size and treatment of skin injury and/or any new or worsened alterations in skin integrity. Resident 3's ISP does not mention Resident 3's pressure wound to his/her heels, his/her pressure wound to his/her buttocks, admission to hospice/hospice orders, and his/her psychotropic PRN. Resident 3's ISP documents the following, "I am/have the potential to be verbally aggressive or to demonstrate behaviors. Has thrown items at staff including silverware utensils." Resident 3's ISP hadn't been updated with new concerns and/or needs since 06/15/2023. On 02/07/2024 at 10:00 AM, Surveyor discussed Resident 3 with Med Tech L. Med Tech L stated s/he did not administer medications while Resident 3 lived at the facility. Med Tech L stated s/he had provided personal cares for Resident 3 while s/he lived at the facility. Med Tech L stated s/he recalled a time when staff reported they couldn't administer Resident 3's medications because the pills were not listed on the medication administration record (MAR). Med Tech L stated s/he enjoyed caring for Resident 3 but that Resident 3 would become verbally aggressive at times.	N 352		

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N 352	Continued From page 22 On 02/07/2024 at 10:15 AM, Surveyor discussed Resident 3 with Caregiver I. Caregiver I stated s/he administered medications and provided caregiving services to Resident 3. Caregiver I stated when Resident 3 returned from the hospital. The pharmacy sent a bunch of medications in blister packs for Resident 3; but the facility MAR didn't have the medications listed so s/he did not administer them. Caregiver I stated Resident 3 had a couple medications listed on his/her MAR and those medications were administered to Resident 3. Caregiver I stated s/he reported Resident 3's incomplete MAR to Former Resident Care Director Q. Caregiver I stated pharmacy would only deliver medications from 9:00 AM to 12:00 PM and at 8:00 PM. Caregiver I stated s/he cared about Resident 3 but Resident 3 needed a much higher level of care then the facility could provide. Caregiver I stated his/her life partner works at [Name of Psychiatric Hospital] and Resident 3 seem more like that type of resident. Caregiver I reported Resident 3 would not allow staff to assist him/her with showers and that s/he would steal things from around the unit to hide in their room. Caregiver I stated Resident 3 would become verbally aggressive and at times attempt to hit staff if s/he had not been approached in the correct manner. Caregiver I stated Resident 3 would refuse to be showered to the point Resident 3's body odor could be detected in the hallways outside of his/her room. Caregiver I stated s/he would report Resident 3's behaviors to Former Resident Care Director Q. Caregiver I stated Resident 3 would require multiple re-approaches a day to complete personal cares. On 02/07/2024 at 12:50 PM, Surveyor received a return phone call from Pharmacist T. Pharmacist	N 352		

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N 352	Continued From page 23 T stated while Resident 3 was admitted to the hospital in mid-December 2023 many of his/her medication orders were changed. Pharmacist T stated s/he could see on the pharmacy computer system from 12/26/2023 to 12/30/2023 multiple medications were dispensed by the pharmacy and then delivered to the facility for Resident 3. Pharmacist T stated the above facility's nurse transcribed new medication orders to resident MARs between the monthly cycle fill. Pharmacist T stated all resident MARs are delivered to the facility once a month with cycle fill. Pharmacist T stated on 01/04/2024 Former Resident Care Director Q sent an email to the pharmacy asking for a new MAR because Resident 3's January 2024 MAR was incomplete. Pharmacist T stated the pharmacy delivers prescription medications as needed for residents/facilities. On 02/07/2024, Surveyor reviewed Resident 3's December 2023 MAR. The following medication orders were transcribed to Resident 3's December 2023 MAR: 1.) Lamotrigine Tablet 300 MG ER - Once daily (This order is listed as discontinued as of 12/26/2023) 2.) Quetiapine Tablet 25 MG - Once daily (This order is listed as discontinued as of 12/06/2023) 3.) Fentanyl 25 MCG/HR - Apply patch once every 3 days 4.) Olanzapine 2.5 MG Tablet - Once daily 5.) Polyethylene Glycol - Once daily 6.) Quetiapine Tablet 50 MG - As Needed (PRN) (This order is listed as discontinued as of 12/06/2023) 7.) Polyethylene Glycol - PRN 8.) Naloxone 4 MG/0.1 ML Nasal Spray - PRN 9.) Olanzapine 2.5 MG - PRN 10.) Bisacodyl 10 MG Suppository - PRN	N 352		

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N 352	Continued From page 24 On 02/07/2024, Surveyor reviewed Resident 3's January 2024 MAR. The following medication orders were transcribed to Resident 3's January 2024 MAR: 1.) Lamotrigine Tablet 300 MG ER - Once daily (This order is listed as discontinued as of 12/26/2023) 2.) Fentanyl 25 MCG/HR - Apply patch once every 3 days 3.) Polyethylene Glycol - Once daily 4.) Naloxone 4 MG/0.1 ML Nasal Spray - PRN 5.) Bisacodyl 10 MG Suppository - PRN On 02/07/2024, Surveyor reviewed the facilities list of Resident 3's medication orders. The following medication orders were listed as follows: 1.) Zeasorb-AF Powder 2% - Apply topically twice daily - Order was initiated on 12/25/2023 2.) Acetaminophen 650 MG Tablet - PRN every 6 hours for pain - Order was initiated on 12/27/2023 3.) Melatonin 3 MG Tablet - PRN at bedtime for insomnia - Order was initiated on 12/25/2023 4.) Olanzapine 2.5 MG Tablet - PRN once daily for aggressive behavior - Order was initiated on 12/27/2023 5.) Ondansetron 4 MG Tablet - PRN every 8 hours for nausea - Order was initiated on 12/27/2023 On 02/07/2024 at 3:30 PM, Surveyor discussed the above concerns with Executive Director A, Interim Director of Nursing J and Interim Executive Director K. Executive Director A stated s/he could not acknowledge if Resident 3 had been administered his/her medications as prescribed or not from 12/27/2023 to 01/03/2024. Executive Director A produced a hospital discharge summary dated 12/26/2023 for Resident 3 stating all prescription medications	N 352		

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besides the Lamotrigine had been discontinued. Executive Director A stated s/he did not understand what Caregiver I was referring to in relation to having physical pills in the medication cart that were not administered to Resident 3. Executive Director A stated there had been instances where discontinued medications had been left in the medication cart until the next cycle fill. Executive Director A stated s/he believed Caregiver I had mistaken discontinued medications for newly delivered medication. Surveyor asked Executive Director A if the list of medication orders the facility had on file for Resident 3 was correct. Executive Director A stated the medication orders list was sent to him/her that day from an outside pharmacy. Executive Director A stated Resident 3 was no longer his/her resident so s/he didn't know exactly what the pharmacy was doing for him/her now.

On 02/08/2024 at 9:00 AM, Surveyor spoke with Family Member U over the phone. Family Member U stated Hospice Nurse S discovered Resident 3 had not been given his/her medications since 12/27/2023. Family Member U stated facility staff would not provide Resident 3 personal cares due to Resident 3's aggressive behaviors. Family Member U stated facility staff would not administer medications due to Resident 3's consistent refusals. Family Member U stated on 01/03/2024, s/he visited Resident 3 early in the morning and s/he was conscious at that time. Family Member U stated Resident 3's hair looked like it had not been showered in days, Resident 3's pants were pulled halfway down his/her legs, Resident 3's urinary collection bag was on the floor, Resident 3's clothing and linens were covered in dried bits of food. Family Member U stated when Resident 3 was admitted to the hospital on 12/14/2023 s/he had open sores on

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his/her feet. Family Member U stated the facility never reported the development of open sores on Resident 3's feet to him/her.

