STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525352	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Health Services	1350 S Madison St Lancaster, WI 53813

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that 1 (R8) of 5 residents drug regimen was free from unnecessary drugs. R8 was prescribed Risperidone for verbal and physical aggression. The facility failed to adequately monitor R8's response to Risperidone and failed to recognize adverse consequences of Risperidone therapy including lethargy, decreased Activities of Daily Living (ADL) function and decreased oral intake. The facility failed to adjust R8's Risperidone when R8 presented with adverse consequences. R8 was administered Risperidone (Antipsychotic) daily starting on 6/22/25 following two days of intermittent verbal and physical aggression. Following initiation of Risperidone, R8 presented with lethargy, decreases in activity participation, ADL abilities and oral intake. The facility continued the Risperidone without evidence of monitoring for adverse consequences or side effects related to the initiation of the antipsychotic. The Risperidone was not reduced in attempts to see if the Risperidone was the causative factor for R8's acute decline. R8 was observed multiple times to be somnolent, lethargic, and non-interactive with staff during survey.The facility's failure to ensure R8 drug regime was free from unnecessary drugs created a finding of Immediate Jeopardy, beginning on 7/10/25. The NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the Immediate Jeopardy on 8/7/25 at 3:49 PM. The immediate jeopardy was removed on 8/7/25; however, the deficient practice continues at a scope/severity level of D (Potential for harm/Isolated) as the facility continues to implement its action plan.Findings include:The facility's policy and procedure entitled, Restraint Free Environment, dated 9/22/22, states, in part: Policy: It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Chemical Restraint refers to any medication that is used for discipline or staff convenience, and not required to treat medical symptoms. Convenience refers to any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. Medical Symptom refers to an indication or characteristic of a physical or psychological condition. 5. Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine: a. How the use of restraints would treat the medical symptom. b. The length of time the restraint is anticipated to be used to treat the medical symptom. c. The direct monitoring and supervision that will be provided during use of the restraint. d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place. e. How to assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.The facility policy entitled, Use of Psychotropic Medication(s), dated 4/27/25, states in part: Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. For psychotropic (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review of articles that are published in medical and/or pharmacy journals. Adverse consequence is a broad term referring to unwanted, unintended, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics. 2. Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). 6. Non-pharmacological approaches should be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. 7. The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. 14. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis such as: a. Upon physician evaluation (routine and as needed), b. During the pharmacist's monthly medication regimen review, c. During MDS (Minimum Data Set) review, and d. In accordance with nurse assessment and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications and the resident's comprehensive plan of care. 15. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.R8 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations (movement disorder caused by neuron degeneration that affects the nervous system), weakness, type 2 diabetes, mild cognitive impairment of uncertain or unknown etiology, congestive heart failure (heart is unable to pump blood effectively leading to fluid buildup in the lungs and legs), and adult failure to thrive.R8's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 5/9/25 indicates R8 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Section GG indicates R8 was independent with eating, required supervision/touching assistance with oral hygiene, and required partial/moderate assistance with rolling left/right. Section GG also indicates R8 required substantial/maximal assistance with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, moving from sitting to lying, lying to sitting, sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer, and walking 10 feet.