STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017288	A. BUILDING: _____ B. WING _____	R-C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD AT MULBERRY	1281 W MAIN ST WHITEWATER, WI 53190

(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 07/30/2024, Surveyors conducted a verification visit at Glenwood at Mulberry. Four deficiencies were identified. Two of the 4 deficiencies were repeat violations. See statement of deficiency (SOD) YOGC11, dated 01/02/2024, and SOD HPQH11, dated 12/16/2020. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 18	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report a serious injury resulting in emergency room treatment to the Department, within 3 days. Resident 4 required staples for a head laceration after a fall on 05/04/2024. Findings include: On 07/30/2024, Surveyor reviewed Resident 4's record and identified the following: Resident 4 admitted to the facility on 10/05/2022 with diagnosis including Parkinson's and	N 165		

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

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N 165	Continued From page 1	N 165		

osteoporosis. Resident 4 had an activated healthcare power of attorney. Resident had a visit to the emergency room on 05/04/2024 after s/he had a fall.

Resident 4's progress notes documented:

"05/04/2024- 2:00 PM: Resident was escorted to staff after wandering into another residents (sic) room- as [s/he] had some blood coming from [his/her] head. Resident has hit [his/her] head and has moderate gash. Resident denies pain. It is unknown how the injury occurred and res unable to remember. First aid was provided, and bleeding was controlled. Advised staff send resident out to hospital via emergency ambulance for evaluation due to head injury. Staff notified POA [son/daughter] and this RN did a nurse-to-nurse with Fort Hospital ER, where ambulance was transporting [him/her].

05/04/2024- 5:00 PM: Spoke with ER Nurse at Fort Hospital. Resident will return to building this evening. [His/her] [son/daughter] will be transporting. Resident had staples applied to the head laceration. Staples can get wet- just do not scrub them directly. Scans WNL. PRN acetaminophen to be used for pain.

05/07/2024- 10:00 AM: Please wash residents' (sic) staples gently with soap and water 2 x daily, [son/daughter] will come and remove sutures on Friday."

On 07/30/2024, Surveyor reviewed Department records, which indicated no self-report had been submitted regarding Resident 4's injury requiring staples.

On 07/30/2024 at 2:30 PM, Surveyor interviewed

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N 165	Continued From page 2 Nurse Manager J and Assistant Administrator I. Nurse Manager J confirmed there should have been a self-report submitted for Resident 4's injury and was unsure why it was not done. Nurse Manager J stated the on-call nurse was supposed to submit any self-reports required during his/her on call times. Assistant Administrator I and Nurse Manager J acknowledged the 3-day reporting requirement.	N 165		
{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 4 of 4 residents received prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 missed medications on 06/05/2024 and 06/27/2024. Resident 4 missed medications on 07/26/2024 and 07/30/2024. Resident 5's medications were not administered at prescribed times due to unavailability and staff documenting as given when medications were still in the bubble back. Resident 6 missed his/her medication on	{N 352}		

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{N 352}	Continued From page 3 07/25/2024. This is a repeat deficiency. See statement of deficiency (SOD) YOGC11, dated 01/02/2024. Findings include: On 07/30/2024, Surveyors conducted a verification visit and reviewed resident records. The following was found: Example 1- Resident 1 Resident 1 was admitted to the facility on 10/07/2021 with diagnosis including dementia and hypertension. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP), date unknown, documented: "Medication Management- [Resident 1] requires staff to manage/administer medications. Ordering and coordinating meds, staff attention and/or physical assistance with taking meds, storage of meds. Narcotic Medications- Resident receives narcotic medications, staff should be alert to pain control ..." Surveyor reviewed Resident 1's physician orders which included: "Tramadol 50 mg tablet- Take 1 tablet by mouth two times daily and may take 1 additional tablet once daily in the afternoon as needed for pain." Surveyor reviewed Resident 1's medication administration record (MAR) for the months of	{N 352}		

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{N 352}	Continued From page 4 April through July 2024 which documented: "06/05/2024 2:20 PM- Tramadol 50 mg tablet- No Pass Reason: Other reason(s): Forgot to pop out for med pass. 06/27/2024 7:49 AM- Tramadol 50 mg tablet- No Pass Reason: Other reason(s): [Resident 1] has had a rough day and is now sleeping." Surveyor reviewed Resident 1's progress notes and did not identify communication with the nurse or physician regarding the decision to not administer Resident 1 his/her medication on 06/05/2024 or 06/27/2024. Example 2- Resident 4 On 07/30/2024 at 11:50 AM, Surveyor toured medication cart and observed Resident 4's 6:00 AM bubble pack of Carbidopa-Levodopa. The bubble pack still had doses left in the pack from 07/26/2024 and 07/30/2024. On 07/30/2024, Surveyor reviewed Resident 4's record and identified the following: Resident 4 admitted to the facility on 10/05/2022 with diagnosis including Parkinson's and osteoporosis. Resident 4 had an activated healthcare power of attorney. Resident 4's ISP, date unknown, documented: "A. Medication Management- Staff Administer: Resident requires staff to manage/administer medications. Ordering and coordinating meds, staff attention and/or physical assistance with taking meds, storage of meds." Resident 4's physician orders included the	{N 352}		