On 02/08/2024 at 9:50 AM, Surveyor spoke with Nurse Practitioner R over the phone. Nurse Practitioner R stated on 01/03/2024 s/he entered Resident 3's room with Hospice Nurse S. Nurse Practitioner R stated Resident 3 had a decreased level of consciousness. Nurse Practitioner R and Hospice Nurse S immediately attempted to wake up Resident 3. As Nurse Practitioner R started interventions s/he assessed Resident 3 was covered in dried food, his/her bed linens were soiled with dried food, a metal clasp on his/her undergarment was making a red 0.5 inch indentation into his/her back, and his/her urinary collection bag was left on the floor. Nurse Practitioner R stated s/he visualized signs of infection within Resident 3's urinary collection system. Nurse Practitioner R stated s/he was meaning to obtain a straight catheter urine sample but when s/he opened Resident 3's incontinence brief s/he found it to be saturated with an unknown purulent drainage. Nurse Practitioner R stated s/he could not decipher the cause of the purulent drainage; and decided a urinary sample would need to be obtained in the ER. Nurse Practitioner R stated Hospice Nurse S reported s/he could not find Resident 3's fentanyl patch on Resident 3's shoulders. Nurse Practitioner R stated Hospice Nurse S and Director V observed Resident 3's prescription blister packs in the facility medication cart had zero pills administered from them; and it was then discovered Resident 3 had not been receiving his/her medications as prescribed.

On 02/08/2024 at 12:06 PM, Surveyor spoke with Director V over the phone. Director V stated s/he

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remembered concerns related to Resident 3's medications. Director V stated Resident 3's January 2024 MAR arrived at the facility while Resident 3 was in the hospital from 12/14/2023 to 12/26/2023. Director V stated the January 2024 MAR provided did not have the orders for the medications prescribed after 12/24/2023. Director V stated s/he observed the facility medication cart with Hospice Nurse S on 01/03/2024 and found many of Resident 3's prescription blister packs had zero pills administered from them.

On 02/08/2024 at 3:00 PM, Surveyor conducted a TEAMS virtual interview with Pharmacist W and Pharmacist X. Pharmacist W verified the above facility received MARs from the pharmacy once a month with cycle fill, and any changes to medication orders were transcribed to the MAR by the facility nurse. Pharmacist X stated Resident 3's January 2024 MAR was sent to the facility on 12/22/2023 at 11:21 AM. Pharmacist X stated on 12/28/2023 Former Resident Care Director Q emailed them to verify Resident 3's new medication orders were on file. Pharmacist X and Pharmacist W stated they would provide Surveyor with documentation related to the dispersion of Resident 3's medications from 12/26/2023 to 01/04/2024.

On 02/08/2024, Surveyor reviewed an email sent from Pharmacist W on 02/08/2024 at 4:18 PM. The documents attached to the email were as follows:

1.) The medications ordered for Resident 3 by Doctor Y on 12/25/2023 and 12/26/2023. The medications ordered were as follows: Acetaminophen 650 MG 6-hour PRN for pain, Melatonin 3 MG PRN at bedtime for insomnia, Miconazole Nitrate 2 % Topical Powder

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scheduled twice daily for 5 days, Ondansetron 4 MG 8-hour PRN for nausea, Senna-Docusate 8.6-50 MG scheduled twice daily for 5 days, and Lamotrigine 25 MG scheduled take 1 tablet daily for 3 days, then 2 tablets daily for 14 days.

2.) The pharmacy delivery receipt dated 12/26/2023. The pharmacy delivery receipt stated the following medications were delivered to the facility for Resident 3: Acetaminophen 325 MG tablets, Melatonin 3 MG tablets, Ondansetron 4 MG tablets, Senna-Docusate 8.6-50 MG Tablets, and Lamotrigine 25 MG Tablets. This delivery receipt was signed by Caregiver I on 12/27/2023 at 10:35 AM. On 02/13/2024 at 1:51 PM, Surveyor received an email from Executive Director A stating the signature on this pharmacy delivery slip belonged to Caregiver I.

3.) The medications ordered by Nurse Practitioner R for Resident 3 on 12/27/2023. The medications were Olanzapine 5 MG scheduled once daily and Olanzapine 2.5 MG once daily PRN for behaviors related to dementia.

4.) The pharmacy receipt dated 12/27/2023. The pharmacy receipt states the following medications were delivered: Olanzapine 5 MG tablets, Olanzapine 2.5 MG tablets and Miconazole Powder 2 %. This pharmacy receipt was signed by Former Resident Care Director Q on 12/28/2023 at 10:42 AM.

5.) The email chain between Former Resident Care Director Q, Hospice Nurse S and Pharmacist X:

-On 12/28/2023 at 11:57 AM, Former Resident Care Director Q emailed Resident 2's hospice medication list to Pharmacist X.

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N 352	Continued From page 29 -On 12/28/2023 at 2:40 PM, Pharmacist X responds to Former Resident Care Director Q's email and states there are discrepancies between Resident 3's hospice medication list and the medication orders the pharmacy had on file. Pharmacist X reported Resident 3's hospice medication list did not have the following medications listed: Acetaminophen PRN, Ondansetron PRN, Olanzapine PRN, Senna-Docusate and the Miconazole 2% powder. Pharmacist X stated the pharmacy had orders for those medications and those medication orders would remain active until a discontinuation order was received. Pharmacist X reported Resident 3's hospice medication list also had Lamotrigine 300 MG ER listed, and the pharmacy only had an order for Lamotrigine 25 MG. -On 12/28/2023 at 3:00 PM, Former Resident Care Director Q forwarded the most recent email from Pharmacist X to Hospice Nurse S with the following message, "Dear [Hospice Nurse S] - I am deferring to you for clarification on [Resident 3's] orders. I forwarded the [Name of Hospice] orders to [Pharmacist X] and still appears discrepancies. Please review the attached email and advise. Thank you, [Former Resident Care Director Q]". -On 12/28/2023 at 3:23 PM, Hospice Nurse S responded to Former Resident Care Director Q's email and CC'd Pharmacist X. Hospice Nurse S stated s/he just faxed the most recent medication list for Resident 3 to the pharmacy. -On 12/28/2023 at 3:35 PM, Pharmacist X emailed both Hospice Nurse S and Former Resident Care Director Q which stated, "We did get the list. I have reconciled it and d/c'd the	N 352		

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moi-stir. All other medications reconciled now."