(Of note: R8's previous MDS data, dated 3/27/25 indicates R8 had improved from not being able to ambulate previously to now being able to ambulate 10 feet.)R8's Comprehensive Care Plan states, in part:Focus: Enjoys activities such as (reading newspapers and magazines, music, pets/animals, outdoors). Date Initiated: 3/22/25.Goals: Will actively participate in independent activities of choice. Date Initiated: 3/22/25. Target Date: 10/9/25. Will participate in activities that promote socialization with peers consistent with likes and interests such as: eating in the dining room, music groups, Bingo, and other games as he allows. Date Initiated: 3/22/25. Target Date: 10/9/25. Will participate in independent activities of choice such as: watching TV in his room, visiting with family. Date Initiated: 3/22/25. Target Date: 10/9/25.Interventions:Assist in planning and/or encourage to plan own leisure time activities. Date Initiated: 3/22/25.Assist to transport to and from activities of choice. Date Initiated: 3/22/25.Encourage participation in group activities of interest. Date Initiated: 3/22/25.Offer activities consistent with resident's known interest, physical and intellectual capabilities such as: outdoor activities, Bingo, Music Groups. Date Initiated: 3/22/25.Offer/supply large print materials. Date (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Initiated: 3/22/25.Provide supplies/materials for leisure activities as needed/requested. Date Initiated: 3/22/25.The Resident's preferred activities are: Animals/Pets (Dogs, Visiting Resident Birds), Music (Oldies, Rock & Roll, Country, Hymns, Music Entertainment), Reading (Our Wisconsin, etc., Variety Newspapers), Games/Cards (Bingo Euchre), TV (Gameshow Network, Old Shows, Friends), Current Events (News/Weather on TV, Variety Newspapers), Sitting Outdoors/Fresh Air (Weather Permitting), Socializing/reminiscing With Others, Family Centered Functions. Date Initiated: 7/14/25. Focus: The resident has limited physical mobility. Date Initiated: 3/17/254. Revision on: 3/17/25.Goal: The resident will increase level of mobility through the next review date. Date Initiated: 3/17/25. Target Date: 10/9/25.Interventions:AMBULATION/LOCOMOTION - ASSIST - ONE. Date Initiated: 3/17/25. Revision on: 3/27/25.BED MOBILITY - ASSIST - ONE. Date Initiated: 3/17/25. Revision on: 3/17/25.TRANSFER - ASSIST - 2, Hoyer, lg (large) sling risk vs benefit completed on resident choosing to use different sling size than recommended by manufacturer. Date initiated: 7/2/25. Revision on: 7/11/25. Focus: At risk for behavior symptoms r/t (related to): (specify) end stage disease (Parkinson's). Date Initiated: 6/21/25. Revision on: 6/24/25.Goal: Will accept care and medications as prescribed. Date Initiated: 6/24/25. Target Date: 10/9/25. Maintain involvement with ADL (Activities of Daily Living) performance and social activities. Date Initiated: 6/21/25. Revision on: 6/24/25. Target Date: 10/9/25.Interventions:Administer medications per physician order. Date Initiated: 6/21/25. Revision on: 6/26/25.Behavior 1 aggressive. Intervention #1: redirection. Intervention #2: another staff member. Intervention #3: try later. Date Initiated: 6/21/25. Revision on: 6/26/25.Staff to take vitals as resident allows. Date Initiated: 6/25/26. Revision on: 6/26/25. Focus: Verbal/physical agitation/aggression (specify actions) r/t: cognitive impairment. Date Initiated: 7/3/25. Revision on: 7/3/25.Interventions:Administer medications per physician orders. Date Initiated: 7/3/25.Approach slowly and slightly to the side. Date Initiated: 7/3/25.Give resident clear, concise explanation of anything about to occur. Date Initiated: 7/3/25.If strategies are not working, leave (if safe to do so) and reapproach later. Date Initiated: 7/3/25.Involve in 1:1 recreational activity. Date Initiated: 7/3/25. Focus: The resident is at risk for behavioral problem. Resident had exhibited inappropriate sexual behavior such as grabbing, touching, verbal statements r/t: mild cognitive impairment. Date Initiated: 3/17/25. Revision on: 6/16/25.Goal: The resident will have no evidence of behavior problems by review date. Date Initiated: 3/17/25. Revision on: 3/17/25. Target Date: 10/9/25.Interventions:Anticipate and meet the resident's needs. Date Initiated: 3/17/25.Distract if able. Date Initiated: 6/16/25.Encourage resident to express feelings. Date Initiated: 3/17/25.Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 6/16/25.Praise resident. Date Initiated: 6/16/25.Redirect as needed. Date Initiated: 6/16/25.Resident may not be able to remember passcode to phone due to DX (Diagnosis) of dementia. Passcode is [Resident's Passcode]. Date Initiated: 4/6/25. Focus: At risk for adverse effects r/t: use of antipsychotic medication. Date Initiated: 6/26/25. Revision on: 6/26/25.Goal: . To show minimal/no side effects of medications taken. Date Initiated: 6/26/25. Target Date: 10/9/25.Interventions:Antipsychotic Medication: Report adverse effects such as dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, EPS (Extrapyramidal Symptoms; tremors, increased agitation, restlessness, involuntary movement of mouth or tongue). Date Initiated: 6/26/25.AIMS (Abnormal Involuntary Movement Scale) testing per facility guidelines (upon admission, initiation of, change of, every 6 months, and PRN). Date Initiated: 6/26/25.Non-Pharm (Non-pharmacological) Interventions for behaviors:1. Address in a calm manner2. Attempt to orientate to place and time3. Allow resident to express feelings or frustrations and provide reassurance as needed4. Provide assistance as needed5. Family visits6. Offer activities of choice7. Provide emotional support to resident as needed8. Offer to close door and curtains to facilitate sleep. Date Initiated: 6/26/25.TARGET BEHAVIOR 1: Physically aggressive behavior (pinching, kicking, biting or hitting) (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Intervention #1: ensure safety leave, try again later. Intervention #2: try using different staff. Interventions #3: diversion, engage in conversation about his dog, bingo, music, therapy dog ([Name].). Date Initiated: 6/26/25. Revision on: 6/26/25.TARGET BEHAVIOR 2: Verbally aggressive or sexually inappropriate language. Intervention #1: Remain calm, don't react. Intervention #2: Try cares at a later time. Intervention #3: Try other staff. Date Initiated: 6/26/25. Revision on: 6/26/25. Focus: Cognitive loss as evidenced by confusion and agitation r/t (related to): Parkinson's disease. Date Initiated: 7/3/25. Revision on: 7/3/25.Interventions:Allow adequate time to respond. Do not rush or supply words. Date Initiated: 7/3/25.Approach/speak in a calm, positive/reassuring manner. Date Initiated: 7/3/25.Attempt to provide consistent routines/caregivers. Date Initiated: 7/3/25.Encourage low stress activities such as music, small group activities. Date Initiated: 7/3/25.Identify self when speaking to resident. Date Initiated: 7/3/25.Invite to participate in activities such as trivia, reminiscence, current events/newspapers. Date Initiated: 7/3/25.R8's Weight Documentation indicates R8 weighed 194 lbs. on 5/19/25.R8's Behavior Monitoring Documentation from May 2025 indicates R8 exhibited behaviors such as: yelling/screaming, abusive language, threatening behavior, rejection of care, pushing, and sexually inappropriate behavior on 6 out of 93 shifts in May 2025.A physician note dated 6/5/25 at 5:22 PM, written by DO O (Doctor of Osteopathic Medicine), states, in part: . Nursing reports that he has not had any essentially aggressive behaviors since medications changes were made. Patient has [sic] had episodes of confusion which has resulted in activation of his POA (Power of Attorney) in April. He has not tried leaving the facility within the last 6 weeks.R8's Weight Documentation indicates R8 weighed 190.5 on 6/16/25.On 6/17/25 at 21:53 (9:53 PM), a Behavior Note is written that states: Resident was very aggressive towards staff during cares, found walking in hall and unable to redirect, staff assisted as resident would allow with wheelchair to follow. Resident refused gait belt and became aggressive when staff tried. Resident did calm some and was able to eat dinner in dining room without incident. Resident went back to room and was watching television and seemed to be back to his baseline. Resident was later found to be exiting the building through the patio door. Resident was in sight by writer before exiting the building. Resident was walking with walker unassisted, appropriate clothing and footwear, staff assisted resident to wheelchair, and he calmly came back into facility. No other incidents this shift.On 6/19/25 at 16:21 (4:21 PM), a Psychosocial Assessment is completed that indicates R8 has no psychosocial symptoms related to communication or cognitive status. The assessment also states, in part: . 