STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

(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 01/17/2024, with information obtained through 01/23/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Lilac Springs Assisted Living LLC, a community-based residential facility (CBRF) located in Lake Mills, WI. As a result of the survey, 5 deficiencies were identified. Four deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023. The complaint was substantiated. Census: 19	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists	N 239		

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

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N 239	Continued From page 1 residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 4 employees reviewed obtained all department approved training as required. Caregiver F, who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties. This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023. Findings include: On 01/17/2024, Surveyor conducted a complaint investigation into concerns that staff who were untrained in medication administration were passing residents' medications. On 01/17/2024, at approximately 3:25 p.m., while interviewing Interim Administrator B, Surveyor observed Caregiver F at the medication cart working at the laptop located on the cart. Surveyor observed Caregiver F retrieve keys from his/her pocket and use the keys to open a drawer in the medication cart. Interim Administrator B confirmed that Caregiver F was the medication passer for second shift that day.	N 239		

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N 239	Continued From page 2 On 01/17/2024, while reviewing Resident 1's medication administration records (MARs) for December 2023 and January 2024, Surveyor observed that Caregiver F had initialed off on 23 days of administering Resident 1 his/her medications, which included: 12/01/2023, 12/06/2023 through 12/08/2023, 12/10/2023, 12/11/2023, 12/13/2023, 12/15/2023, 12/18/2023, 12/20/2023, 12/21/2023, 12/27/2023 through 12/29/2023, 01/01/2024, 01/04/2024 through 01/08/2024, 01/10/2024, 01/11/2024, and 01/15/2024. On 01/17/2024, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. Surveyor requested training records from Interim Administrator B for Caregiver F. The record for Caregiver F, hired 10/03/2022, did not contain evidence of training or evidence of meeting an exemption for medication administration. On 01/17/2024, at approximately 4:00 p.m., Surveyor interviewed Interim Administrator B. Interim Administrator B confirmed that Caregiver F is responsible for medication administration duties. Interim Administrator B confirmed the provider did not have evidence that Caregiver F completed or met an exemption for medication management training prior to assuming these job duties. Interim Administrator B reported s/he was unaware that Caregiver F was not trained in medication administration. On 01/17/2024, Surveyor verified Caregiver F was not on the Community-Based Care and Treatment training registry for medication administration.	N 239		

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N 352	Continued From page 3	N 352		
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 that Resident 1 received all medications in the dosage prescribed by a practitioner. Resident 1 received the incorrect dosage of sliding scale insulin on 45 occasions between 12/01/2024 - 01/17/2024. Resident 1 went to the emergency department on 12/03/2023 where s/he was diagnosed with hypokalemia (low potassium levels). On that day, s/he was prescribed potassium chloride 20 mEq tablets with directions to take 2 tablets 2 times daily for 3 days. There was no evidence in Resident 1's record that this prescription was filled or that Resident 1 received his/her potassium chloride tablets as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023. Findings include: On 01/17/2024, Surveyor conducted a complaint investigation into concerns of medication administration errors.	N 352		

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N 352	Continued From page 4 On 01/17/2024, at approximately 11:29 a.m., Surveyor observed Caregiver C take Resident 1's blood sugar in his/her room and then administer his/her dose of sliding scale insulin via pen. Caregiver C was observed to follow the sliding scale documented in the computer, on the provider's electronic record platform. On 01/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 10/27/2023 with diagnoses including type II diabetes mellitus. Resident 1's prescriptions included the following orders active from 11/05/2023 - 12/12/2023: - Insulin lispro 100 units/mL pen: "Inject subcutaneously: Sliding scale: <100 - 0 units, 101-200 - 4 units, 201-300 - 6 units, >300 - 8 units." Four separate entries on Resident 1's medication administration record (MAR) indicated that the sliding scale was to be administered 4 times daily: 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. On 12/12/2023, Resident 1's bedtime (8:00 p.m.) sliding scale insulin order was changed with the following prescription directions: "Inject subcutaneously at bedtime based on sliding scale: Less than 200 = 0 units; 200-250 = 2 un; 251-300 = 3 un; greater than 300 = 4 un." Surveyor reviewed Resident 1's MAR from 12/01/2023 - 01/17/2024 and observed the following 38 discrepancies: - 12/02/2023 (12:00 p.m.): Blood sugar documented as 168, 3 units documented as administered (despite blood sugar being within parameters for 4 units) - 12/06/2023 (7:28 a.m.): Blood sugar	N 352		

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N 352	Continued From page 5	N 352		

documented as 163, 5 units documented as administered (despite blood sugar being within parameters for 4 units)
- 12/12/2023 (11:45 a.m.): Blood sugar documented as 348, 6 units documented as administered (despite blood sugar being within parameters for 8 units)
- 12/13/2023 (8:30 p.m.): Blood sugar documented as 350, 8 units documented as administered (despite blood sugar being within parameters for 4 units)
- 12/14/2023 (7:33 p.m.): Blood sugar documented as 212, 6 units documented as administered (despite blood sugar being within parameters for 2 units)
- 12/15/2023 (7:24 p.m.): Blood sugar documented as 348, 8 units documented as administered (despite blood sugar being within parameters for 4 units)
- 12/17/2023 (9:34 p.m.): Blood sugar documented as 227, 6 units documented as administered (despite blood sugar being within parameters for 2 units)
- 12/18/2023 (7:38 p.m.): Blood sugar documented as 334, 8 units documented as administered (despite blood sugar being within parameters for 4 units)
- 12/19/2023 (11:32 a.m.): Blood sugar documented as 249, 4 units documented as administered (despite blood sugar being within parameters for 6 units)
- 12/20/2023 (9:30 p.m.): Blood sugar documented as 371, 8 units documented as administered (despite blood sugar being within parameters for 4 units)
- 12/21/2023 (12:06 p.m.): Blood sugar documented as 186, 3 units documented as administered (despite blood sugar being within parameters for 4 units). The annotation, "(instructed 3 instead of 4 at lunch from sheet in