On 02/09/2024, Surveyor reviewed Resident 3's hospice record. On 01/03/2024 at 5:31 PM, Hospice Nurse S documented the following, "RN performed comprehensive assessment, medication reconciliation, and plan of care review. Symptoms addressed and recommendations: Upon arrival, writer was stopped by lead nursing staff [Former Resident Care Director Q] at facility. [Former Resident Care Director Q] asks writer to meet with [him/her] and [Director V] in [his/her] office. [Former Resident Care Director Q] tells writer that they do not have updated medication list for patient and they have not known what to give patient since start of January. [Former Resident Care Director Q] and [Director V] report last medications were given on 12/31. Writer inquired about Fentanyl patch; [Director V] stated new patch would not have been placed since prior to 1/1 as no medications have been given. Writer reviewed importance of giving medications and noted that [Name of Hospice] could have been called with any questions about medication orders 24/7. [Former Resident Care Director Q] gave writer faxed documents and a December MAR for patient stating, "this is all we have, it's so confusing." Writer reviewed documents and found updated faxed copy of patient's medication list from hospice attending office. Writer gave this to [Former Resident Care Director Q]. [Former Resident Care Director Q] and [Director V] then questioning if they have all medications available in facility. Writer and [Director V] reviewed med cart - all medications available aside from PRN Bisacodyl supps. Writer to f/u on this. [Director V] denies needing any further follow up for ordered medications to be given. [Nurse Practitioner R] then arrived and stated [s/he] is here to see

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patient. Writer and [Nurse Practitioner R] completed joint visit. Patient found lethargic in [his/her] room. Patient able to deny pain, but otherwise unresponsive with eyes closed throughout remainder of visit. Patient's catheter bag dragging on floor, no securement device in place. Writer found Medline box of supplies ordered last week upstairs and arranged them. [Nurse Practitioner R] expressing concern to writer that patient may have UTI and requests to complete a UA. [Nurse Practitioner R] called son [Family Member U], VM left asking to do UA. [Family Member U] returned call and stated [s/he] would join visit. Writer and [Nurse Practitioner R] completed cares - Significant purulent white/yellow discharge present around catheter and vaginal area. Old catheter removed. Incontinence cares performed as stool also present. Patient wearing [undergarment] with metal clasps and pants halfway on. Writer removed pants and bra d/t risk of pressure injuries from metal clasps. Clean shirt placed on patient. Old food in bed around patient - writer and [Nurse Practitioner R] cleaned area. Skin under breasts is fragile and pink. Antifungal powder applied. [Family Member U] then arrived. updated on patient's condition (unresponsiveness and concerns of UTI) and [Family Member U] requests patient be taken to the ED. Writer provided education on option of testing for UTI and treating at facility with oral antibiotics if UA does indicate UTI. [Family Member U] states, "Would they even give [him/her] the antibiotics here?" Writer validated [Family Member U's] concerns and frustrations."

On 02/09/2024 at 2:30 PM, Surveyor spoke on the phone with Hospice Social Worker Z and Hospice Nurse S. Hospice Nurse S stated s/he was one of the nurses who found Resident 3 very

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lethargic in his/her room on 01/03/2024. Hospice Nurse S stated s/he found Resident 3 to have his/her pants pulled halfway down, urinary collection bag on the floor, his/her hair was matted with his/her glasses stuck in his/her hair. Hospice Nurse S stated the metal clasps on his/her undergarment was digging into his/her skin. Hospice Nurse S stated Resident 3's brief was saturated with purulent thick white drainage and stool. Hospice Nurse S stated while preforming incontinence cares s/he found Resident 3's skin and clothing to be covered in dried food. Hospice Nurse S stated Resident 3's bed linens were covered in dried food particles and other unidentified substances. Hospice Nurse S stated the skin under Resident 3's breasts was red from a fungal skin infection. Hospice Nurse S stated s/he applied the Miconazole 2% powder to Residents 3's affected skin. Hospice Nurse S stated s/he asked Director V about Resident 3's medications. Hospice Nurse S stated s/he looked at the facility medication cart with Director V and found all of Resident 3s new medications to be unopened/all the pills still in their blister pack slots.

On 02/13/2024 at 4:00 PM, Surveyor completed an exit interview with the TEAMS conference system with Executive Director A, Interim Director of Nursing J and Interim Executive Director K. Executive Director A acknowledged s/he was not aware Resident 3 not been administered his/her medications as prescribed from 12/27/2023 to 01/03/2024. Executive Director A stated s/he knew staff and nurses found Resident 3 unresponsive the morning of 01/03/2024; but was not aware of other details related to Resident 3's physical presentation. Executive Director A acknowledged s/he was not aware Resident 3's practitioner ordered a psychotropic PRN to

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N 352	Continued From page 33 manage behaviors related to dementia. Executive Director A, Interim Director of Nursing J and Interim Executive Director K did not have any questions related to Surveyor's findings. Interim Executive Director K stated s/he would work with staff to be sure issues like this are reported to administrators in the future. CROSS REFERENCE N0214 DHS Chapter 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE N0431 DHS Chapter 83.38(1)(h) Health Monitoring	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 with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan was updated when there was a change in the resident's needs, abilities or physical or mental condition.	N 389		

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N 389	Continued From page 34 Resident 2's individual service plan (ISP) was not updated to address anxiety and insomnia, use of as needed (prn) psychotropic medications or mental health treatment by outside providers. Findings include: Per 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". From 02/07/2024-02/14/2024, Surveyor received and reviewed Resident 2's record. S/he was admitted 06/30/2023. Diagnoses included generalized anxiety disorder and insomnia. The record contained 2 comprehensive assessments dated 06/28/2023 and 08/01/2023. Pre-admission Assessment dated 06/28/2023- In the area of Orientation and Behavior- " ...Does the Resident [sic] have a diagnosis of depression or mental health history? [neither yes or no were checked] ...Does Resident [sic] have a diagnosis or symptoms of depression? [followed by mood related questions A-J including C. trouble falling or staying asleep or sleeping too much?] ..." Questions A-J were not answered. In the area of Sleep Patterns- " ...Does the Resident display or verbalize a sleep cycle disturbance or insomnia? NO ..." Assessment dated 08/01/2023 did not include areas for mood or sleep. On 02/08/24 at 6:56 PM, Surveyor emailed Executive Director A requesting any additional assessments regarding Resident 2's mood since 08/01/2023.	N 389		

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N 389	Continued From page 35 02/09/2024 at 12:42 PM, Surveyor received a BIMs (Brief Interview for Mental Status that assesses memory, orientation, and recall) dated 06/30/2023 via email from Executive Director A. No additional assessments were received. On 02/14/2024 at 9:11 AM Surveyor emailed Executive Director A requesting all quarterly scheduled psychotropic and monthly prn psychotropic reviews for Resident 2 since his/her admission on 06/30/2023 to determine if Resident 2's anxiety and insomnia, appropriate use of and effectiveness of psychotropics were monitored. Admission orders dated 06/30/2023 (received by the Department on 02/13/2024 2:19 PM from Executive Director A) included psychotropic medications eszopiclone 2 MG 1 tablet at bedtime as needed for insomnia, lorazepam 0.5 MG 1 tablet every 6 hours as needed for anxiety, and escitalopram 20 MG 1 tablet and 10 MG 1 tablet (30 MG total) every morning for generalized anxiety disorder. Psychotropic medications started after admission included temazepam 7.5 MG 1 capsule prn at bedtime for sleep started 07/03/2023 when prn eszopiclone was discontinued 07/03/2023, and scheduled mirtazapine started 07/13/2023, was increased to 15 MG on 08/02/2023 and continued through 02/07/2024. Scheduled escitalopram continued through 02/07/2024. Surveyor received and reviewed MARs from Executive Director A on the following dates: July 2023 MAR received 2/13/2024 at 11:07 AM via email; August 2023-December 2023 received onsite 02/07/2024; and January 2024 and	N 389		

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February 2024 Mars received 02/09/2024 at 2:32 PM via email from Executive Director A.