1. Mood or Behavior concerns since last assessment: Increased anger and inappropriate sexual comments with increased dementia and confusion. Additional Comments: POA-HC (Power of Attorney- Healthcare) will be asked to provide consent for psych (psychiatric) consult. D. Psychosocial status: 1. Check all those that apply: 1. Difficulty accepting placement and circumstances. 5. Participates in Living Center Programs 6. Pursues Indepedendent Activities. 7. Maintains Supportive Relationships. 1b. Comments: [Resident Name] doesn't understand why he can't go home and have his wife care for him. She is no longer able. He attends many activities including euchre, bingo, daily music, and special events. [Resident Name] continues to maintain relationship with his sister, brother, sister-in-law, and his wife.On 6/20/25 at 08:23 AM, a Quarterly Activity Participation Review is completed that indicates R8 participates in facility led small group activities daily, large group activities weekly, and 1:1s daily. The review also indicates R8 participates in daily independent activities and his favorite activities include cognitive (trivia, discussion, reading, word puzzles), entertainment (television, music, movies, visiting groups), games (board games, bingo, cards, video games, tablets), and social parties (parties, visiting w/ friends & family, social media, etc.).On 6/20/25 at 07:42 AM, an eINTERACT SBAR (Situation, Background, Assessment, Recommendations) Summary for Providers Note is written that states, in part: . Mental Status Evaluation: Increased confusion (e.g. disorientation) New or worsened delusions or hallucinations. Behavioral Status Evaluation: Verbal aggression Personality change. Nursing observations, evaluation, and recommendations are: resident has increased agitation and behaviors. Primary Care Provider Feedback:. monitor per policy update with further changes.On (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6/20/25 at 14:07 (2:07 PM), a Clinical Follow Up Note is written that states: Resident is on follow up for: change in condition for increased agitation and behaviors. The current status is resident refused to allow nurses to get vitals even after several attempts. Resident is agitated and exit seeking, one on one at this time. monitor per policy.On 6/20/25 at 21:23 (9:23 PM) a Behavior Note is written that states: Resident is very aggressive towards staff tonight hitting grabbing yelling kicking and making inappropriate sexual comments very difficult to redirect.On 6/20/25 at 22:11 (10:11 PM) a Clinical Follow Up Note is written that states: Resident is on follow up for: change in condition for increased behaviors and agitation. The current status is resident is resting in wheel chair; has been one on one with DON (Director of Nursing) this shift due to exit seeking and behaviors. Resident hit, kicked, pinched staff swore at them. Resident given a snack; music played. Calm at this time. monitor per policy.On 6/20/25 at 22:45 (10:45 PM) a Behavior Note is written that states: this shift, resident has been agitated, aggressive, hitting, kicking, spitting on staff, redirection, one on one, music, snack, activity all provided. Resident had attempted to remove his shirt himself, would not allow staff to help, resident had shirt stuck around his wrists and hand, resident kept trying to pull shirt off and this may cause bruising.On 6/21/25 at 03:57 AM, a Behavior Note is written that states: Resident was restless and crawling out of bed tonight. Resident was incontinent of urine and changed both times. Resident was grabbing and was sexually inappropriate while staff was performing hygiene cares. Resident was dressed in a brief; gown and transferred to a w/c (wheelchair) and brought up front by the nurse's station to be under direct staff supervision.On 6/21/25 at 06:03 AM, a Clinical Follow Up Note is written that states: The current status is resident slid out of bed, head and chest on bed, legs on floor, kneeling. resident alert and confused at baseline. resident has been on a change in condition for increased agitation and behaviors. resident is calm at this time, sitting in wheelchair asking when it is time to go home. monitor per policy.On 6/21/25 at 07:14 AM, a Clinical Follow Up Note is written that states: Resident is on follow up for: resident on change in condition for increased behaviors and agitation. The current status is resident is