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N 352	Continued From page 6	N 352		

room)," was documented with the entry.
- 12/21/2023 (9:01 p.m.): Blood sugar documented as 248, 8 units documented as administered (despite blood sugar being within parameters for 2 units)
- 12/22/2023 (11:45 a.m.): Blood sugar documented as 172, 3 units documented as administered (despite blood sugar being within parameters for 4 units). The annotation, "instructed by sliding scale in room to do 3 units," was documented with the entry.
- 12/25/2023 (7:37 p.m.): Blood sugar documented as 261, 6 units documented as administered (despite blood sugar being within parameters for 3 units)
- 12/27/2023 (4:27 p.m.): Blood sugar documented as 301, 6 units documented as administered (despite blood sugar being within parameters for 8 units)
- 12/27/2023 (7:18 p.m.): Blood sugar documented as 277, 6 units documented as administered (despite blood sugar being within parameters for 3 units)
- 12/28/2023 (7:10 p.m.): Blood sugar documented as 301, 8 units documented as administered (despite blood sugar being within parameters for 4 units)
- 12/29/2023 (7:06 p.m.): Blood sugar documented as 273, 6 units documented as administered (despite blood sugar being within parameters for 3 units)
- 12/30/2023 (8:23 p.m.): Blood sugar documented as 230, 6 units documented as administered (despite blood sugar being within parameters for 2 units)
- 12/31/2023 (12:05 p.m.): Blood sugar documented as 153, 3 units documented as administered (despite blood sugar being within parameters for 4 units)
- 12/31/2023 (8:23 p.m.): Blood sugar

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N 352	Continued From page 7 documented as 218, 6 units documented as administered (despite blood sugar being within parameters for 2 units) - 01/01/2024 (7:56 p.m.): Blood sugar documented as 347, 8 units documented as administered (despite blood sugar being within parameters for 4 units) - 01/02/2024 (8:14 p.m.): Blood sugar documented as 246, 6 units documented as administered (despite blood sugar being within parameters for 2 units) - 01/03/2024 (11:28 p.m.): Blood sugar documented as 210, 4 units documented as administered (despite blood sugar being within parameters for 6 units) - 01/03/2024 (9:06 p.m.): Blood sugar documented as 398, 8 units documented as administered (despite blood sugar being within parameters for 4 units) - 01/05/2024 (8:29 p.m.): Blood sugar documented as 301, 8 units documented as administered (despite blood sugar being within parameters for 4 units) - 01/06/2024 (11:49 a.m.): Blood sugar documented as 200, 3 units documented as administered (despite blood sugar being within parameters for 4 units) - 01/06/2024 (8:16 p.m.): Blood sugar documented as 301, 8 units documented as administered (despite blood sugar being within parameters for 4 units) - 01/07/2024 (11:29 a.m.): Blood sugar documented as 300, 8 units documented as administered (despite blood sugar being within parameters for 6 units) - 01/07/2024 (8:41 p.m.): Blood sugar documented as 332, 8 units documented as administered (despite blood sugar being within parameters for 4 units) - 01/08/2024 (7:52 p.m.): Blood sugar	N 352		

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N 352	Continued From page 8	N 352		

documented as 290, 6 units documented as administered (despite blood sugar being within parameters for 3 units)
- 01/09/2024 (9:09 p.m.): Blood sugar documented as 295, 6 units documented as administered (despite blood sugar being within parameters for 3 units)
- 01/10/2024 (8:22 p.m.): Blood sugar documented as 290, 6 units documented as administered (despite blood sugar being within parameters for 3 units)
- 01/11/2024 (8:14 p.m.): Blood sugar documented as 140, 4 units documented as administered (despite blood sugar being within parameters for 0 units)
- 01/12/2024 (7:48 p.m.): Blood sugar documented as 249, 6 units documented as administered (despite blood sugar being within parameters for 2 units)
- 01/13/2024 (8:42 p.m.): Blood sugar documented as 266, 6 units documented as administered (despite blood sugar being within parameters for 3 units)
- 01/15/2024 (7:37 p.m.): Blood sugar documented as 240, 6 units documented as administered (despite blood sugar being within parameters for 2 units)
- 01/16/2024 (8:26 p.m.): Blood sugar documented as 178, 4 units documented as administered (despite blood sugar being within parameters for 0 units)

On 01/18/2024, at approximately 11:20 a.m., Surveyor requested from Interim Administrator B all medical provider notes/records for Resident 1 from 12/01/2023 through 01/18/2024, including any notes in his/her record showing communication with his/her medical provider(s).

On 01/19/2024, Surveyor reviewed the records

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N 352	Continued From page 9 provided by Interim Administrator B and observed a medication list from a clinic visit Resident 1 had dated 12/04/2023. The list documented that Resident 1's previous insulin order, which was active until 12/12/2023, contained the same sliding scale as above for the same date range, but also contained directions for staff to deduct 1 unit when administering his/her lunchtime sliding scale insulin. Upon reviewing Resident 1's MAR again, from 12/05/2023 through 12/11/2023, Surveyor observed the following 7 occasions in which staff did not subtract 1 unit as directed when administering his/her lunchtime insulin: - 12/05/2023 (11:41 a.m.): Blood sugar documented as 211, 6 units documented as administered (despite blood sugar being within parameters for 5 units) - 12/06/2023 (12:08 p.m.): Blood sugar documented as 164, 4 units documented as administered (despite blood sugar being within parameters for 3 units) - 12/07/2023 (11:34 a.m.): Blood sugar documented as 236, 6 units documented as administered (despite blood sugar being within parameters for 5 units) - 12/08/2023 (11:40 a.m.): Blood sugar documented as 246, 6 units documented as administered (despite blood sugar being within parameters for 5 units) - 12/09/2023 (11:57 a.m.): Blood sugar documented as 262, 6 units documented as administered (despite blood sugar being within parameters for 5 units) - 12/10/2023 (11:50 a.m.): Blood sugar documented as 114, 4 units documented as administered (despite blood sugar being within parameters for 3 units) - 12/11/2023 (11:43 a.m.): Blood sugar documented as 217, 6 units documented as	N 352		