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{N 352}	Continued From page 5 following medication order: "Carbidopa-levo ER 25-100 mg: Take 1 tablet by mouth four times daily (6am/11am/4pm/9pm)." Resident 4's MAR was missing documentation for the 6:00 AM dose of carbidopa-levodopa on 07/26/2024 and 07/30/2024. Example 3: Resident 5 On 07/30/2024 at 12:05 PM, Surveyors toured medication cart #2 with Caregiver K and observed Resident 5's 5pm bubble packs of Diltiazem, Pantoprazole, and Sertraline. The bubble packs still had doses left in the pack from 07/22/2024. Surveyor asked Caregiver K why Resident 5's bubble packs of the above medications still had doses left from 7/22. Caregiver K stated s/he did not know and explained the provider's process of reordering medications is easy as pushing a button on their e-mar system. Resident 5 was admitted to the facility on 10/24/2016 with diagnosis including Alzheimer's and atrial fibrillation. Resident 5 had an activated healthcare power of attorney. Resident 5's ISP with an unknown dated documented: "Medication Management-Staff Administer. Resident requires staff to manage/administer medications. Ordering and coordinating meds, staff attention and/or physical assistance with taking meds, storage of meds." Resident 5's physician orders documented: "Pantoprazole 40 mg with directions to take 1 tablet once daily with a start date of 05/20/24. Sertraline 25 mg with directions to take 1 tablet	{N 352}		

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{N 352}	Continued From page 6	{N 352}		

once daily with a start date of 05/20/24.
Diltiazem 90 mg with directions to take 1 tablet 2x daily with a start date of 02/23/24."

Surveyor reviewed Resident 5's MAR from 04/01/2024-07/29/2024. Resident 5's July 2024 MAR indicated the above 3 medications were documented as "given" on 07/22/2024 at 5pm. Further review identified the following:

May 2024:
-Pantoprazole was marked as being not available on 05/20/2024, 05/21/2024, 05/22/2024, 05/29/2024 and 05/30/2024.
-Sertraline was marked as being not available on 05/20/2024, 05/21/2024, and 05/22/2024
-Diltiazem was marked as being not available on 05/30/2024.

The record did not include any other evidence to show the provider followed up with the pharmacy to see the status of Resident 5's above medications.

Example 4: Resident 6

On 07/30/2024 at 12:05 PM, Surveyors toured medication cart #2 with Caregiver K and observed Resident 6's bubble packs of Donepezil 8pm. The bubble pack still had a dose left in the pack from 07/25/2024. Surveyor asked Caregiver K why Resident 6's bubble pack of Donepezil still had a dose left from 07/25. Caregiver K stated s/he did not know and explained the provider's process of reordering medications is easy as pushing a button on their e-mar system.

Resident 6 was admitted to the facility on 05/14/2019 with diagnosis including dementia. Resident 6 had an activated healthcare power of

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{N 352}	Continued From page 7	{N 352}		

attorney.

Resident 6's ISP with an unknown date documented: "Medication Management-Staff Administer. Resident requires staff to manage/administer medications. Ordering and coordinating meds, staff attention and/or physical assistance with taking meds, storage of meds."

Resident 6's physician orders documented: "Donepezil 10mg with direction to take 1 tablet once daily related to cognitive communication deficit with a start date of 12/06/2023.
Iprat-Albut 0.5-3(2.5) MG with directions to inhale 3ml via hand held nebulizer three times a day with a start date of 01/02/24."

Surveyor reviewed Resident 6's MAR from 04/01/2024-07/29/2024. Resident 6's July 2024 MAR indicated Donepezil was documented as "given" on 07/25/2024 at 8pm. Further review identified the following:

May 2024:
- Iprat-Albut 0.5-3(2.5) MG was marked as being not available on 05/12/2024 at 8pm.

June 2024:
- Iprat-Albut 0.5-3(2.5) MG was marked as being not available on 06/05/2024 at 8pm.