hallucinating, hitting, kicking, pinching, swearing at staff. Resident is being sent to [Facility Name] ER (Emergency Room) for this change. sent to ER.On 6/21/25 at 08:10 AM, a Nursing Note is written that states: resident has been hallucinating, aggressive. This nurse called and got an order to eval (evaluate) and treat at [Facility Name] ER. resident POA (Power of Attorney) approved transfer. This nurse called sheriff dept (department) and requested [Emergency Medical Service Name] for transfer to [Facility Name]. [Emergency Medical Service Name] came, and resident was combative with them as well. resident hitting, kicking, spitting, swearing. resident alert but confused, does have diagnosis for mild cognitive impairment. resident was safely secured to cot and taken by EMS (Emergency Medical Services).On 6/21/25 at 10:41 AM, a Clinical Note is written that states: Resident is on follow up for: resident on change in condition for increased behaviors and agitation. The current status is Resident is currently being returned to facility by ambulance after being evaluated by [Facility Name], resident will be returning to facility with new orders for Risperidone Q (every) day. Continue to monitor and update MD as needed.R8's Behavior Monitoring Documentation from June 2025 indicates R8 exhibited behaviors such as: yelling/screaming, abusive language, threatening behavior, rejection of care, pushing, grabbing, and sexually inappropriate behavior on 22 out of 93 shifts in June 2025, with 6 of these shifts occurring between 6/17/25 and 6/21/25.R8's Physician Orders for June 2025 state, in part:Carbidopa-Levodopa (Treats Parkinson's disease by Oral Tablet 25-250 MG (Carbidopa Levodopa) Give 1 tablet by mouth three times a day related to PARKINSONS DISEASE WITHOUT DYSKENESIA, WITHOUT MENTIONS OF FLUCTUATIONS. Start Date: 4/5/25. D/C (Discontinue) Date: 6/24/25.Risperidone Oral Tablet 0.5 MG (Milligrams) (Risperidone) Give 1 tablet by mouth one time a day for Agitation. Start date: 6/22/25. Active Order.Risperidone Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth every 24 hours as needed for agitation. Give at HS (Bedtime) if needed for agitation. Start date: 6/21/25. D/C date: 7/7/25.On 6/21/25 at 14:00 (2:00 PM), a Behavior Note is written that states: Resident is attempting to pack his belongings, states he is leaving because staff (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	feet. R8 was indicated to be dependent with toileting hygiene and lower body dressing.On 6/24/25 at 06:00 AM, a Behavior Note is written that states: New order for Risperidone on 6/22/25. No adverse effects from medication, no behaviors noted this shift.On 6/24/25 at 11:38 AM, an Orders - General Note from eRecord Note is written that states: Resident sleeping during AM med pass, when awoken, resident refused medications and went back to sleep.On 6/24/25 at 14:51 (2:51 PM), a Behavior Note is written that states: Resident refused meals on this shift as well as fluids and medications. Resident becomes [sic] combative and abusive with staff with cares and interactions. Reapproach, distraction, 1:1 ineffective.On 6/24/25 at 14:53 (2:43 PM), a COMMUNICATION - with Physician Note is written that states, in part: Situation: Resident refusing cares, medications, fluids and meals and becomes combative with staff during care. Spouse/POA wanted resident evaluated in ER due to decreased oral intake.On 6/24/25 at 17:57 (5:57 PM), an eINTERACT SBAR Summary for Providers Note is written that states, in part: . Functional Status Evaluation: Needs more assistance with ADLs (Activities of Daily Living) Behavioral Status Evaluation: Physical aggression Verbal aggression Personality change Other behavioral symptoms. Abdominal/GI Status Evaluation: Decreased appetite/fluid intake. Nursing observations, evaluation, and recommendations are: resident came back from ER with hospice order wife requesting [Hospice Provider Name] hospice. Primary Care Provider responded with the following feedback: A. Recommendations: monitor per policy.