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N 352	Continued From page 10 administered (despite blood sugar being within parameters for 5 units) While reviewing the medical records for Resident 1, provided by Interim Administrator B, Surveyor observed a emergency department after visit summary, dated 12/03/2023, in which Resident 1 was diagnosed as having hypokalemia. An order for Resident 1 to take potassium chloride 20 mEq tablets with directions to take 2 tablets 2 times daily for 3 days was included in the note. There was no evidence in Resident 1's record that this prescription was filled or that Resident 1 received his/her potassium chloride tablets as prescribed. On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A reported s/he was recently hired as a consultant by the provider upon the last administrator leaving. Consultant Administrator A acknowledged Surveyor's concerns that Resident 1 was not receiving the correct insulin dosage, especially upon the change of his/her bedtime parameters. Consultant Administrator A reported unawareness of the concerns regarding Resident 1 not receiving his/her prescribed potassium chloride since s/he was not working with the provider at that time. Consultant Administrator A reported s/he would have to look further into the concerns. On 01/23/2024, at approximately 11:55 a.m., Surveyor interviewed Pharmacy Technician D, from the pharmacy that handled Resident 1's prescription medication. Pharmacy Technician D reported s/he could not find anything in the pharmacy's system showing an order received or prescription filled of potassium chloride tablets.	N 352		

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N 389	Continued From page 11	N 389		
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 that the individual service plans (ISPs) for 2 of 2 residents reviewed was updated when there were changes in their needs and physical condition. The ISP for Resident 3 was not updated to include additional fall risk mitigation strategies after s/he experienced 2 falls between 12/01/2023 - 01/17/2024. Resident 3 fractured his/her T12 vertebra after the first of these falls, on 12/02/2023. The ISP for Resident 4 was not updated to include additional fall risk mitigation strategies after s/he experienced 3 falls from 12/01/2023 - 01/17/2024. This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023.	N 389		

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N 389	Continued From page 12 Findings include: Example 1 - Resident 3 On 01/17/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 08/22/2023. There was no information in Resident 3's record regarding his/her diagnoses. Within Resident 3's observation notes and incident reports, Surveyor observed the following 2 falls documented in his/her record, occurring between 12/01/2023 - 01/17/2024: - Incident report dated 12/02/2023, at 10:50 a.m.: "Resident was in lobby ...Resident stood up with walker to shake hands of carolers and while lifting up a hand from the walker, [s/he] lost balance and fell backward ...[S/he] stated [his/her] back is in a lot of pain ..." - Incident report dated 12/24/2023, at 1:30 p.m.: "Resident was walking back to [his/her] room from lunch ...resident went to open the door to [his/her] room and lost [his/her] balance and fell backwards on the floor ..." Within Resident 3's observation notes in the same date range, Surveyor observed the following: - 12/26/2023 (10:00 a.m.): "******WHEN WALKING, RESIDENT NEEDS SOMEONE WITH [HIM/HER] AT ALL TIMES!****** Resident is almost a two assist to standing now ...While standing or walking, please stand very close to resident even with a hand on [his/her] back or under [his/her] arm as it makes [him/her] feel safer and is safer in case [s/he] loses balance."	N 389		

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N 389	Continued From page 13 - 12/28/2023 (9:30 a.m.): " ...Please keep an eye resident while [s/he] is walking. [S/he] still thinks [s/he] can do some stuff without staff members, but staff told [him/her] [s/he] cant[sic] be do[sic] them without anyone." - 01/01/2024 (5:45 p.m.): " ...Staff was assisting resident back to [his/her] recliner and resident stated [s/he] needed to sit down immediately. Resident began to drop and staff members helped assist resident back into [his/her] walker to sit and take a break." - 01/08/2024 (9:45 p.m.): " ...We are to use the gait belt when [s/he] is walking to each meal and when [s/he] is walking to the bathroom." On 01/18/2024, while reviewing Resident 3's record, Surveyor reviewed a "Patient Discharge Summary" dated 12/02/2023, which documented Resident 3's emergency room visit after his/her fall earlier that day (documented above). Resident 3 was diagnosed with a closed wedge compression fracture of his/her T12 vertebra. On 01/18/2024, Surveyor reviewed Resident 3's current ISP, which documented the following in relation to his/her ambulation and falls risk: - Under the "Falls Risk" section: "Resident is a High Falls Risk[sic]. Ensure proper footwear and keep living area free from clutter." This information was dated 08/19/2023 (prior to his/her admission to the provider). - Under the mobility and transferring sections, Resident 3 was documented as requiring standby or assistance of 1 staff with use of his/her walker. This information was dated 11/08/2023.	N 389		

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N 389	Continued From page 14 Surveyor did not observe any updated fall prevention measures utilized by the provider to mitigate Resident 3's fall risk or directions to use a gait belt during ambulation, as directed in the observation notes, documented in his/her ISP. On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A acknowledged Surveyor's concern with lack of ISP update in relation to Resident 3's fall risk mitigation measures. Consultant Administrator A reported that s/he hasn't been working with the provider long but s/he was going to have another consultant staff work with Interim Administrator B to help review resident ISPs and update them as needed. Example 2 - Resident 4 On 01/17/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 06/08/2023 with a diagnosis of dementia. Within Resident 4's observation notes and incident reports, Surveyor observed the following 3 falls documented in his/her record, occurring between 12/01/2023 - 01/17/2024: - Incident report dated 12/11/2023, at 8:43 p.m.: "Staff was doing 2-hour checks and noticed resident was laying on the floor with a sweatshirt and blanket. Staff was able to assist resident up and into [his/her] bed. Resident stated [s/he] had no idea how [s/he] ended up on the floor." Resident 4's pain level was documented as 10. - Observation note entry dated 12/30/2023, at 2:15 a.m.: "Upon opening [his/her] room staff ...found resident on the floor. Writer asked resident what happened and resident stated	N 389		

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[s/he] fell due to [his/her] hip pain ...While walking back to bed resident was complaining of pain in [his/her] back and right hip ..."

- Incident report dated 01/03/2024, at 12:20 p.m.: " ...i[sic] seen[sic] resident kind of like walking but running. Also like sliding, I did try to stop [him/her] but it seemed like [s/he] was going faster than me. Resident eventually lost balance and fell on [his/her] belly but kind of [his/her] face ...Resident did mention that [his/her] knee hurt [him/her], so all staff did check and [s/he] did have a little scuff ...Resident seemed very confused on what had happened ..."

Within Resident 4's observation notes in the same date range, Surveyor observed the following:

- 12/23/2023 (8:30 p.m.): "Resident was very unstable, constantly tripping and leaning into the wall ..."

- 12/26/2023 (9:30 a.m.): "Resident almost fell this morning getting on to a recliner for exercises. I did catch [him/her] before anything serious happened ...all staff should try to encourage resident to use [his/her] walker [s/he]'s been very wobbly while walking. Not very steady."