The record did not include any other evidence to show the provider followed up with the pharmacy to see the status of Resident 6's above medications.

On 07/30/2024 at 2:30 PM, Surveyor interviewed Nurse Manager J and Assistant Administrator I. Nurse Manager J and Assistant Administrator I acknowledged the above concerns. Neither

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{N 352}	Continued From page 8 Nurse Manager J or Assistant Administrator I provided a reason for the doses on 06/05/2024 and 06/27/2024 being held for Resident 1. Nurse Manager J and Assistant Administrator I did not provide a reason to why Resident 5's and Resident 6's medications were still within the July 2024 bubble packs, even when staff documented as given. Nurse Manager J stated they would need to start looking at MARs more closely moving forward.	{N 352}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the individual services plan (ISP) was not updated for 2 of 4 residents reviewed when there was a change in resident needs and abilities. Resident 1's ISP was not updated to include hospice services that s/he was receiving or updated to reflect exit seeking behaviors and	N 389		

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difficulty sleeping at night.

Resident 5's ISP was not updated to include interventions for staff to mitigate continued refusals of medications.

This is a repeat deficiency. See statement of deficiency (SOD) HPQH11, dated 12/16/2020.

Findings include:

Example 1- Resident 1

On 07/30/2024, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 10/07/2021 with diagnosis including dementia and hypertension. Resident 1 had an activated healthcare power of attorney.

Resident 1's ISP with unknown date documented:

"Antipsychotic Medication: Resident receives antipsychotic medications, staff should be aware of behavior and response to these medications.

Demonstrate Anxious Behavior Requiring Additional Attention: Resident experiences anxious behavior and needs gentle redirection and reassurance to calm and feel less stressed. Signs of stress may include, pacing, crying, wringing hands, calling out. Staff sit quietly with resident, talk quietly in calm voice, offer gentle reassuring touch on hand or arm. Check for pain/discomfort, use SDD to determine trends related to anxiety, reduce stressful situations by creating a calm and predictable environment. Remove resident from congested and/or disruptive environments.

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N 389	Continued From page 10 Demonstrate Disruptive Behavior Requiring Additional Attention: Resident needs assistance with disruptive behavior which may include unprovoked confrontation, violations of others personal space, physical or verbal aggression related to others or the environment. Staff to intervene with soft conversation, offer gentle touch on hand or arm, offer preferred activity, provide validation, offer assistance to resolve issue, attempt to guide resident to private area. Behavior Monitoring: Resident has behavior expressions that require documentation and monitoring ... Night Checks: Resident should be checked on during the night. Safety/Wellness Checks: Resident should be checked on throughout the day/evening/night for safety and/or wellness. Care Coordination: Resident needs and/or wants Capri staff to schedule and arrange for services provided by non-Capri staff." Resident 1's progress notes documented: "06/07/2024 5:14 AM- Night Checks- up during night and having some carrot cake and conversation. 07/16/2024 8:45 PM- Resident was very anxious and crying wanting to leave. PRN (as needed) was given. 07/21/2024 8:30 PM- Resident at the beginning of shift came out tugging on kitchen door. Crying and saying, "Where's Jonsey ?" Resident would start to get fixated on certain residents and when trying to separate [him/her] from grabbing at them	N 389		

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and pulling them resident got aggressive with staff. Resident and [peer] were both pulling another residents catheter trying to fight over who's it was. When separated from situation resident began to hit writer and scratch at writer. Lorazepam was given. Redirection and snacks was (sic) unsuccessful.
07/26/2024 5:56 AM- Night Checks- [Resident 1] usual up and down during night/ate some snacks."
Resident 1's medication administration record (MAR) for the months of April through July 2024, documented the following PRNs and reasons indicated by staff for administration of the PRN:
"04/23/2024 10:05 AM- Lorazepam 0.5 mg- Reason: very anxious trying to leave the building.
05/26/2024 12:50 PM- Lorazepam 0.5 mg- Reason: agitated and anxious.
05/26/2024 6:59 PM- Lorazepam 0.5 mg- Reason: very anxious.
06/27/2024 9:06 AM- Lorazepam 0.5 mg- Reason: very anxious about [his/her] [husband/wife] and where the kids were going.
07/02/2024 2:14 AM- Lorazepam 0.5 mg- Reason: very anxious and restless.
07/11/2024 4:45 AM- Lorazepam 0.5 mg- Reason: restless.
07/11/2024 2:39 PM- Lorazepam 0.5 mg- Reason: anxiety.
07/15/2024 5:19 PM- Lorazepam 0.5 mg- Reason: anxiety about wanting to be dead, and people killing, [s/he] is very restless, keeps saying people are [expletive] [him/her].
07/16/2024 2:39 PM- Lorazepam 0.5 mg- Reason: anxiety wanting to leave, hit staff.
07/21/2024 3:13 PM- Lorazepam 0.5 mg- Reason: resident grabbing another's catheter bag going up to other residents saying they need to get out resident very anxious shaking crying redirection not successful.