According to the MAR, dated 07/01/2023-2/07/2024:
PRN eszopiclone was administered 6 times from 07/01/2023-07/06/2023.

PRN lorazepam was administered 77 times from 07/01/2023-02/07/2024:
July 2023- 44 times
August 2023-6 times
September 2023- 6 times
October 2023- 3 times
November 2023- twice
December 2023- 3 times
January 2024- twice
February 2024- once

PRN temazepam was administered 9 times from 07/02/2023-02/07/2024:
September 2023- 3 times
October 2023- once
December 2023- 3 times
January 2023- 3 times

02/08/2024 9:17 PM Surveyor received and reviewed Resident 2's MyChart emergency room note dated 10/21/2023, psychiatry clinic note dated 10/16/2023, and behavioral health clinic telephone encounter notes dated 10/23/2023 and 12/14/2023 from Family Member N.

10/16/2023 at 1:00 PM Psychiatry clinical note- " ...today present anxious, labile, easily overwhelmed ...consistent with major neurocognitive disorder with associated depressive and anxious features, Will [sic] decrease escitalopram to 10 mg in the setting of associated night sweats and 20 mg and increase

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mirtazapine to target depressive symptoms and insomnia ..."

10/21/2023 at 1:09 PM Emergency room note- " ...history of major neurocognitive disorder, anxiety, recurrent major depression, confusion/encephalopathy who presents secondary to anxiety and episode of confusion ...Independent review of [his/her] psychiatry telephone note dated October 20, 2023 a phone call was taken at that time secondary to anxiety and worsening memory concerns. [S/he] was seen by Psychiatry [sic] on this past Monday, with [his/her] Lexapro dose decreased and [his/her] Mirtazapine dose increased due to night sweats ..."

10/23/2023 at 4:09 PM- "Writer called [Former Resident Care Director Q] ...as far as anxiety , [Former Resident Care Director Q] notes [s/he] has 'Found [Resident 2] to be emotionally labile' ..."

12/14/2023 3:55 PM- "[Social Worker] spoke with [Family Member N] ...[Resident 2's] mood has been worse this past week; anxious, angry, accusatory ...often gets upset and very sad when [Family Member N] drops [him/her] off after appts, Will [sic] cry, sometimes stands behind the car so [Family Member N] can not leave ...a staff member also took [Resident 2] to tour an apartment which got [Resident 2] excited, believing [s/he] could move from [his/her current ALF unit ...[Resident 2] is a compulsive shopper, sends repeated texts on things [s/he] wants and doesn't need, Sometimes [sic] remembers [s/he] asked and gets anxious wanting to know when they're arriving ..."

On 02/14/2024 at 3:48 PM, Surveyor received

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N 389	Continued From page 38 and reviewed a Quarterly Psychotropic /Depression Medication Review form from Executive Director A via email. (Quarterly scheduled psychotropic medication reviews are completed to assess for desired responses and possible side effects of the medication(s) and monthly prn psychotropic medication reviews are completed to monitor for inappropriate use of the prn medication including use contrary to the ISP, adverse side effects, use for discipline or staff convenience, or use contrary to the intended use). Prn lorazepam and prn temazepam were reviewed on 07/2023 and 11/2023. On 02/15/2024 at 11:54 AM, Surveyor received and reviewed a Quarterly Psychotropic/Depression Medication Review form from Executive Director A via email dated 01/2024. Scheduled escitalopram, prn lorazepam and prn temazepam were reviewed on the form. No monthly prn psychotropic medication reviews for Resident 2 were received for August 2023, September 2023, October 2023, or December 2023. A second quarterly scheduled psychotropic review since admission on 06/20/2023 was not received. ISP dated 08/02/2023- In the area of Medications: " ...I need staff to monitor my medications for effectiveness, side effects, interactions ...I request the staff to administer my medications to me ..." Anxiety, insomnia, prn psychotropic medications (including rationale for use and detailed description of the behaviors which indicate the need for administration of PRN psychotropic	N 389		

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medication) and behavioral health services were not addressed on the ISP.

02/08/2024 at 4:34 PM, Surveyor interviewed Family Member N who stated on 12/13/2023 at approximately 7:30 PM, Resident 2 called him/her. Resident 2 was very anxious and crying and a caregiver was trying to comfort him/her.

On 02/09/2024 at 4:58 PM, Surveyor interviewed Former Caregiver P who stated in October 2023, when Resident 2's escitalopram was decreased to 10 MG, Resident 2 had episodes of crying and began getting depressed. Former Caregiver P stated Resident 2 was very depressed in October 2023.

On 02/13/2024 at 4:00 PM, Surveyors discussed concern of Resident 2's ISP not updated to include mood, psychotropic medications or outside mental health services with Interim Director of Nursing J, Interim Executive Director K and Executive Director A. Interim Director of Nursing J stated s/he did not work at facility. Executive Director A stated auditing of the ISPs was a work in progress.

On 02/14/2024 at 3:04 PM, Surveyor received an email from Family Member N stating (summarized): Resident 2 had been on antidepressants since 2008 and anxiety and depression symptoms increased over time. Power of Attorney for Health Care was activated on 06/01/2023 during an ER visit. Resident 2 has been seen at behavioral health at their psychiatry, memory care, and geriatric clinics since July 2023.
On 02/15/2024 at 11:54 AM, Surveyor received an email from Executive Director A stating " ...We will be reviewing [Resident 2's] ISP and CP ..."

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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 an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3's physical and	N 431		

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mental health were adequately monitored to meet his/her needs.

On 12/14/2024, Resident 3 was admitted to the hospital. Resident 3 was diagnosed with metabolic encephalopathy and urinary tract infection (UTI). Per hospital records, Resident 3 had been experiencing a decline in condition for approximately 11 days before Resident 3 was sent to an emergency room. Per clinical interview, from 12/03/2023 to 12/10/2023, the provider had not contacted Resident 3's primary care clinic to report Resident 3's change in condition. Per provider's records, on 12/12/2023, Director V notified Resident 3's primary care clinic s/he had been experiencing a decline in condition for about a week or so. This report on decline in condition included the development of a pressure wound to his/her buttocks and increased weakness.

On 12/26/2024, Resident 3 was discharged from the hospital back to the facility. During Resident 3's hospital stay his/her condition and/or needs changed in the following ways: admitted to hospice service, diagnosed with 2 pressure wounds, indwelling urinary foley catheter, and new medications prescribed including a psychotropic as needed (PRN) for behaviors related to dementia.

On 01/03/2024, Nurse Practitioner R and Hospice Nurse S found Resident 3 in his/her room experiencing a decreased level of consciousness. Nurse Practitioner R and Hospice Nurse S attempted to wake up Resident 3. They found Resident 3 to have matted hair, dried food on his/her skin/clothes/bedding, reddened skin under his/her breasts, his/her urinary collection bag on the floor, a metal clasp from a clothing garment causing a red indentation into his/her skin, a brief

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saturated with unidentifiable purulent drainage and feces, and with his/her pants only pulled partially up his/her legs. Provider's staff reported Resident 3's behaviors had made it difficult for caregivers to assist him/her with showers and/or daily grooming. Resident 3 was sent back to the hospital due to decreased level of consciousness. Resident 3 was diagnosed with acute metabolic encephalopathy, acute cystitis (bladder infection) and 5 pressure wounds. Resident 3 did not return to facility after hospitalization.

