STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013589	A. BUILDING: _____ B. WING _____	R-C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BROOKFIELD AL	660 WOELFEL ROAD BROOKFIELD, WI 53045

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 11/08/2023, Surveyors conducted 1 verification visit and 1 complaint investigation. Five deficiencies were identified. Two of 5 deficiencies were repeat violations. See Statement Of Deficiency #D23H11, dated 10/04/2021 and #Z21G12, dated 06/21/2023. Five of 6 deficiencies from Statement Of Deficiency #Z21G12, dated 06/21/2023 were corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 72	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's legal representative and physician were notified when there was an incident to the resident.	N 169		

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

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Resident 13's legal representative and physician were not notified by staff when Resident 13 choked and the Heimlich maneuver was performed on 08/23/2023.

Findings include:

On 09/25/2023, the Department received a complaint regarding no notification of a significant incident.

On 11/08/2023, Surveyor reviewed Resident 13's record. S/he was admitted 07/31/2023. Diagnoses included dysphagia, unspecified (difficulty swallowing). His/her Power of Attorney for Health Care document was activated on 05/20/2022 with Family Member U as agent (legal representative).

Facility Progress Notes dated 07/31/2023 - 09/15/2023:

There were no progress notes dated 08/23/2023 or 08/24/2023, and no progress notes until 6:00 PM on 08/25/2023.

08/25/2023 6:00 PM by Nurse H- "Note Text: Resident [family member] called writer and I updated [him/her] on resident's vital signs. [Family Member] expressed to writer that resident did not look good to [him/her] and requested writer send resident out to the [name of hospital ER]. Icalled [sic] the front desk and requested receptionist get paperwork for resident. Resident transported via 911 EMT's to [name of hospital].

08/25/2023 6:25 PM by Nurse H- "Note Text: [family member] called community and requested nurse check on resident and take vital signs. Staff

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reported to me that resident stated to them [s/he] did not feel well. Med passer offered to take [his/her] vital signs and resident declined. I updated [family member] that I was unable to check on resident at this time and will send the caregivers to check on [him/her] once again."

08/26/2023 4:53 PM by Nurse H- "Note Text: REsident [sic] admitted with Aspiration [sic] pneumonia."

08/28/2023 12:56 PM by Former Health and Wellness M- "Note Text: Writer placed call to [MD] office this morning to inform [him/her] about the resident being sent out to [name of hospital] on Friday, August 25, 2023 and that [s/he] was admitted with aspiration pneumonia ..."

08/29/2023 11:05 AM by Former Health and Wellness M- "Note Text: The writer was informed by [Family Member U] that the resident had an episode (last week Wednesday, August 23, 2023) in what appeared to be choking d/t a pill that was given to [him/her]. According to the [Caregiver S] who was present, stated that after [s/he] gave the resident [his/her] medications that the resident began coughing forcefully and that [Family Member T] (who was in the resident's apartment at the time) appeared to perform a "procedure" (Heimlich) on the resident. The care associate stated that the entire time the resident was coughing. The resident did cough up the pill. Once the pill was out the resident stated that [s/he] felt better. The care associate stated that [s/he] was breathing heavily for about 10 minutes after the episode and then [his/her] breathing settled down."

On 09/28/2023 at approximately 4:05 PM, Surveyor interviewed Family Member U who

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stated Family Member T had informed him/her of the choking incident that occurred on 08/23/2023. Family Member U stated s/he called Former Health and Wellness M on 08/26/2023 and informed him/her of the events on 08/23/2023 including choking incident and Heimlich maneuver. Family Member U stated if s/he had been notified by staff on 08/23/2023, s/he would have asked for Resident 13's vitals and known Resident 13 had not been assessed and would have requested staff complete a full assessment.

On 11/08/2023 at 8:57 AM, Surveyor interviewed Executive Director A and Assistant Executive Director Q. Assistant Executive Director Q stated s/he was not made aware of Resident 13's choking incident and Heimlich maneuver until 08/26/2023 and Family Member U informed Former Health and Wellness Director of the incident on 08/24/2023.

On 11/08/2023 at 10:14 AM, Surveyor interviewed Caregiver S who stated on 08/2023 Resident 13 choked during medication pass and the Heimlich maneuver was performed. Caregiver S stated Resident 13 was scared afterward but otherwise was fine. Caregiver S stated s/he did not report the incident to anyone on 08/23/2023, Resident 13 seemed fine on 08/24/2023 and s/he informed Former Health and Wellness Director M on 08/24/2023.