(Of note: This is the last documentation of staff reporting decreased appetite and fluid intake and needing more assistance with ADLs until 8/7/25).On 6/24/25 at 19:12 (7:12 PM), a Health Status Note is written that states, in part: Resident is currently resting in bed with eyes closed. Work of breathing is regular with equal chest rise and fall. Resident continues to have brief moments of agitation with cares but returns to sleeping soon after. Resident continues to refuse drink or beverage.On 6/25/25 at 04:54 AM, a Clinical Follow Up Note is written that states, in part: Resident is on follow up for: Overall decline in condition; resident has decreased food and fluid intake; increased assist with ADLs; increased behaviors. The current status is resting in bed. No display of pain noted.On 6/25/25 at 09:28 AM, a Behavior Note is written that states: New order for Risperidone on 6/22/25. No adverse effects from medication, no behaviors noted this shift. Resident pleasant and cooperative with cares, up in w/c for breakfast and ate 100%.R8's Weight Documentation indicates R8 weighed 177.5 lbs. on 7/1/25.(Of note: This documentation indicates a 6.82% weight loss over 2 weeks between 6/16/25 and 7/1/25, and the risperidone was started on 6/22/25).On 7/3/25 at 11:20 AM, a Psychosocial Assessment is completed that indicates R8 has psychosocial symptoms related to his cognitive status, stating [Resident Name] is confused and sometimes has thoughts and his relationship with his wife and also with staff members . The assessment also states, . 1. Mood or Behavior concerns since last assessment: yelling, hitting, spitting, verbal threats, swearing. 2. Is resident on any psychotropic medications? 1. Yes. 2b. If Yes to Psychotropic medications, list psychotropic medications and target behaviors: Risperdal (Risperidone) TARGET BEHAVIOR 1: Physically aggressive behavior (pinching, kicking, biting or hitting) TARGET BEHAVIOR 2: Verbally aggressive or sexually inappropriate language. 3. Mental Health Services. 1. No Need.On 7/9/25, a Physician Order was placed to admit R8 to hospice with the diagnosis of coronary artery disease.R8's Significant Change Minimum Data Set with Assessment Reference Date, 7/10/25, indicates R8 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. Section GG indicates R8 requires supervision or touching assistance with eating and partial/moderate assistance with oral hygiene. Section GG also indicates R8 is dependent with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, personal hygiene, and roll left/right, chair/bed to chair transfer, and tub/shower transfer. R8 could not attempt moving from sit to lying, lying to sitting, sit to stand, toilet transfer, and walking 10 feet.(Of note: This MDS indicates a decrease in R8's functional abilities with e

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect 39 of 39 residents.Surveyor observed food to have been removed from the original packaging and not dated with an expiration date, an open date, or a use by date. Evidenced by: Facility policy, entitled Food Storage, date revised 8/16/2022, states in part: .13. Frozen Foods: .c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. Example - Undated food removed from original packaging On 8/4/25 at 9:35 AM, during the initial tour of the kitchen, Surveyor observed in the freezer the following: an opened package of mixed vegetables, out of original cardboard box, without a use by or expiration date; an opened package of diced carrots, out of original cardboard box, without a use by or expiration date; an opened package of peas, out of original cardboard box, without a use by or expiration date; and an opened package of yellow beans, out of original cardboard box, without a use by or expiration date. On 8/4/25 at 1:59 PM, Surveyor interviewed DM C and showed him the unlabeled and undated bags of frozen vegetables. DM C verified these opened bags of food were not labeled and indicated they should have been labeled and dated.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect 2 of 16 sampled residents (R4 and R22) and 13 residents who eat in the main dining room. R4 voiced concerns with his cold food not being cold enough.R22 voiced concerns with vegetables being mushy.Surveyor conducted 1 test tray for the main dining room which was not palatable. Evidenced by: Facility policy, entitled Food Storage, last revised 8/16/2022, includes, in part: . 