On 02/07/2024, Surveyor found the provider had not documented an assessment on Resident 3 since 09/13/2023. Resident 3's decline in condition had not been documented in his/her facility observation notes from 12/03/2023 to 12/10/2023 or from 12/19/2023 to 01/03/2024. Resident 3's individualized service plan (ISP) had not been updated since 06/15/2023. Resident 3's December 2023 medication administration record (MAR) and January 2024 MAR had not been updated with medication orders prescribed after 12/25/2023. Provider's staff did not offer Resident 3 his/her new psychotropic PRN medication for behaviors related to dementia and subsequently Resident 3 was not provided personal cares based on those behaviors.

This is a repeat violation of statement of deficiency (SOD) Z1LL11 dated 09/22/2023.

FINDINGS INCLUDE:

According to Department facesheet the facility provides care to the following client groups: irreversible dementia, Alzheimer's, and advanced aged.

On 01/04/2024 & 01/23/2024, The Department

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received complaints related to care and services.

On 02/07/2024, Surveyors arrived at facility for 3 complaint investigations and a verification visit.

On 02/07/2024 at 10:00 AM, Surveyor discussed Resident 3 with Med Tech L. Med Tech L stated s/he did not administer medications while Resident 3 lived at the facility. Med Tech L stated s/he had provided personal cares for Resident 3 while s/he lived at the facility. Med Tech L stated s/he recalled a time when staff reported they couldn't administer Resident 3's medications because the pills were not listed on the medication administration record (MAR). Med Tech L stated s/he enjoyed caring for Resident 3 but that Resident 3 would become verbally aggressive at times.

On 02/07/2024 at 10:15 AM, Surveyor discussed Resident 3 with Caregiver I. Caregiver I stated s/he administered medications and provided caregiving services to Resident 3. Caregiver I stated when Resident 3 returned from the hospital, the pharmacy sent a bunch of medications in blister packs for Resident 3; but the facility MAR didn't have the medications listed so s/he did not administer them. Caregiver I stated Resident 3 had a couple medications listed on his/her MAR and those medications were administered to Resident 3. Caregiver I stated s/he reported Resident 3's incomplete MAR to Former Resident Care Director Q. Caregiver I stated pharmacy would only deliver medications from 9:00 AM to 12:00 PM and at 8:00 PM. Caregiver I stated s/he cared about Resident 3 but Resident 3 needed a much higher level of care then the facility could provide. Caregiver I stated his/her signifcant other works at [Name of Psychiatric Hospital] and Resident 3 seem more

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like that type of resident. Caregiver I reported Resident 3 would not allow staff to assist him/her with showers and that s/he would steal things from around the unit to hide in their room. Caregiver I stated Resident 3 would become verbally aggressive and at times attempt to hit staff if s/he had not been approached in the correct manner. Caregiver I stated Resident 3 would refuse to be showered to the point Resident 3's body odor could be detected in the hallways outside of his/her room. Caregiver I stated s/he would report Resident 3's behaviors to Former Resident Care Director Q. Caregiver I stated Resident 3 would require multiple re-approaches a day to complete personal cares.

On 02/07/2024, Surveyor reviewed Resident 3's facility record:

On 02/07/2024, Surveyor reviewed Resident 3's facility facesheet. Resident 3 had an activated power of attorney. Resident 3 was diagnosed with but not limited to: dementia with behavioral disturbance, psychotic disorder with delusions due to known physiological condition, localization-related symptomatic epilepsy, and dysuria (discomfort while urinating).

On 02/07/2024, Surveyor reviewed the facilities copy of Resident 3's hospice record. The hospice record is dated 12/26/2023. The hospice record included a document titled, "Routine Standing Orders Order," which stated the following, "...If oral medication held more than 24 hours, notify attending physician/designee. May give medications in applesauce/pudding...Oxygen orders: Oxygen via nasal cannula or mask at 0L - 4L per minute PRN for dyspnea (shortness of breath) or labored breathing. Humidify PRN...Indwelling urinary catheter." The hospice

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record included an order to administer Olanzapine 2.5 MG for behaviors related to dementia.

On 02/07/2024 at 12:00 PM, Surveyor requested Resident 3' s hospital aftercare summary for the 12/14/2023 to 12/26/2023 admission. Interim Director of Nursing J stated s/he did not have a copy of Resident 3's hospital after visit summary. Interim Director of Nursing J acknowledged the facility is to maintain documentation of resident medical visits.

On 02/07/2024, Surveyor reviewed Resident 3's facility observation notes:

-On 12/12/2023 at 5:16 PM, Director V documented the following, "Phone conversation with [Nurse KK] with [Doctor L]: we discussed residents typical/baseline behavior and habits compared to what staff have been reporting for the past week or so. Resident has some sores on [his/her] bottom and a bruise on one buttocks. Residenthas (sic) not been getting out of [his/her] bed either on [his/her] own or with assistance except 2 instances. Resident has been slightly more agreeable to being changed and staff have been doing so while [s/he] lay in bed. [Nurse KK] and I discussed possible sensory cues that could help calm the resident when staff are doing cares (voice of [Family Member U's] voice, showing [him/her] what we're doing, music, and lavender soap/lotion). [Nurse KK] was going to call [Family Member U] to discuss these ideas."

-On 12/14/2023 at 9:32 AM, Director V documented the following, "[Family Member U] decided that [s/he] wanted the resident to be sent to the ER via ambulance for evaluation due to [his/her] cognitive and physical decline. [S/he]

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N 431	Continued From page 46 was admitted to [Name of Hospital] for UTI and observation." -No, documentation occurred in the observation notes: from 12/01/2023 to 12/11/2023 & from 12/19/2023 to 01/03/2024. On 02/07/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) signed on 06/15/2023. Under the subsection "ADL Needs: Ambulation," the following is documented, "I am able to ambulate independently (may use cane, walker, wheelchair independently)." Under the subsection "ADL Needs: Bathing," the following is documented "I may RESIST bathing activities. Per [Family Member U]- [Resident 3] has not taken a bath/shower in a while but will wash up in the sink. Since admission staff from [Name of Facility] and [Previous Hospice Facility] have been unsuccessful in having [Resident 3] take a shower or bath...My caregivers will observe for any changes in my ability to participate in my care and report any changes in ADL function/need to the nurse and coordinator." Under the subsection "ADL Needs: Dressing," the following is documented "I need physical assistance with dressing. I will be able to participate in some of dressing activities. I need frequent clothing changes. I need application of stockings...I may RESIST care...I require more than one change of clothing per day, i.e., morning and pm care." Under the subsection related to medication Resident 3's ISP states facility staff are to assist Resident 3 with medication administration. Under the subsection "I have potential/actual impairment to integrity," the following is documented, "My caregivers will observe/document/report location, size and treatment of skin injury and/or any new or worsened alterations in skin integrity. Resident 3's ISP does not mention Resident 3's pressure	N 431		