- 12/26/2023 (9:45 a.m.): "Resident is very unstable again today ...[s/he] was also gripping onto the wall due to being unstable. Staff told resident that [s/he] needs to use [his/her] walker and staff got [his/her] walker and placed it next to [him/her] in the living room."

- 01/03/2024 (12:15 p.m.): "...RESIDENT NEEDS [HIS/HER] WALKER AT ALL TIMES NO MATTER WHAT!!!.[sic] Resident seems to be very top

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N 389	Continued From page 16 heavy and not very steady with [his/her] feet." On 01/18/2024, Surveyor reviewed Resident 4's current ISP, which documented the following in relation to his/her ambulation and falls risk: - Under the "Falls Risk" section: "Resident is a low falls risk." This information was dated 06/08/2023 (day of his/her admission to the provider). - Under the "Mobility & Walking" section: "Monitor that they are walking properly and comfortably. Give resident verbal prompting and encouragement as needed. Requires monitoring and cuing with all walking needs. Issuance of verbal prompting and physical assistance as needed." Surveyor did not observe any updated fall prevention measures utilized by the provider to mitigate Resident 4's fall risk or information regarding his/her walker use documented in his/her ISP. On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A acknowledged Surveyor's concern with lack of ISP update in relation to Resident 4's fall risk mitigation measures. Consultant Administrator A reported that s/he hasn't been working with the provider long but s/he was going to have another consultant staff work with Interim Administrator B to help review resident ISPs and update them as needed.	N 389		
N 415	83.37(2)(d) Documentation of medication administration.	N 415		

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N 415	Continued From page 17 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 interview, the provider did not ensure that at the time of medication administration for 2 of 2 residents reviewed that the person administering the medication initialed the medication administration record and recorded the dosage of medication administered. From 12/01/2023 - 01/17/2024, the medication administration record (MAR) for Resident 1 contained 31 missing entries across 5 days. Staff did not record the number of sliding scale units administered to Resident 1 on 2 occasions. From 12/01/2023 - 12/20/2023, the MAR for Resident 2 contained 19 missing entries across 3 days. This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023. Findings include:	N 415		

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N 415	Continued From page 18 On 01/17/2024, Surveyor conducted a complaint investigation into concerns of medication administration. Example 1 - Resident 1 On 01/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 10/27/2023 with diagnoses including type II diabetes mellitus. Surveyor reviewed Resident 1's MAR from 12/01/2023 - 01/17/2024 and observed the following missing 31 entries across 5 days: - 12/13/2023: Blank entries for Finasteride 5 mg tablet (8:00 a.m.), Lantus SoloStar (36 units injected at 8:00 a.m.), Levothyroxine 25 mcg tablet (7:00 a.m.), Memantine HCl 5 mg tablet (8:00 a.m.), Venlafaxine HCl extended release 150 mg capsule (8:00 a.m.), and Insulin lispro 100 unit/mL injection (7:30 a.m. and 11:30 a.m.) - 12/15/2023: Blank entries for Finasteride 5 mg tablet (8:00 a.m.), Lantus SoloStar (36 units injected at 8:00 a.m.), Levothyroxine 25 mcg tablet (7:00 a.m.), Memantine HCl 5 mg tablet (8:00 a.m.), Venlafaxine HCl extended release 150 mg capsule (8:00 a.m.), and Insulin lispro 100 unit/mL injection (7:30 a.m.) - 12/19/2023: Blank entries for Atorvastatin 40 mg tablet (8:00 p.m.), Donepezil HCl 10 mg tablet (8:00 p.m.), Memantine HCl 5 mg tablet (8:00 p.m.), Tamsulosin HCl 0.4 mg capsule (8:00 p.m.), Trazodone 100 mg tablet (8:00 p.m.), and Insulin lispro 100 unit/mL injection (8:00 p.m.) - 12/22/2023: Blank entries for Atorvastatin 40 mg tablet (8:00 p.m.), Donepezil HCl 10 mg tablet (8:00 p.m.), Memantine HCl 5 mg tablet (8:00 p.m.), Tamsulosin HCl 0.4 mg capsule (8:00 p.m.), Trazodone 100 mg tablet (8:00 p.m.), and Insulin lispro 100 unit/mL injection (8:00 p.m.) - 12/26/2023: Blank entries for Atorvastatin 40 mg	N 415		

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tablet (8:00 p.m.), Donepezil HCl 10 mg tablet (8:00 p.m.), Memantine HCl 5 mg tablet (8:00 p.m.), Tamsulosin HCl 0.4 mg capsule (8:00 p.m.), Trazodone 100 mg tablet (8:00 p.m.), and Insulin lispro 100 unit/mL injection (8:00 p.m.)

Surveyor also observed 2 occasions in which staff documented administering Resident 1 his/her sliding scale insulin, but did not correctly record the number of units:

- 01/04/2024 (8:08 p.m.): Blood sugar documented as 118, "104" units documented as administered
- 01/12/2024 (8:34 a.m.): Blood sugar documented as 140, the word "units" documented as the number of units administered.

On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A acknowledged Surveyor's concern with the missing entries and reported that s/he was going to have another consultant staff work onsite with Interim Administrator B to help the provider achieve compliance.

Example 2 - Resident 2

On 01/17/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 05/10/2022 until s/he passed away on 12/20/2023. There was no information in Resident 2's record regarding his/her diagnoses. Surveyor reviewed Resident 2's MAR from 12/01/2023 - 12/20/2023 and observed the following missing 19 entries across 3 days:

- 12/13/2023: Blank entries for Levothyroxine 50 mcg tablet (7:30 a.m.), Vitamin D 1,000-unit

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N 415	Continued From page 20 capsule (8:30 a.m.), Metoprolol tartrate 25 mg tablet (8:30 a.m.), Acetaminophen 500 mg tablet (8:00 a.m. and 2:00 p.m.), Lisinopril 30 mg tablet (8:30 a.m.), Cetirizine HCl 10 mg tablet (8:00 a.m.), Senna 8.6 mg tablet (8:00 a.m.), and Lorazepam (7:00 a.m. and 1:00 p.m.) - 12/14/2023: Blank entry for Lorazepam (7:00 a.m.) - 12/15/2023: Blank entries for Levothyroxine 50 mcg tablet (7:30 a.m.), Vitamin D 1,000-unit capsule (8:30 a.m.), Metoprolol tartrate 25 mg tablet (8:30 a.m.), Acetaminophen 500 mg tablet (8:00 a.m.), Lisinopril 30 mg tablet (8:30 a.m.), Cetirizine HCl 10 mg tablet (8:00 a.m.), Senna 8.6 mg tablet (8:00 a.m.), and Lorazepam (7:00 a.m.) On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A acknowledged Surveyor's concern with the missing entries and reported that s/he was going to have another consultant staff work onsite with Interim Administrator B to help the provider achieve compliance.	N 415		
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.	N 431		