On 11/08/2023 at 4:08 PM, Surveyor discussed concern of staff not immediately notifying Family Member U and Resident 13's physician of the choking incident and Heimlich maneuver on 08/23/2023 with Executive Director A and Assistant Executive Director Q. Assistant Executive Director Q stated it appeared there was lack of documentation by Former Health and

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N 169	Continued From page 4 Wellness M. Cross Reference: N0431 DHS 83.38(1)(g) Health Monitoring	N 169		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not complete a medication administration record for 4 out of 5 residents reviewed which included the name, dosage, date and time of medication taken. The provider did not ensure the medication administration record was complete. Findings include: Example 1 - Resident 8 On 11/08/2023, Surveyor requested to review the record of Resident 8. Resident 8 was admitted to the provider on 08/17/2023. Resident 8 had physician orders including the following:	N 415		

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Nifedipine ER Osmotic Release 24 hour 30 MG-order dated 08/17/2023.
Travoprost Ophthalmic Solution 0.004% eye drops was order dated 08/17/2023.
Staff administer medications. Order dated 08/17/2023.

A review of the medication administration for the month of October 2023 noted the following:

Nifedipine ER osmotic release 24 hour 30 MG at 2000 was not documented as administered on 10/15/2023 at 2000. (8PM).
Travoprost ophthalmic solution 0.004% eye drops was not documented as administered on 10/15/2023 at 2000. (8PM). No reason was documented on the medication administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered.

A review of the medication administration for the month of November 2023 noted the following medications were not documented as administered:
Nifedipine ER osmotic release 24 hour 30 MG-11/05/2023 at 2000.
Travoprost ophthalmic solution 0.004% eye drops-11/05/2023 and 11/07/2023 at 2000.

No reason was documented on the medication administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered.

Example 2 - Resident 9
On 11/08/2023, Surveyor requested to review the record of Resident 9. Resident 9 was admitted to the provider on 02/10/2020. Resident 9 had physician orders including the following:

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N 415	Continued From page 6 Donepezil HCL 10 MG- order dated 05/02/2023. PreserVision AREDS one capsule two times per day. Order dated 08/08/2023. Staff administer medications. Order dated 08/08/2023. A review of the medication administration record for the month of October 2023 noted the following medications were not documented as administered on 10/15/2023. Donepezil HCL 10 MG and PreserVision AREDS. No reason was documented on the medication administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered. A review of the medication administration record for the month of November 2023 noted on 11/05/2023 and 11/07/2023- Donepezil HCL 10 MG- was not documented administered. No reason was documented on the medication administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered. PreserVision AREDS-was not documented as administered on 11/05/2023 and 11/07/2023. No reason was documented on the medication administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered. Example 3 - Resident 10 On 11/08/2023, Surveyor requested to review the record of Resident 10. Resident 10 was admitted to the provider on 10/10/2023. Resident 10 had physician orders including the following: Staff administer medications. Order dated 010/10/2023.	N 415		

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Amoxicillin-Pot Clavulanate 500-125 MG one tablet two times day from 10/30/2023 to 11/09/2023.
Atorvastatin Calcium 80 MG order dated 10/09/2023.
Doxazosin Mesylate 2 MG order dated 10/10/2023.
Montelukast Sodium 10 MG order dated 10/10/2023.
Aspirin 81 MG twice per day. Order dated 10/10/2023.
Bumetanide 2 MG twice per day. Order dated 10/10/2023.
Buspirone HCL 10 MG twice per day. Order dated 10/10/2023.
Lantus 100 Unit/ML inject 36 units subcutaneous two times a day. Order dated 10/10/2023.
Lorazepam 0.5 MG twice per day-order dated 11/01/2023.
Pantoprazole Sodium 40 MG one tablet twice day. Order dated 10/10/2023.