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N 431	Continued From page 47 wounds to his/her heels, his/her pressure wound to his/her buttocks, admission to hospice/hospice orders, nor his/her psychotropic PRN. Resident 3's ISP documents the following, "I am/have the potential to be verbally aggressive or to demonstrate behaviors. Has thrown items at staff including silverware utensils." Resident 3's ISP hadn't been updated with new needs, interventions or goals since 06/15/2023. On 02/07/2024, Surveyor reviewed Resident 3's December 2023 MAR. The following medication orders were transcribed to Resident 3's December 2023 MAR: 1.) Lamotrigine Tablet 300 MG ER - Once daily (This order is listed as discontinued as of 12/26/2023) 2.) Quetiapine Tablet 25 MG - Once daily (This order is listed as discontinued as of 12/06/2023) 3.) Fentanyl 25 MCG/HR - Apply patch once every 3 days 4.) Olanzapine 2.5 MG Tablet - Once daily 5.) Polyethylene Glycol - Once daily 6.) Quetiapine Tablet 50 MG - As Needed (PRN) (This order is listed as discontinued as of 12/06/2023) 7.) Polyethylene Glycol - PRN 8.) Naloxone 4 MG/0.1 ML Nasal Spray - PRN 9.) Olanzapine 2.5 MG - PRN 10.) Bisacodyl 10 MG Suppository - PRN On 02/07/2024, Surveyor reviewed Resident 3's January 2024 MAR. The following medication orders were transcribed to Resident 3's January 2024 MAR: 1.) Lamotrigine Tablet 300 MG ER - Once daily (This order is listed as discontinued as of 12/26/2023) 2.) Fentanyl 25 MCG/HR - Apply patch once every 3 days	N 431		

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3.) Polyethylene Glycol - Once daily
4.) Naloxone 4 MG/0.1 ML Nasal Spray - PRN
5.) Bisacodyl 10 MG Suppository - PRN

On 02/07/2024, Surveyor reviewed the facilities list of Resident 3's medication orders. The following medication orders were listed as follows:
1.) Zeasorb-AF Powder 2% - Apply topically twice daily - Order was initiated on 12/25/2023
2.) Acetaminophen 650 MG Tablet - PRN every 6 hours for pain - Order was initiated on 12/27/2023
3.) Melatonin 3 MG Tablet - PRN at bedtime for insomnia - Order was initiated on 12/25/2023
4.) Olanzapine 2.5 MG Tablet - PRN once daily for aggressive behavior - Order was initiated on 12/27/2023
5.) Ondansetron 4 MG Tablet - PRN every 8 hours for nausea - Order was initiated on 12/27/2023
On 02/08/2024 at 8:24 AM, Surveyor emailed Executive Director A requesting all 2023 and 2024 assessments completed on Resident 3 by the facility.

On 02/09/2024, Surveyor reviewed an email sent from Executive Director A on 02/08/2024 at 4:27 PM. Executive Director A stated all requested documents were attached to the email. The last assessment completed on Resident 3 was on 09/13/2023.

On 02/09/2024, Surveyor reviewed Resident 3's hospice record. On 01/03/2024 at 5:31 PM, Hospice Nurse S documented the following, "RN performed comprehensive assessment, medication reconciliation, and plan of care review. Symptoms addressed and recommendations: Upon arrival, writer was stopped by lead nursing staff [Former Resident

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SEBRING ASSISTED CARE RESIDENCE	7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719

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Care Director Q] at facility. [Former Resident Care Director Q] asks writer to meet with [him/her] and [Director V] in [his/her] office. [Former Resident Care Director Q] tells writer that they do not have updated medication list for patient, and they have not known what to give patient since start of January. [Former Resident Care Director Q] and [Director V] report last medications were given on 12/31. Writer inquired about Fentanyl patch; [Director V] states new patch would not have been placed since prior to 1/1 as no medications have been given. Writer reviewed importance of giving medications and noted that [Name of Hospice] could have been called with any questions about medication orders 24/7. [Former Resident Care Director Q] gave writer faxed documents and a December MAR for patient stating, "this is all we have, it's so confusing." Writer reviewed documents and found updated faxed copy of patient's medication list from hospice attending office. Writer gave this to [Former Resident Care Director Q]. [Former Resident Care Director Q] and [Director V] then questioning if they have all medications available in facility. Writer and [Director V] reviewed med cart - all medications available aside from PRN Bisacodyl supps. Writer to f/u on this. [Director V] denies needing any further follow up for ordered medications to be given. [Nurse Practitioner R] then arrived and stated [s/he] is here to see patient. Writer and [Nurse Practitioner R] completed joint visit. Patient found lethargic in [his/her] room. Patient able to deny pain, but otherwise unresponsive with eyes closed throughout remainder of visit. Patient's catheter bag dragging on floor, no securement device in place. Writer found medline box of supplies ordered last week upstairs and arranged them. [Nurse Practitioner R] expressing concern to writer that patient may have UTI and requests to

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complete a UA. [Nurse Practitioner R] called [Family Member U], VM left asking to do UA. [Family Member U] returned call and stated [s/he] would join visit. Writer and [Nurse Practitioner R] completed cares - Significant purulent white/yellow discharge present around catheter and vaginal area. Old catheter removed. Incontinence cares performed as stool also present. Patient wearing [undergarment] with metal clasps and pants halfway on. Writer removed pants and bra d/t risk of pressure injuries from metal clasps. Clean shirt placed on patient. Old food in bed around patient - writer and [Nurse Practitioner R] cleaned area. Skin under breasts is fragile and pink. Antifungal powder applied. [Family Member U] then arrived. updated on patient's condition (unresponsiveness and concerns of UTI) and [Family Member U] requests patient be taken to the ED. Writer provided education on option of testing for UTI and treating at facility with oral antibiotics if UA does indicate UTI. [Family Member U] states, "Would they even give [him/her] the antibiotics here?" Writer validated [Family Member U's] concerns and frustrations."

On 02/09/2024 at 2:30 PM, Surveyor spoke on the phone with Hospice Social Worker Z and Hospice Nurse S. Hospice Nurse S stated s/he was one of the nurses who found Resident 3 very lethargic in his/her room on 01/03/2024. Hospice Nurse S stated s/he found Resident 3 to have his/her pants pulled halfway down, urinary collection bag on the floor, his/her hair was matted with his/her glasses stuck in his/her hair. Hospice Nurse S stated the metal clasps on his/her undergarment was digging into his/her skin. Hospice Nurse S stated Resident 3's brief was saturated wit a purulent thick white drainage and stool. Hospice Nurse S stated while

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preforming incontinence cares s/he found Resident 3's skin and clothing to be covered in dried food. Hospice Nurse S stated Resident 3's bed linens were covered in dried food particles and other unidentified substances. Hospice Nurse S stated the skin under Resident 3's breasts was red and excoriated from a fungal skin infection. Hospice Nurse S stated s/he applied the Miconazole 2% powder to Residents 3's affected skin. Hospice Nurse S stated s/he asked Director V about Resident 3's medications. Hospice Nurse S stated s/he looked at the facility medication cart with Director V and found all of Resident 3's new medications to be unopened/all the pills still in their blister pack slots.