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N 431	Continued From page 21 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 that the health for 5 of 6 residents reviewed was monitored. Resident 1 was prescribed Alprazolam 0.25 mg tablets to be taken up to 3 times daily as needed (PRN), until 12/05/2023, when a prescription from a new medical provider reduced the potential frequency to twice daily as needed. Resident 1's new medical provider documented the prescription was an increase of Resident 1's Alprazolam, despite it actually being a decrease compared to what Resident 1's previous prescription. From 12/01/2023 - 01/17/2024, staff administered Alprazolam 59 times to Resident 1,	N 431		

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N 431	Continued From page 22 48 of which they did not document the reason for use, response to administration, or both. On 18 occasions, staff documented administering Resident 1's Alprazolam as a "scheduled" dose, despite it being a PRN medication. On 7 occasions, staff specifically documented that the direction to administer Alprazolam to Resident 1 came from "administration", with no other reasons documented. There was no evidence that staff's administration of Resident 1's PRN Alprazolam as a scheduled dose was done so under the direction of a medical provider or that staff attempted to communicate with Resident 1's medical provider regarding his/her PRN Alprazolam use or to reconcile the discrepancy in his/her updated order (decrease when it had intended to be an increase). Resident 3 was documented as having a headache with vitals showing an elevated blood pressure on 12/04/2023. There was no evidence that staff conducted follow up monitoring of these changes. After Resident 3 fell twice onto his/her back (on 12/02/2023 and 12/24/2023), s/he was documented as experiencing a change of condition marked by changes in posture, balance, and ambulation as evidenced by observation note entries on 12/26/2023, 12/28/2023, 01/01/2024, and 01/02/2024. There was no evidence of these changes in condition having been communicated to Resident 3's medical provider or evidence of staff monitoring these observed changes between the days they were made or after 01/02/2024. There was no evidence of follow up monitoring regarding the "lump" on resident's back observed by staff on 12/31/2023 or the bruise on his/her back observed by staff on 01/09/2024. From 01/11/2024 through 01/14/2024, staff documented concerns of Resident 4 experiencing	N 431		

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increased lethargy and confusion. There was no evidence of follow up monitoring by staff after these concerns were documented or that these concerns were communicated to Resident 4's hospice provider.

Resident 5 was documented as having concerns for a potential urinary tract infection (UTI) on 12/06/2023 and 12/08/2023, with the last note regarding the concerns documenting that Resident 5 was being taken to urgent care. No follow up information about the potential UTI was documented in Resident 5's record. A clinic note, diagnosing Resident 5 with a UTI on 12/14/2023 was not obtained by the provider until 01/18/2024, the day after Surveyor was on site.

Resident 6 experienced changes in skin condition with onset of rashes on 12/11/2023, 12/27/2023, and 12/29/2023, all observed and documented by Caregiver F. Caregiver F documented a request for other staff to continue follow up monitoring and documentation regarding the rashes, but there was no evidence of this being followed on any other day.

Findings include:

On 01/17/2023, at approximately 10:53 a.m., Surveyor conducted an on-site conference with Interim Administrator B. Interim Administrator B reported that s/he had been left in charge of the provider as of 12/15/2023, when the last administrator was let go. Interim Administrator B reported that s/he worked as a medication technician with the provider prior to this role. Interim Administrator B reported that s/he mostly worked the daily operation and that Consultant Administrator A had visited "a couple of times" since being hired by the licensee a couple weeks

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ago. Interim Administrator B reported s/he did not feel familiar with the regulations and did not have any training prior to taking on his/her new responsibilities.

Example 1 - Resident 1

On 01/18/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 10/27/2023 with anxiety. Resident 1's prescriptions included Alprazolam 0.25 mg tablet with instructions to take 1 tablet 3 times daily as needed for anxiety, which was active until 12/05/2022. On 12/05/2022, Resident 1 received a new prescription from a new medical provider for the same dosage Alprazolam but with new instructions to take 1 tablet twice daily as needed for anxiety.

While reviewing Resident 1's medication administration record (MAR) from 12/01/2023 - 01/27/2024, Surveyor observed that Resident 1 was documented as receiving his/her PRN Alprazolam on 59 occasions, 48 of which, as documented below, did not document either reason for use or response to administration, or both.

- 12/02/2023 (8:49 p.m.): No information about the reason for use or response documented
- 12/03/2023 (7:26 p.m.): No information about the reason for use or response documented
- 12/04/2023 (7:51 p.m.): No information about the reason for use or response documented
- 12/05/2023 (7:53 a.m.): No information about the reason for use or response documented
- 12/05/2023 (7:37 p.m.): "resident requested due to anxiety," no response documented
- 12/06/2023 (7:21 a.m.): "Resident requested for anxiety," no response documented

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N 431	Continued From page 25 - 12/07/2023 (7:27 a.m.): "Resident requested for anxiety," no response documented - 12/08/2023 (7:23 a.m.): "resident requested," no response documented - 12/09/2023 (7:52 a.m.): "Resident requested," no response documented - 12/09/2023 (8:08 p.m.): "Resident Request," no response documented - 12/12/2023 (7:56 a.m.): "Resident requested stated [s/he] was getting axiety[sic]," no response documented - 12/12/2023 (7:38 p.m.): "Resident Requested," no response documented - 12/14/2023 (7:29 p.m.): "Resident requested," no response documented - 12/16/2023 (8:57 p.m.): "Resident requested," no response documented - 12/18/2023 (7:59 a.m.): "Resident requested due to feeling anxious," no response documented - 12/18/2023 (9:27 p.m.): "Res reqquested[sic]," no response documented - 12/19/2023 (7:40 a.m.): "Resident requested due to anxiety," no response documented - 12/20/2023 (10:26 p.m.): "Resident requested due to being anxiuos[sic]," no response documented - 12/22/2023 (10:16 a.m.): "Administration requested ...one dose in [morning] per administrations[sic] request," no response documented - 12/23/2023 (7:49 a.m.): "Administration requested giving as scheduled dose," no response documented - 12/23/2023 (7:24 p.m.): "Due to feeling anxious," no response documented - 12/24/2023 (8:38 p.m.): "Resident requested due to anxiety," no response documented - 12/25/2023 (8:54 a.m.): "for anxiety," no response documented - 12/25/2023 (7:34 p.m.): "Resident Requested,"	N 431		