12. Refrigerated food storage: b. TCS (time/temperature control for safety) foods must be maintained at or below 41 degrees Fahrenheit unless otherwise specified by the law. Periodically take temperatures of refrigerated foods to assure temperatures are maintained at or below 41 degrees Fahrenheit. Example 1 R4 admitted to the facility on [DATE]. R4's most recent Minimum Data Set (MDS), with a target date of 5/28/25, indicates a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R4's cognition is moderately impaired. On 8/5/25 at 10:03 AM, R4 indicated during Resident Council cold food isn't cold enough when he gets it. R4 eats in the main dining room.Example 2:On 8/4/25 at 10:55 AM, Surveyor interviewed R22 during the initial screening process. During the interview R22 was asked if he had any concerns with his meals. R22 indicated the vegetables look like they have been run through a washing machine. Example 3 - Test TrayOn 8/5/25 at 12:45 PM, Surveyor conducted a test tray from the main dining room. Surveyor took the temperature of the items on the test tray. The temperatures were as follows:Beef tips in gravy - 152.3 degrees FahrenheitNoodles - 134.1 degrees FahrenheitVegetable blend (corn, green beans, peas, carrots) - 136.8 degrees FahrenheitMilk - 53.3 degrees FahrenheitSurveyor tasted the food and drink on the tray. The hot food was hot enough, but the milk did not taste as cold as it should have been, as it was warm. The green beans in the vegetable blend were very soft and mushy. Surveyor could not pick them up while sticking the fork into the beans. Surveyor had to scoop up the beans by putting the fork under them due to the beans being so soft and mushy. The tray was not palatable and at a safe and appetizing temperature.While in the dining room waiting for the test tray, Surveyor observed glasses of milk and juice which were poured ahead of time sitting on a tray on the counter, not sitting in ice.Of note: 13 Residents eat their meals in the dining room.On 8/5/25 at 1:22 PM, Surveyor interviewed DM C (Dietary Manager) and asked what temperature milk should be when serving it. DM C indicated milk should be 40 degrees Fahrenheit or lower. Surveyor asked what the process is for serving drinks to residents at mealtime. DM C indicated staff pre-pour drinks ahead of time for room trays and put them on a tray, then put tray in a reach in cooler until serving them with the meal. DM C indicated for the dining room; staff usually fill a tub with ice and place gallons of milk and pitchers with juice in the tub and pour drinks to order. DM C also indicated sometimes staff use the left-over drinks that were pre-poured from the room trays for residents in the dining room. Surveyor told DM C the temperature of the milk from Surveyor's test tray was 53.3 and DM C stated the milk should have been 40 degrees or lower. DM C indicated he will have staff stop using pre-poured drinks that were left over from room trays for residents in the main dining room. Surveyor discussed the mushy green beans with DM C, and he indicated they should not have been mushy.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the resident's right to request, refuse, and/or discontinue treatment and to formulate an advanced directive for 2 of 12 residents (R2 and R32) reviewed. R2 and R32's charts did not contain current copies of their advanced directive and/or did not contain evidence of advanced care planning, other than code status, for a time when they are not able to make their own healthcare decisions. Evidenced by:On 8/7/25 at 11:08 AM, ADON D (Assistant Director of Nursing) informed surveyor that they did not have an advanced directive policy.The facility admission Agreement, indicates, in part: Advanced Directives Policy and Record: Policy: It is the Center's policy to recognize and implement the resident's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical treatment, and the right to formulate Advance Directives.Example 1R2 was admitted to the facility on [DATE].On 8/5/25 at 10:53 AM, During the record review portion of the initial pool process, surveyor was unable to locate a copy of R2's advanced directive/Power of Attorney for Health Care (POAHC) in his electronic medical record. On 8/5/25 at 11:38 AM, Surveyor reviewed R2's care plan which indicated he had an advanced directive in place. On 8/5/25 at 12:25 PM, Surveyor reviewed R2's admission agreement from the scanned documents in the electronic health record. The Record portion of the Advance Directives Policy and Record portion of the admission agreement, indicates, in part: Power of Attorney for Health Care. A column labeled Documents not yet received, but center was informed of document(s) in existence, includes a date of 3/7/23 and initials. Of note, resident had a previous admission with this facility.On 8/5/25 at 3:01 PM, Surveyor interviewed R2 who indicated he recalled someone asking about an advanced directive/POAHC when he came into the facility. R2 indicated that his mom said he had one because it had been discussed at the hospital, however, he could