A review of the medication administration record dated October 2023 noted the following:
Atorvastatin Calcium 80 MG was not documented as administered on 10/28/2023.
Doxazosin Mesylate 2 MG was not documented as administered on 10/28/2023.
Montelukast Sodium 10 MG was not documented as administered on 10/28/2023.
Aspirin 81 MG was not documented as administered on 10/28/2023 at 2000. (8:00 PM)
Bumetanide 2 MG-was not documented as administered on 10/28/2023 at 2000. (8:00 PM)
Buspirone HCL 10 MG-was not documented as administered on 10/28/2023 at 2000. (8:00 PM)
Lantus 100 Unit/ML inject 36 units subcutaneous-was not documented as administered on 10/28/2023 at 2000. (8:00 PM).
Pantoprazole Sodium 40 MG one tablet twice

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day-was not documented as administered on 10/28/2023 at 2000. (8:00 PM).

A review of the medication administration record for the month of November 2023 noted the following:
Atorvastatin calcium 80 MG - was not documented as administered on 11/03/2023 and 11/06/2023.
Doxazosin mesylate 2 MG was not documented as administered on 11/03/2023 and 11/06/2023.
Lorazepam 0.5 MG- was not documented as administered on 11/03/2023 and 11/06/2023.
Amoxicillin-Pot Clavulanate 500-125 MG - was not documented as administered on 11/03/2023 and 11/06/2023 at 2000. (8:00 PM).
Aspirin 81 MG was not documented as administered as administered on 11/03/2023 and 11/06/2023 at 2000. (8:00 PM).
Bumetanide 2 MG-was not documented as administered on 11/03/2023 and 11/06/2023 at 2000. (8:00 PM).
Buspirone HCL 10 MG-was not documented as administered on 11/03/2023 and 11/06/2023 at 2000. (8:00 PM).
Montelukast sodium 10 MG was not documented as administered on 11/03/2023 and 11/06/2023 at 2000. (8:00 PM).
Lantus 100 Unit/ML inject 36 units subcutaneous-was not documented as administered on 11/03/2023 and 11/06/2023 at 2000. (8:00 PM).
Pantoprazole Sodium 40 MG one tablet twice day-was not documented as administered on 11/03/2023 and 11/06/2023 at 2000. (8:00 PM).

No reason was documented on the medication administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered.

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Example 4- Resident 11
On 11/08/2023, Surveyor requested to review the record of Resident 11. Resident 11 was admitted to the provider on 09/03/2020. Resident 11 had physician orders including the following:
Staff administer medications ordered 09/03/2020.

Acetaminophen 500 MG two tablets three times per day. Order dated 05/01/2023.
Atorvastatin Calcium 20 MG one tablet at bedtime. Order dated 01/18/2023.
Gabapentin 100 MG two capsules by mouth two times per day. Order dated 10/10/2023.
Lidocaine External Patch 4% apply to left hip one time a day. Order dated 02/10/2023.
Timoptic Solution 0.5% one drop in both eyes one time a day. Order dated 01/19/2023 and 11/06/2023.
Tramadol HCL 50 MG one tablet twice day. Order dated 04/26/2023.
Warfarin 2.5 MG one tablet one time day. Order dated 04/19/2023.
Xalatan Solution 0.005% one drop in both eyes at bedtime. Order dated 01/19/2023.

A review of the medication administration record for the month of October 2023 noted the following:
Atorvastatin Calcium 20 MG was not documented as administered on 10/04/2023 and 10/28/2023.
Lidocaine External Patch 4% was not documented as administered on 10/04/2023 and 10/28/2023.
Timoptic Solution 0.5% was not documented as administered on 10/04/2023 and 10/28/2023.
Warfarin 2.5 MG one tablet one time day was not documented as administered on 10/04/2023 and 10/28/2023.

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Xalatan Solution 0.005% was not documented as administered on 10/04/2023 and 10/28/2023.
Gabapentin 100 MG was not documented as administered on 10/28/2023 at 2000.
Tramadol HCL 50 MG was not documented as administered on 10/04/2023 at 1700.
Acetaminophen 500 MG was not documented as administered on 10/04/2023 and 10/28/2023 at 2000.

A review of the medication administration record for the month of November 2023 noted the following:
Atorvastatin Calcium 20 MG was not documented as administered on 11/06/2023 at 2000.
Lidocaine External Patch 4% was not documented as administered on 11/06/2023 at 2000.
Warfarin 2.5 MG was not documented as administered on 11/06/2023 at 2000.
Xalatan Solution 0.005% was not documented as administered on 11/06/2023 at 2000.
Gabapentin 100 MG was not documented as administered on 11/06/2023 at 2000.
Acetaminophen 500 MG was not documented as administered on 11/06/2023 at 2000.

No reason was documented on the medication administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered.