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no response documented
- 12/26/2023 (8:10 a.m.): "Resident requested," no response documented
- 12/29/2023 (9:00 p.m.): "scheduled," no response documented
- 12/30/2023 (8:22 p.m.): "Anxiety," no response documented
- 12/31/2023 (8:39 a.m.): "Administration requested as scheduled dose in [morning] and [afternoon/evening]," no response documented
- 12/31/2023 (8:22 p.m.): "Anxiety," no response documented
- 01/01/2024 (9:14 a.m.): "administration requested given as scheduled daily," no response documented
- 01/01/2024 (7:40 p.m.): "scheduled," no response documented
- 01/03/2024 (9:00 p.m.): "Resident requested for anxiety," no response documented
- 01/04/2024 (8:08 a.m.): " ...Resident requested," no response documented
- 01/04/2024 (8:51 p.m.): "scheduled," no response documented
- 01/05/2024 (8:24 a.m.): "Prn[sic] given as scheduled dose, administration requested," no response documented
- 01/05/2024 (8:26 p.m.): "scheduled," no response documented
- 01/06/2024 (7:44 a.m.): "Administration requested as scheduled dose," no response documented
- 01/06/2024 (7:59 p.m.): "scheduled," no response documented
- 01/07/2024 (8:32 a.m.): "scheduled," no response documented
- 01/07/2024 (8:37 p.m.): "schedueld[sic]," no response documented
- 01/08/2024 (7:45 p.m.): "Scheduled," no response documented
- 01/09/2024 (9:02 p.m.): "Resident requested

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due to anxiety," no response documented
- 01/10/2024 (8:06 a.m.): "Administration requested as scheduled dose," response documented as "affective[sic]"
- 01/10/2024 (8:14 p.m.): "scheduled," no response documented
- 01/11/2024 (8:10 p.m.): "scheduled," no response documented
- 01/13/2024 (8:40 p.m.): "For anxiety," no response documented
- 01/14/2024 (9:06 p.m.): "Resident requested for anxiety," no response documented
- 01/15/2024 (7:32 p.m.): "scheduled," no response documented

From the above entries, Surveyor observed a total of 18 occasions in which staff documented administering Resident 1 his/her PRN Alprazolam as a scheduled dose, and a total of 7 occasions in which staff specifically documented that this direction came from administration (who was not named). Surveyor did not observe evidence of Resident 1 having an order for scheduled Alprazolam in his/her record.

Surveyor reviewed Resident 1's individual service plan (ISP), which documented that Resident 1 had a diagnosis of anxiety. The ISP also documented, "Staff are to monitor for ----," which was followed by a list of potential symptoms of anxiety, not individualized to Resident 1. There was no information in Resident 1's ISP regarding his/her PRN Alprazolam use, and no information about health monitoring.

Surveyor reviewed Resident 1's observation notes, dated 12/01/2023 - 01/17/2024, and observed the following entries related to his/her anxiety:

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- 12/03/2023 (9:15 p.m.): "[Power of attorney] stated hospital found nothing serious and feels that this[sic] may have anxiety ..."

- 12/05/2023 (10:45 a.m.): "Resident this morning around 745 this morning[sic] and asked writer if [s/he] could get [his/her] medication for [his/her] anxiety. Staff let med passer know that [s/he] needed something. [S/he] did seem a little out of breath when I went in there. Writer did let resident know that [s/he] needed to breath thru[sic] [his/her] nose and out [his/her] mouth ...You could tell [s/he] was having a hard time breathing again so staff reminded [him/her] that [s/he] needed to breath thru[sic] [his/her] nose and out [his/her] mouth. Once [s/he] did that [s/he] seemed to be more calm ..."

On 01/18/2024, at approximately 11:20 a.m., Surveyor requested from Interim Administrator B all medical provider notes/records for Resident 1 from 12/01/2023 through 01/18/2024, including any notes in his/her record showing communication with his/her medical provider(s).

On 01/19/2024, Surveyor reviewed the records provided by Interim Administrator B and observed an after visit summary from a clinic visit Resident 1 had with his/her medical provider on 12/04/2023. The summary documented that Resident 1's diagnoses of severe recurrent major depressive disorder and anxiety were addressed. The instructions documented, "I have increased alprazolam to 0.25 mg twice a day as needed ...Return in 2 weeks for follow-up on new medication." Surveyor observed that this correlated with the new PRN Alprazolam entry on Resident 1's MAR, starting on 12/05/2023, but observed that this was also a decrease in the total daily amount of Alprazolam that Resident 1

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could be administered (as opposed to an increase like his/her medical provider documented).

Within Resident 1's record, Surveyor did not observe any evidence of communication with Resident 1's medical provider, including to provide information regarding his/her near daily PRN Alprazolam use, follow up regarding his/her decrease in prescribed daily dosing, or to seek parameter guidance upon administering Resident 1's PRN Alprazolam as a scheduled dose.

Example 2 - Resident 3

On 01/17/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 08/22/2023. There was no information in Resident 3's record regarding his/her diagnoses. Resident 3 was documented as having an activated power of attorney (POA) for healthcare. Surveyor reviewed Resident 3's current ISP, not dated. There was no information about Resident 3's health monitoring needs. Surveyor reviewed Resident 3's observation notes from 12/01/2023 - 01/17/2024 and observed the following:

- 12/02/2023 (11:42 a.m.): Incident report was created due to a fall. The incident report and the corresponding emergency department note documented that Resident 3 had fallen backward and due to his/her back being "in a lot of pain," went to the emergency department where s/he was found to have a closed wedge compression fracture of his/her T12 vertebra.

- 12/04/2023 (5:15 p.m.): "Resident has been complaining of a headache. Resident stated [s/he] has been super sore ...Resident stated it happens when [s/he] stands up. [S/he] also

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stated this was a new occurrence. Vitals were taken and [blood pressure] was 163/80, pulse 61, and oxygen was at 97%. Please continue to monitor and document..."