On 02/13/2024 at 4:00 PM, Surveyor completed an exit interview with the TEAMS conference system with Executive Director A, Interim Director of Nursing J and Interim Executive Director K. Executive Director A acknowledged s/he was not aware of Resident 3's pressure wounds. Executive Director A acknowledged s/he was not aware of Resident 3 not being administered his/her medications as prescribed from 12/27/2023 to 01/03/2024. Executive Director A stated s/he knew staff and nurses found Resident 3 unresponsive the morning of 01/03/2024 but was not aware of other details related to Resident 3's physical presentation. Executive Director A acknowledged s/he was not aware Resident 3's practitioner had ordered a psychotropic PRN to manage behaviors related to dementia. Executive Director A acknowledged the facility did not assess Resident 3 upon return from the hospital on 12/26/2024; and Resident 2's care plan was not updated with his/her new needs. Executive Director A, Interim Director of Nursing J and Interim Executive Director K did not have any questions related to Surveyor's findings. Interim

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Executive Director K stated s/he would work with staff to be sure issues like this are reported to administrators in the future.

On 02/22/2024 at 8:25 AM, Surveyor discussed Resident 3's care with Nurse MM. Nurse MM stated s/he worked with Resident 3's primary care physician Doctor LL. Nurse MM stated s/he had access to Resident 3's EHR (electronic health record). Nurse MM stated the facility did not contact Resident 3's primary care clinic from 12/03/2023 to 12/10/2023 to report changes in condition. Nurse MM stated facility called primary care clinic on 12/11/2023 and 12/12/2023 to discuss open sore on buttocks and decline in condition.

On 02/23/2024, Surveyor reviewed Resident 3's hospital record for admission on 12/14/2023 and discharge on 12/26/2023: On 12/14/2023 at 8:22 PM, Doctor DD documented the following, " Chief Diagnosis: Acute on Chronic Encephalopathy likely due to UTI...[Resident 3]...was brought in from [his/her] facility on 12/14/23 with an 11-day history of weakness and worsened confusion. [S/he] has decreased mental status with infections but usually [s/he] rebounds after a few days but hasn't this time. [S/he] decompensated to the point that now [s/he] using a wheelchair to get around (typically can ambulate)." On 12/17/2023 at 12:22 PM, Occupational Therapist GG documented the following, "[Resident 3] admitted fw/ AMS (acute metabolic syndrome) and UTI. Hx (history) of Alzheimer's. At baseline [Resident 3] resides in memory care facility and receives assist for ADLs/IADLs (activities of daily living/independent activities of daily living), [s/he] typically ambulates IND (independently) w/out AD (assistive device). Today [Resident 3] is functioning below [her/his] baseline - difficult to

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discern if d/t physical ability or motivation. [Resident 3] is resistance to physical activity, follows commands intermittently. Perseverates easily and can be difficult to redirect at times. [S/he] does sit up at EOB (edge of bed) for extended time. [S/he] is a heavy sit stand using 2ww w/ forward flexed posture. [S/he] returns to supine shortly after standing. Ideally [Resident 3] would return to [his/her] familiar environment at memory care...[S/he] has not yet transfers or ambulated, would require SNF (skilled nursing facility) at this time." On 12/18/2023 at 2:15 PM, Nurse Practitioner EE documented, "Writer met with [Resident 3] and [Family Member U], bedside today. [Family Member U] provided a brief health history for pt, particularly over the past few weeks. [S/he] notes that pt was independent at [his/her] (assisted living facility) ALF prior to this hospitalization...[S/he] notes [s/he] has had significant weight loss over the past few months as well." On 12/18/2024 at 2:06 PM, Nurse AA documented the following related to Resident 3's skin integrity needs, "Lots of dry/flaky skin noted to peri wound skin likely due to use of barrier cream versus hydrating lotion/moisture barrier...On further assessment a DTPI (deep tissue pressure injury) was noted to [Resident 3's] right heel. Unclear when it first began to develop as [Resident 3] is oriented x1 and [Family Member U] has not looked at [his/her] feet in a while. [S/he] does report that for the past 2 weeks [s/he's] been much more confused and deconditioned so [s/he] has been essentially bed bound since then, plan for heel mepilex and prevalon boots to prevent any further damage, although the heel is likely to continue breaking down before it begins to heal....Recommendation: Q2 turns (reposition every 2 hours), -Mepilex on buttocks unless patient begins to have frequent incontinent stools,

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HOB <30 (head of bed less than 30 degrees) if possible at all times." On 12/21/2023 at 5:12 PM, Social Worker FF documented the following, "Writer spoke with [Interim Executive Director K] and [s/he] stated that they unable to accept [Resident 3] back since [s/he] is requiring too much assistance from them even with hospice. Writer informed [Interim Executive Director K] that per [Director V], memory care director at [Name of Facility], [Resident 3] has been like this for 2 weeks before getting admitted to [Name of Hospital] therefore [s/he] is at [his/her] baseline of when [s/he] left there. If they are unable to meet [his/her] needs, they would need to accept [him/her] back and give a 30 days noticed to POA (power of attorney). [Interim Executive Director K] understand and requested writer to work with [Name of Hospice] to provide discharge date. "Surveyor reviewed Resident 3's hospital aftervisit discharge summary dated 12/26/2023. The aftervisit summary documented the following, "Your medications have changed...START taking: acetaminophen, lamotrigine, melatonin, miconazole (MICOTIN), moi-stir, ondansetron (ZOFRAN-ODT), senna-docusate...Upcoming Appointments Follow up with [Name of Clinic] UROLOGY." Attached to the hospital aftercare summary is an education packet titled, "Learning About Indwelling Catheter care To Prevent Infection Overview." The subsection titled, "How can you help prevent infection?" states, "when you clean around the catheter, check the surrounding skin for signs of infection. Look for things like pus and irritated, swollen, red, or tender skin around the catheter." The education packet also explain how to appropriately empty and secure the urinary collection bag."

On 02/27/2024, Surveyor reviewed Resident 3's clinic notes from his/her primary care clinic. On

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N 431	Continued From page 55 01/03/2024 at 1:15 PM, Nurse Practitioner R documented the following, "hospitalized at [Name of Hospital] from 12/14 - 12/26/2023 for acute metabolic encephalopathy. [S/he] discharged back to [Name of Facility] with [Name of Hospice] support. Writer collaborated at start of visit with memory care director. [Director V] and [Hospice RN S]. [Hospice RN S] discovered that no medications had been given to [Resident 3] since [his/her] discharge home, including lamotrigine. Writer and [Hospice Nurse S] want to see [Resident 3] in [his/her] room. [S/he] was found lying in [his/her] bed and minimally responsive. [His/her] foley catheter bag was lying on the floor and tubing was unsecured...lying in bed, wearing glasses on top of head which were removed...eyelid crusting...linear pressure marks around chest from bra. This was removed and akin cleansed. Peri care provided with purulent ...drainage and stool noted. Mepilex in place to bilateral heels. New 1cm x 1cm skin tear noted to posterior R thigh. Food debris cleansed from entire body...ALF room has food on the sticky floor." On 02/27/2024, Surveyor reviewed Resident 3's hospital record for admission on 01/03/2024 with discharge on 01/04/2024. On 01/03/2024, Resident 3 was diagnosed with the following: acute cystitis, metabolic encephalopathy, pressure wound to left heel, pressure would to right heel, pressure wound to left buttock, pressure wound to right buttock and pressure would to area unspecified. On 01/03/2024 at 2:14 PM, Nurse HH documented the following, "While rolling pt, blister noted to right lateral ribcage, [Family Member U] at side states that [s/he] had wounds develop due to care at facility [s/he] was at. Pt has bilateral heel ulcers as well, dressings in place over wounds and heels elevated off of	N 431		