Example 5 - Resident 12
On 11/08/2023, Surveyor requested to review the record of Resident 12. Resident 12 was admitted to the provider on 05/31/2023. Resident 12 had physician orders including the following:
Staff administer medications ordered 05/31/2023.

Advair HFA 230-21 MCG/ACT 2 puff orally two

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times a day. Order dated 05/31/2023.
Atorvastatin Calcium 20 MG- order dated 06/01/2023.
Betamethasone Dipropionate External Cream 0.05% apply to affected areas topically two times a day. Order dated 05/31/2023.
Tamsulosin HCl 0.4MG 2 capsules by mouth one time a day. Order dated 06/01/2023.

A review of the medication administration record for the month of October 2023 noted the following:
Atorvastatin Calcium 20 MG- was not documented as administered on 10/04/2023 and 10/28/2023.
Tamsulosin HCl 0.4MG- was not documented as administered on 10/28/2023.
Advair HFA 230-21 MCG/ACT - was not documented as administered on 10/04/2023 and 10/28/2023 at 2000.
Betamethasone Dipropionate External Cream 0.05% - was not documented as administered on 10/04/2023 and 10/28/2023 at 2000.

A review of the medication administration record for the month of November 2023 noted the following:
Atorvastatin Calcium 20 MG- was not documented as administered on 11/06/2023 at 2000.
Tamsulosin HCl 0.4MG- was not documented as administered on 11/06/2023 at 2000.
Advair HFA 230-21 MCG/ACT - was not documented as administered on 11/06/2023 at 2000.
Betamethasone Dipropionate External Cream 0.05% - was not documented as administered on 11/06/2023 at 2000.

No reason was documented on the medication

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N 415	Continued From page 12 administration as to if the medication was refused, if the resident was not available, was hospitalized or why it was not administered. On 11/08/2023, at 1:29 PM Surveyor interviewed Associate Executive Director Q (AED Q) regarding the medication administration record. AED Q stated s/he would have to interview the scheduled medication passer for those dates when the medication administration record was not complete. AED Q stated staff should enter a reason if the medication is not administered. Otherwise, staff are to record it was administered. AED Q stated s/he believed the residents received the medication but they did not document it as it should have been. AED Q stated staff training would be implemented as the record should be completed when medications are administered.	N 415		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure medication aides received supervision and registered nurse delegation for administration of injectable medication such as insulin.	N 416		

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N 416	Continued From page 13 This is a repeat deficiency. See Statement of Deficiency (SOD) # D23H11, dated 10/04/2021. Findings include: On 11/08/2023, at 9:55 AM, Surveyor interviewed Resident 10. Resident 10 recalled a concern with receiving insulin in the evening believed to be on or around 11/07/2023. Resident 10 stated s/he did not report this concern to anyone. Surveyor reviewed Resident 10's record and noted Resident 10 was admitted to the provider on 10/10/2023 with a diagnosis including diabetes mellitus. Resident 10 had a physician order for Lantus 100 Unit/ML inject 36 units subcutaneous two times a day. Order was dated 10/10/2023. Resident 10 had a physician order for staff to administer all medications to Resident 10. The order was dated 10/10/2023. Surveyor reviewed the medication administration record for Resident 10. The record noted Med Tech R had documented administering insulin to Resident 10 most recently on 10/14/2023. On 11/08/2023, at approximately 2:53 PM, Surveyors interviewed Executive Director A and Assistant Executive Director Q regarding the nurse delegation for insulin. Executive Director A stated that the former Wellness Director M had completed delegation of insulin to the medication tech's while employed at Brookdale Brookfield. Former Wellness Director M's last day of employment was 09/21/2023. Executive Director A stated s/he believed that the RN delegation by Former Wellness Director M was still current even though no longer employed at Brookdale Brookfield as s/he did not rescind the delegation in writing. Executive Director A stated two employees, recent hires, were delegated by their	N 416		

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N 416	Continued From page 14 corporate RN and all the other employees who administer the insulin were delegated by the Former Wellness Director M and Executive Director A was not aware of the requirement that the other staff, who administer insulin needed to be delegated again. On 11/09/2023, at 1:18 PM, Surveyor received email confirmation that Med Tech R was not currently delegated to administer insulin by the corporate registered nurse, in addition to Med Tech W, Med Tech X, Med Tech V, Med Tech Y, Med Tech Z and Med Tech AA not having current delegation to administer insulin.	N 416		
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	N 431		

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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 services adequate to meet the needs of the residents in the area of health monitoring were provided or arranged.