- 12/24/2023 (6:31 p.m.): Incident report was created due to a fall, which documented that Resident 3 had "lost [his/her] balance and fell backwards on the floor." The report indicated that Resident 3 was questioned about his/her pain level but there was no information about his/her pain documented.

- 12/26/2023 (10:00 a.m.): "******WHEN WALKING, RESIDENT NEEDS SOMEONE WITH [HIM/HER] AT ALL TIMES!****** Resident is almost a two assist to standing now. Since resident's fall on the 24th of December, [s/he] has had a harder time walking and standing up. [S/he] is walking slower than usual and needs a while to stand before [s/he] can start walking. Please keep a very close eye on [him/her] as [s/he] is having increased difficulty walking and standing. When standing or walking, please stand very close to resident even with a hand on [his/her] back or under [his/her] arm as it makes [him/her] feel safer and is safer in case [s/he] loses balance." An incident report for "change of condition" was documented at 10:03 a.m.

- 12/28/2023 (9:30 a.m.): " ...Resident then walked to the sink and was brushing [his/her] teeth. While standing there making sure [s/he] didn't fall, resident was leaning so far into [his/her] sink that [s/he] looked like [s/he] was going to fall over. While walking with [him/her] down to breakfast this morning, resident was stating that it was getting too hard for to walk down the hallways. Staff stated that maybe we should start using a wheelchair ...While resident was sitting at

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the dining room table staff noticed that resident is sitting with a more bend[sic] posture ...While walking with resident, staff noticed that resident is more bend[sic] over, cant[sic] walk straight, and unbalanced. Also while watching resident walk, staff noticed that resident cant[sic] really lift [his/her] feet much off the floor. Please keep an eye resident while she is walking ..."

- 12/31/2023 (10:30 a.m.): "While staff was putting a patch on residents[sic] back this morning, staff noticed a lump on the right side of [his/her] lower back. There is no bruising and resident stated that the lump is causing [him/her] no pain. This is the first time staff has ever noticed this and writer also showed staff member [unidentified staff] the lump as well."

- 01/01/2024 (5:45 p.m.): "Resident is very unsteady this evening. Staff was assisting resident back to [his/her] recliner and resident stated [s/he] needed to sit down immediately. Resident began to drop and staff members ...helped assist resident back into [his/her] walker to sit and take a break."

- 01/02/2024 (10:30 a.m.): " ...When writer walked into residents[sic] room, staff member found resident on the floor in front of [his/her] recliner ...While getting resident ready to come for breakfast, resident started locking [his/her] legs, went frozen, and started leaning back like [s/he] was going to sit down Staff member [unidentified staff] went and got a wheelchair for resident and staff members[sic] safety. Resident came down to the dining room in the wheelchair ...Admit[sic] will contact care team and follow up with staff members."

- 01/09/2024 (8:30 p.m.): "When getting resident

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ready for the night, staff notice[sic] that the resident has a bruise in the middle of [his/her] lower back ...Resident stated that it was hurting when [s/he] got back from the hospital, but when staff looked at it on Sunday there wasn't a bruise on [his/her] back. Staff did call POA to let [him/her] know about it and [s/he] will stop in tomorrow and look at it ...Please keep an eye on it and let POA know."

There was nothing else documented regarding Resident 3's headache or elevated blood pressure from 12/04/2023. Surveyor observed that after Resident 3 fell twice onto his/her back (on 12/02/2023 and 12/24/2023), s/he was documented as experiencing a change of condition marked by changes in posture, balance, and ambulation as evidenced by the above entries on 12/26/2023, 12/28/2023, 01/01/2024, and 01/02/2024. There was no evidence of these changes having been communicated to Resident 3's medical provider or evidence of monitoring these observed changes between the days they were made or after 01/02/2024. There was no follow up monitoring documented regarding the "lump" on resident's back observed on 12/31/2023 or the bruise on his/her back observed on 01/09/2024.

On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A reported s/he was recently hired as a consultant by the provider upon the last administrator leaving. Consultant Administrator A reported that being newer s/he was unfamiliar with resident-specific information but reported s/he agreed with Surveyor's concerns regarding the lack of monitoring by staff after Resident 3 experienced health changes. Consultant Administrator A reported s/he was

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going to have another consultant staff work with Interim Administrator B to help train him/her.

Example 3 - Resident 4

On 01/17/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 06/08/2023 with a diagnosis of dementia. Resident 4 was documented as being his/her own legal representative. Resident 4 was documented as receiving hospice services since 08/09/2023. Surveyor reviewed Resident 4's current ISP, and observed that an update made on 11/01/2023 documented that "Staff will alert Hospice to changes in condition including but not limited to: uncontrolled pain, uncontrolled anxiety, alteration of breathing, acute illness or injury ..." There was no other information about Resident 4's health monitoring needs. Surveyor reviewed Resident 4's observation notes from 12/01/2023 - 01/17/2024 and observed the following:

- 01/11/2024 (7:45 p.m.): "Resident was sitting in the living room and noticed that resident was slouching on one of the chairs ...resident stated [s/he] was ok, but when continued to talk, staff noticed [s/he] wasn't really awake while talking. Resident was very tired ...Please continue to monitor and document."

- 01/13/2024 (1:15 p.m.): " ...[S/he] continues to be very tired ...[S/he] struggled to follow directions and would start saying random words and sentences irrelevant to what staff was asking resident to do. [S/he] also started grabbing at the air and at things on [his/her] bed that were not actually there ...Once resident got out to the dining room for lunch, resident was tying [his/her] hair around [his/her] spoon above [his/her] head. Staff had to take spoon out of hair many times.

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Then [s/he] began to stick [his/her] fork in [his/her] hair stating it was [his/her] brush ...[S/he] continued to grab at the air and at things on the table that weren't actually there. Please continue to monitor resident as [s/he] has been more confused than usual."

- 01/13/2024 (4:30 p.m.): "Around 4pm, staff went into residents bedroom and did not see [him/her] in there. Staff member[s] [unidentified] all began to search for resident. Eventually staff members found [him/her] in [other unidentified resident]'s room. [S/he] was sitting behind the recliner eating cookies while playing with [his/her] hair. Staff got [him/her] up and took [him/her] to the bathroom ...Please keep an extra eye on resident as [s/he] is progressively getting more confused and wandering into other rooms."