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N 389	Continued From page 12 07/21/2024 9:13 PM- Lorazepam 0.5 mg- Reason: resident anxious tugging at doors pacing between dining room and room." Example 2: Resident 5 Resident 5 was admitted to the facility on 10/24/2016 with diagnosis including Alzheimer's and atrial fibrillation. Resident 5 had an activated healthcare power of attorney. Resident 5's individual service plan (ISP) with an unknown dated documented: "Medication Management-Staff Administer. Resident requires staff to manage/administer medications. Ordering and coordinating meds, staff attention and/or physical assistance with taking meds, storage of meds." Resident 5's physician orders documented: "Pantoprazole 40 mg with directions to take 1 tablet once daily with a start date of 05/20/24. Sertraline 25 mg with directions to take 1 tablet once daily with a start date of 05/20/24. Diltiazem 90 mg with directions to take 1 tablet 2x daily with a start date of 02/23/24. Polyethylene Glycol with directions to take 1 capful once daily with a start date of 02/23/2024." Surveyor reviewed Resident 5's MAR for April, May, June, and July 2024. The following was found: Pantoprazole 40 mg-Resident 5 refused 25 out of 109 administrations. Sertraline 25 mg-Resident 5 refused 25 out of 109 administrations. Diltiazem 90 mg-Resident 5 refused 106 out of 238 administrations. Polyethylene Glycol-Resident 5 refused 41 out of 51 administrations.	N 389		

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N 389	Continued From page 13 Resident 5's progress notes documented: "07/22/24: When writer arrived at 4pm. Other staff stated [Resident 5] didn't want to get up all day, so writer went into resident's room and [s/he] was laying in bed. Writer asked resident if [s/he] was ready to get up, resident stated "no", so writer asked if [s/he] was hungry, resident said "yes." So writer told resident [s/he] would have to get up so [s/he] could eat [s/he] said ok. So writer got [him/her] dressed and put in [his/her] chair. Resident ate all of [his/her] dinner and was ready to go back to bed as soon as [s/he] was done. Other staff put [him/her] back in bed." On 07/30/2024 at 2:30 PM, Surveyors interviewed Nurse Manager J and Assistant Administrator I. Nurse Manager J and Assistant Administrator I acknowledged Resident 1 utilized hospice services and was displaying the above behaviors. Both staff acknowledged Resident 5 refused daily medications frequently, but stated his/her physician was aware. Surveyor noted Resident 5's record did not contain any evidence communication to Resident 5's physician occurred. Neither Nurse Manager J or Assistant Administrator I could present where within Resident 1's and Resident 5's ISP, there was mention of hospice involvement or strategies for staff to mitigate exit seeking behavior, difficulty sleeping at night, and repeated medication refusals. Both Nurse Manager J and Assistant Administrator I agreed that Resident 1's and Resident 5's ISP's required additional details.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017288	A. BUILDING: _____ B. WING _____	R-C 07/30/2024

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N 408	Continued From page 14	N 408		

an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) included the rational for use, a detailed description of the behaviors indicating the need for administration of PRN (as needed).

Findings include:

On 07/30/2024, Surveyor reviewed resident records and identified the following:

Resident 1 was admitted to the facility on 10/07/2021 with diagnosis including dementia and hypertension. Resident 1 had an activated healthcare power of attorney.

Resident 1 had a physician order for "Lorazepam 0.5 mg tablet- Take 1 tablet by mouth every 6

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N 408	Continued From page 15 hours as needed for anxiety." Surveyor reviewed Resident 1's medication administration record (MAR) for April- July 2024 and confirmed s/he had received a total of 11 doses of PRN Lorazepam within this time. Surveyor reviewed Resident 1's ISP, unknown date, which did not include the rational for the use of, or a description of behaviors that required the use of a PRN. On 07/30/2024 at 2:30 PM, Surveyor interviewed Nurse Manager J and Assistant Administrator I. Neither Nurse Manager J or Assistant Administrator I could present where within Resident 1's ISP, there was a statement or description of the behaviors that warrant the use of PRN Lorazepam. Both Nurse Manager J and Assistant Administrator I agreed that Resident 1's ISP required an update to identify this PRN psychotropic and its appropriate use, on the ISP.	N 408		