On 08/23/2023 at approximately 9:00 PM, Resident 13 choked during medication administration and the Heimlich maneuver was administered. Resident 13 was not assessed, and vitals were not taken until 08/25/2023 evening when family requested s/he be checked on. On 08/25/2023 evening, Resident 13 was transported to the emergency room and diagnosed with aspiration pneumonia. On 09/06/2023 Resident 13 was discharged back to the facility with hospice services, on 09/14/2023 discharged from facility to family's home with hospice services. Resident 13 passed away on 10/10/2023.

Findings include:

On 09/25/2023, the Department received a complaint regarding health monitoring.

On 11/08/2023, Surveyor reviewed Resident 13's

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record. S/he was admitted 07/31/2023 from a skilled nursing facility. Diagnoses included dysphagia, unspecified (difficulty swallowing).

Facility Progress Notes dated 07/31/2023 - 09/15/2023:
There were no progress notes dated 08/23/2023 or 08/24/2023, and no progress notes until 6:00 PM on 08/25/2023.

08/25/2023 6:00 PM by Nurse H- "Note Text: Resident [family member] called writer and I updated [him/her] on resident's vital signs. [Family Member] expressed to writer that resident did not look good to [him/her] and requested writer send resident out to the [name of hospital ER]. Icalled [sic] the front desk and requested receptionist get paperwork for resident. Resident transported via 911 EMT's to [name of hospital].

08/25/2023 6:25 PM by Nurse H- "Note Text: [family member] called community and requested nurse check on resident and take vital signs. Staff reported to me that resident stated to them [s/he] did not feel well. Med passer offered to take [his/her] vital signs and resident declined. I updated [family member] that I was unable to check on resident at this time and will send the caregivers to check on [him/her] once again."

08/26/2023 4:53 PM by Nurse H- "Note Text: REsident [sic] admitted with Aspiration [sic] pneumonia."

08/28/2023 12:56 PM by Former Health and Wellness M- "Note Text: Writer placed call to [MD] office this morning to inform [him/her] about the resident being sent out to [name of hospital] on Friday, August 25, 2023 and that [s/he] was admitted with aspiration pneumonia ..."

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N 431	Continued From page 17 08/29/2023 11:05 AM by Former Health and Wellness M- "Note Text: The writer was informed by [Family Member U] that the resident had an episode (last week Wednesday, August 23, 2023) in what appeared to be choking d/t a pill that was given to [him/her]. According to the [Caregiver S] who was present, stated that after [s/he] gave the resident [his/her] medications that the resident began coughing forcefully and that [Family Member T] (who was in the resident's apartment at the time) appeared to perform a "procedure" (Heimlich) on the resident. The care associate stated that the entire time the resident was coughing. The resident did cough up the pill. Once the pill was out the resident stated that [s/he] felt better. The care associate stated that [s/he] was breathing heavily for about 10 minutes after the episode and then [his/her] breathing settled down." Weights and Vitals Summary dated 07/31/2023-09/06/2023- Blood pressure, temperature, pulse, and respirations were documented on 07/31/2023, 08/18/2023 and 09/06/2023. No vitals were documented 08/23/2023-08/25/2023. Hospital Records (obtained by Surveyor from hospital 10/23/2023 3:28 PM): Resident 13 was admitted to hospital on 08/25/2023, discharged back to Brookdale Brookfield with hospice services 09/06/2023. Hospital History and Physical " ...History of Present Illness: ...history of ...aspiration risk, ...Earlier this week [s/he] was taking [his/her] medications with water instead of applesauce which [s/he] normally does when [s/he] was	N 431		

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choking on them. Nursing had to do the Heimlich maneuver on [him/her]. 2 [sic] days later [s/he] now presents with fever and difficulty breathing. Chest x-ray shows evidence of left lower lobe infiltrate. Patient has fever to 101.2 [sic]. [S/he] has been started on Rocephin and Zithromax in the emergency room. [S/he] is admitted for further treatment ..."

Hospital Discharge Summary dated 09/06/2023 " ...Physical exam was notable for a systolic murmur and rales in the lower lung fields ...Patient was admitted to the hospital for further treatment ...After further discussion with [MD name] the patient's [family member] has elected to transition to comfort measures only/hospice care ...Arrangements have [sic] made for hospice support at [his/her] assisted living facility ..."