- 01/14/2024 (6:30 p.m.): "All day today, resident has been sleeping in [his/her] bed ...We think that [s/he] is tired due to not sleeping much last night. Please keep an eye on [him/her]."

There was no evidence of any follow up monitoring by staff after these documented occurrences of lethargy and increased confusion or any documentation that these changes were communicated to Resident 4's hospice provider.

On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A reported s/he was recently hired as a consultant by the provider upon the last administrator leaving. Consultant Administrator A reported that being newer s/he was unfamiliar with resident-specific information but reported s/he agreed with Surveyor's concerns regarding the lack of monitoring by staff after Resident 4 experienced increased lethargy

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and confusion. Consultant Administrator A reported s/he was going to have another consultant staff work with Interim Administrator B to help train him/her.

Example 4 - Resident 5

On 01/17/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 10/25/2023. There was no information in Resident 5's record regarding his/her diagnoses. Resident 5 was documented as being his/her own legal representative. Surveyor reviewed Resident 5's current ISP, not dated. There was no information about Resident 5's health monitoring needs. Surveyor reviewed Resident 5's observation notes from 12/01/2023 - 01/17/2024 and observed the following:

- 12/06/2023 (1:45 p.m.): " ...When writer got to [his/her] room, resident stated that [s/he] has been going to the bathroom a lot today. [S/he] stated that [s/he] has been sleeping in [his/her] recliner because [s/he] is afraid that [s/he] is going to have an accident in [his/her] bed. Writer then told resident that [s/he] will go talk to [his/her] manager about this situation, but then resident got confused and was talking about [his/her] business that [s/he] used to work for. Resident has been very confused today ..." (Of note, Resident 5's ISP indicated that s/he was independent with self-care tasks, including personal hygiene. There was no information in Resident 5's ISP about known incontinence.)

- 12/08/2023 (10:45 a.m.): "Residents[sic] [family] call[sic] to check in[sic] [Resident 5] to see how [s/he] was doing from the other day ...[Family member] stated that [s/he] will come after lunch time to take resident to urgent care to get

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check[sic] o[sic] make sure [s/he] doesn't have a UTI ...Will update when [s/he] gets back from urgent care."

There was no other information in Resident 5's record regarding his/her UTI concerns.

On 01/17/2024, at approximately 4:00 p.m., Surveyor interviewed Interim Administrator B and requested all additional information regarding Resident 5's UTI concerns. Interim Administrator B reported that this incident occurred prior to him/her taking over. Interim Administrator B reported s/he couldn't find anything in the provider's electronic platform, but s/he wasn't sure if the previous administrator had stored information in the provider's paper records. Surveyor gave a deadline of 01/18/2024 at 12:00 p.m. to receive the requested information.

On 01/18/2024, at approximately 3:55 p.m., Surveyor interviewed Interim Administrator B. Interim Administrator B reported s/he could not find anything in Resident 5's record about the UTI concerns. Interim Administrator B reported after s/he could not find any records related to this incident s/he called Person E, who was Resident 5's family member, to ask about the incident. Interim Administrator B reported that s/he was informed by Person E that a urine sample was collected and sent to the medical provider's office for a urinalysis. Interim Administrator B reported that s/he then followed up with Resident 5's medical provider that morning to request the record from that urinalysis.

On 01/18/2024, Surveyor reviewed the records provided by Interim Administrator B. Surveyor observed a telehealth clinic note, dated 12/14/2023, with a time stamp on the record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

(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
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showing that it was printed by the medical provider on 01/18/2024 at 8:26 a.m. (correlating with Interim Administrator B's report that it was provided that day to him/her). The note documented, "We did review the [urinalysis] and culture. Due to [his/her] symptoms and positive [urinalysis] we will treat. I did send in [prescription] for Bactrim for 3 day course. Continue to push fluids. Continue azo/cranberry pills. Discussed symptoms that would require immediate attention."

On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A reported s/he was recently hired as a consultant by the provider upon the last administrator leaving. Consultant Administrator A reported that being newer s/he was unfamiliar with resident-specific information but reported s/he agreed with Surveyor's concerns regarding the lack of documented information following up on Resident 5's urinary tract infection concerns, including once s/he was diagnosed as having a UTI on 12/14/2023.

Example 5 - Resident 6

On 01/17/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 02/15/2023. There were no diagnoses in Resident 6's record. Resident 6 was documented as being his/her own legal representative. Resident 6 was documented as receiving hospice services, with no start date listed. Surveyor reviewed Resident 6's current ISP, not dated, and observed under the "Hospices Services" section: "Staff will alert Hospice to changes in condition including but not limited to: uncontrolled pain, uncontrolled anxiety, alteration of breathing, acute illness or injury ..." There was no other

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	0019044	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

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information about Resident 6's health monitoring needs. There was no information about any skin monitoring needs in Resident 6's ISP. Surveyor reviewed Resident 6's observation notes from 12/01/2023 - 01/17/2024 and observed the following:

- 12/11/2023 (9:15 p.m.): "Staff was assisting resident with getting dressed for the evening when staff noticed that resident has a yeasty rash on [his/her] groin area. Staff cleaned area and applied powder. Please continue to monitor and document."

- 12/27/2023 (9:45 p.m.): "Staff was assisting resident with going to the bathroom and staff noticed resident had a very large rash under resident's [body part]. Staff cleaned and applied powder. Please continue to monitor and document."

- 12/29/2023 (7:45 p.m.): "Resident was going to the bathroom and when staff was cleaning up resident staff noticed resident had a rash in [his/her] groin area. Staff cleaned area and applied powder to groin. Please continue to monitor and document."

Surveyor observed that all three of the above entries were made by Caregiver F, and that no other monitoring of Resident 6's rash was documented besides these entries.

On 01/19/2024, at approximately 2:54 p.m., Surveyor interviewed Consultant Administrator A. Consultant Administrator A reported s/he was recently hired as a consultant by the provider upon the last administrator leaving. Consultant Administrator A reported that being newer s/he was unfamiliar with resident-specific information

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	0019044	A. BUILDING: _____ B. WING _____	C 01/23/2024

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N 431	Continued From page 39 but reported s/he agreed with Surveyor's concerns regarding the lack of follow up monitoring completed by staff of Resident 6's rashes.	N 431		