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N 431	Continued From page 56 bed." CROSS REFERENCE N0214 DHS Chapter 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE N0352 DHS Chapter 83.32(3)(h) Rights of Residents: Receive Medication CROSS REFERENCE N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or On Changes CROSS REFERENCE Y3090 DHS Chapter 50.07(b) Prohibited Acts	N 431		
Y3098	50.07 PROHIBITED ACTS 50.07 Prohibited acts. (1) No person may: (a) Intentionally fail to correct or interfere with the correction of a class A or class B violation within the time specified on the notice of violation or approved plan of correction under s. 50.04 as the maximum period given for correction, unless an extension is granted and the corrections are made before expiration of extension. (b) Intentionally prevent, interfere with, or attempt to impede in any way the work of any duly authorized representative of the department in the investigation and enforcement of any provision of this subchapter. (c) Intentionally prevent or attempt to prevent any such representative	Y3098		

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Y3098	Continued From page 57 from examining any relevant books or records in the conduct of official duties under this subchapter. (d) Intentionally prevent or interfere with any such representative in the preserving of evidence of any violation of any of the provisions of this subchapter or the rules promulgated under this subchapter. (e) Intentionally retaliate or discriminate against any resident or employe for contacting or providing information to any state official, or for initiating, participating in, or testifying in an action for any remedy authorized under this subchapter. (f) Intentionally destroy, change or otherwise modify an inspector?s original report. (2) Violators of this section may be imprisoned up to 6 months or fined not more than $1,000 or both for each violation. This Rule is not met as evidenced by: Based on record review and interview, Executive Director A and Regional Director of Operations BB intentionally interfered with and/or impeded an investigation by the department of an alleged violation or enforcement by the department. FINDINGS INCLUDE:	Y3098		

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Y3098	Continued From page 58 On 02/07/2024 a 9:00 AM, Surveyors arrived at facility for 3 complaint investigations and verification visit. From 02/07/2024 to 02/13/2024, Executive Director A, Interim Director of Nursing J and Interim Executive Director K, assisted Surveyors with gathering documentation for survey. On 02/07/2024 at 12:00 PM, Surveyor requested Resident 3' s hospital aftercare summary for the 12/14/2023 to 12/26/2023 admission. Interim Director of Nursing J stated s/he did not have a copy of Resident 3's hospital after visit summary. Interim Director of Nursing J acknowledged the facility is to maintain documentation of resident medical visits. On 02/07/2024 at 3:30 PM, Surveyor discussed concerns related to Resident 3 not receiving his/her medications as prescribed with Executive Director A, Interim Director of Nursing J and Interim Executive Director K. Executive Director A stated s/he could not acknowledge if Resident 3 had been administered his/her medications as prescribed or not. Executive Director A produced a hospital discharge summary dated 12/26/2023 for Resident 3 stating all prescription medications besides the Lamotrigine had been discontinued. Surveyor asked Executive Director A if the list of medication orders the facility had on file for Resident 3 was correct. Executive Director A stated the medication orders list was sent to him/her that day from an outside pharmacy. Executive Director A stated Resident 3 was no longer his/her resident so s/he didn't know exactly what the pharmacy was doing for Resident 3 at this time. On 02/07/2024, Surveyor reviewed the medication orders the facility had on file for	Y3098		

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Resident 3. The fax cover sheet states Resident 3's medication list was faxed from the pharmacy to the facility on 02/07/2024 to Interim Director of Nursing J.

On 02/20/2024 at 9:55 AM, Surveyor received an email from Interim Director of Nursing J. Interim Director of Nursing J reported s/he was asked to create false documents for Surveyor's during the survey. Interim Director of Nursing J stated s/he refused to create false documents for the survey. Interim Director of Nursing J stated s/he witnessed other facility leaders falsifying documentation for the survey. Interim Director of Nursing J stated the creation of false documentation during the survey is why it took extended periods of time to get records to Surveyors. Interim Director of Nursing J stated Interim Executive Director K could also testify to the creation of false documentation during the survey.

On 02/20/2024 at 11:25 AM, Surveyor called Interim Director of Nursing J. Interim Director of Nursing J stated while Surveyors were at the facility s/he was asked to create resident records and falsify the date/time of creation. Interim Director of Nursing J stated most resident individualized service plans (ISPs) had not been updated in over a year. Interim Director of Nursing J stated while Surveyor's were at the facility Executive Director A started filling in the squares missing documentation on the resident's paper medication administration records (MARS). Interim Director of Nursing J stated all psychotropic reviews signed by Regional Director of Operations BB were created for the survey. Interim Director of Nursing J reported s/he had access to an email showing Executive Director A forwarding a psychotropic review to Surveyors

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and Interim Director of Nursing J's direct email response to Executive Director A stating they will print off then add the psychotropic review to Resident 2's facility chart.

On 02/20/2024, Surveyor reviewed an email sent from Interim Director of Nursing J at 10:59 AM. Interim of Nursing J stated in the email, "This was [Interim Director of Nursing J's] reply to [Executive Director A] showing the psychotropic monitoring was not in [his/her] chart." Attached to Interim Director of Nursing J's email was the email chain used between Surveyors, Executive Director A, Interim Director of Nursing J, Interim Executive Director K and Regional Director of Operations BB. The email chain is titled, "FW: [Name of Facility] state survey - request for documentation". The email conversation was as follows:

-On 02/04/2024 at 9:11 AM, Surveyor emails all parties the following, "[Executive Director A], Please send me all the quarterly scheduled psychotropic and monthly prn psychotropic reviews for [Resident 2] since his/her admission on 06/30/2023 by end of day today. Thanks!".

-On 02/14/2024 at 3:48 PM, Executive Director A responds to all parties, "Here you go [Surveyor]." Attached to the email is a document titled, "QUARTERLY PSYCHOTRPIC (sic.)/DEPRESSION MEDICATION REVIEW" for Resident 2. Resident 2's psychotropic reviews were handwritten and signed by [Regional Director of Operations BB] for July 2023 and November 2023.

-On 02/14/2024 at 3:52 PM, Interim Director of Nursing J sent a direct response to Executive Director A with, "I will print this and add to [his/her]

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	0015333	A. BUILDING: _____ B. WING _____	R-C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBRING ASSISTED CARE RESIDENCE	7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719

(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
Y3098	Continued From page 61 chart." On 02/20/2024 at 12:30 PM, Surveyor called Interim Executive Director K. Interim Executive Director K stated s/he was asked to falsify documentation for state surveyors during the survey. Interim Executive Director K stated some resident (ISPs) had not been updated since 2020. Interim Executive Director K stated Executive Director A instructed him/her to call Regional Director of Operations BB to have a new ISP created for a resident during the survey. Interim Executive Director K stated this was the reason Surveyors identified so many concerns related to resident ISPs. Interim Executive Director K stated Resident 2's psychotropic reviews signed by Regional Director of Operations BB were created at the time of survey. Interim Executive Director K stated s/he witnessed Executive Director A filling in the squares that were missing documentation on the resident's MARs while Surveyors were at the facility. CROSS REFERENCE N0214 DHS Chapter 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE N0352 DHS Chapter 83.32(3)(h) Right of Residents: Receive Medication CROSS REFERENCE N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or On Changes CROSS REFERENCE N0431 DHS Chapter 83.38(1)(g) Health Monitoring	Y3098		