On 09/28/2023 at approximately 4:05 PM, Surveyor interviewed Family Member U who stated around supper time on 08/25/2023 Resident 13 called him/her stating s/he did not feel good and something was wrong. Family Member U stated Resident 13 had a congested sounding cough. Family Member U stated s/he made several calls to facility requesting Resident 13 be seen by the RN. Family Member U stated Nurse H told him/her s/he was dealing with another issue but would see Resident 13 before s/he left for the evening. Family Member U stated after several unanswered calls to facility, s/he was finally able to reach a receptionist and requested Resident 13 be sent to the emergency room. Family Member U stated Nurse H called him/her back and afterwards Resident 13 was sent to the emergency room. Family Member U stated s/he called Former Health and Wellness M on 08/24/2023 and informed him/her of the events on 08/23/2023 including choking incident

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and Heimlich maneuver.

On 11/08/2023 at 10:14 AM, Surveyor interviewed Caregiver S who stated on 08/2023 Resident 13 choked during medication pass and the Heimlich maneuver was performed. Caregiver S stated Resident 13 was scared afterward but otherwise was fine. Caregiver S stated s/he did not report the incident to anyone on 08/23/2023, Resident 13 seemed fine on 08/24/2023 and s/he informed Former Health and Wellness Director M on 08/24/2023.

On 11/08/2023 at 11:28 AM, Surveyor interviewed Assistant Executive Director Q who stated Former Health and Wellness Director M did not monitor Resident 13 after being informed of choking incident on 08/24/2023. Assistant Executive Director Q stated Resident 13 should have been sent out to the hospital immediately on 08/23/2023 and monitored for 72 hours.

On 11/08/2023 at 1:39 PM, Surveyor interviewed Assistant Executive Director Q who stated Resident 13 should have been monitored after choking incident on 08/23/2023. Assistant Executive Director Q stated there was no correlation between the choking incident on 08/23/2023 and the diagnoses of aspiration pneumonia on 08/25/2023 since Resident 13 had a history of aspiration pneumonia.

On 11/08/2023 at 2:53 PM, Surveyor discussed concern of no assessment, vitals, or health monitoring of Resident 13 after s/he choked on 08/23/2023 with Executive Director A and Assistant Executive Director Q. Executive Director A stated there was no assessment and Caregiver S did not report the incident until the next day when s/he informed Former Health and

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N 431	Continued From page 20 Wellness Director M. On 11/09/2023 at 4:08 PM, Surveyor interviewed Family Member T who stated on 08/23/2023 s/he was visiting Resident 13 and at approximately 9:00 PM Caregiver S administered medication to Resident 13 with water. Family Member T stated Resident 13 immediately started choking and Caregiver S performed the Heimlich maneuver. Family Member T stated Caregiver S left the room after performing the Heimlich maneuver and returned approximately 15 minutes later and toileted Resident 13. Family Member T stated from 9:00 PM to when s/he left facility at 9:57 PM no one assessed or checked Resident 13's vitals. On 11/13/2023 at 2:56 PM, Surveyor received a copy of the the death certificate via email from Family Member T. The death certificate was signed 10/13/2023 and stated the condition leading to cause of death was aspiration pneumonia. Cross Reference: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes	N 431		
{N 507}	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible material was not placed within 3 feet of any furnace. This is an uncorrected repeat violation. See	{N 507}		

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{N 507}	Continued From page 21 Statement Of Deficiency #Z21G12, dated 06/21/2023. Findings include: On 11/08/2023 at 9:27 2023, while touring facility with Maintenance F, Surveyor inspected the mechanical room near room 148. Surveyor observed a small trash can containing papers and magazines, a box containing hydrogen peroxide bottles, and 3 boxes of varying sizes containing maintenance parts stored within approximately 1 ½ feet of the side of the furnace. On 11/08/2023 at approximately 9:30 AM, Surveyor interviewed Maintenance F who stated s/he thought combustibles could not be stored within 3 feet of the front of the furnace but could be stored within 3 feet of the side of the furnace. On 11/08/2023 at 10:07 AM, Maintenance F informed surveyor the Material Safety Data Sheet stated peroxide was not flammable. When Surveyor replied the box containing the peroxide was flammable, Maintenance F stated s/he agreed.	{N 507}		