not remember if a copy ever made it to the facility.On 8/6/25 at 9:33 AM, Surveyor requested documentation of R2's advanced directive/POAHC.On 8/6/25 at 2:40 PM Surveyor interviewed SSD E (Social Services Director). During the interview SSD E indicated her process for advanced directives/POAHC is to try to get them from the hospital or family and scan them in the file. SSD E indicated she tries to get them before the resident gets to the facility because the admission agreement asks about it and that triggers her. SSD E indicated the admission agreement asks if we have it, what day we receive it, if it's activated and who it is. Another column says I don't have it, but they say they will bring it and then the date I was told that is initialed. SSD E indicated if the resident doesn't have one, she clicks that, talks to the resident and offers to create one and tells them it's not required but that she can help. SSD E indicated she asks the family repeatedly and checks during care conferences to see if she has it. If she doesn't have it she will ask about getting it. If they still haven't created one, she will ask again if they want help during the care conference.Surveyor asked SSD E if she had R2's advanced directive/POAHC. SSD E indicated she did not, but that she was able to get it from the [Hospital/Clinic Facility Name]. SSD E indicated the person that was here before her marked that he had one but that it wasn't here, and she hadn't gone back that far to check when she started. Surveyor asked SSD E if she checked for it during his last care conference. SSD E indicated she did not look back for his. Surveyor asked SSD E if she should have looked before his care conference. SSD E indicated she checked code status and took for granted that it was all in there from the social worker before. Surveyor asked SSD E if it is her intent for the process to be to check every advanced directive/POAHC prior to each care conference. SSD E indicated yes, and that this one was missed. Example 2R32 was admitted to the facility on [DATE].On 8/5/25 at 7:57 AM, During the record review portion of the initial pool process, surveyor was unable to locate a copy of R32's advanced directive/Power of Attorney for Health Care (POAHC) in his electronic medical record.On 8/5/25 at 5:00 PM, Surveyor requested documentation of R32's advanced directive/POAHC.On 8/7/25 at 9:00 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, Surveyor interviewed SSD E (Social Services Director). During the interview SSD E indicated she had a copy of R32's POAHC in her file cabinet but it was not scanned into the electronic health record. SSD E indicated that R32's wife passed away in the spring of this year and she was originally the one listed on the POAHC and there was no alternate listed. SSD E indicated that his daughter wanted to be the POAHC, however, the paperwork was not completed correctly due to witnesses being family, so it was invalid. SSD E indicated she became aware of the daughter wanting to be the POAHC when she received new POAHC paperwork that someone left. Surveyor asked SSD E if she knew who left the paperwork and she indicated, I guess the daughter. SSD E indicated the paperwork looks like it was done in March 2024. SSD E indicated she thinks it may have been in R32's room for some time and does not recall when she received it, just that she found it on her desk one day. SSD E indicated the paperwork is dated before R32's wife passed. Surveyor asked SSD E if she reapproached R32 about POAHC once she found the paperwork and realized it was invalid due to who was listed as witnesses. SSD E indicated that shortly after R32's wife passed away she tried to talk to him about POA paperwork, but he initially said he was going home and wouldn't talk to me about it and said his daughter had it under control. Surveyor asked SSD E if she had any documentation of this discussion and she indicated she would check. Surveyor asked SSD E if it is accurate that R32 has been without a valid POAHC designee since his wife's passing. SSD E indicated, possibly, he is his own person. Surveyor asked SSD E what would happen if R32 became unresponsive and went to the hospital without a valid designee on his POAHC paperwork. SSD E indicated they would have to speak to his daughter. Of note, SSD E did not provide documentation of discussions with R32 regarding the invalid POA paperwork or discussions regarding the need to update a POAHC designee after R32's wife passed. On 8/7/25 at 10:13AM, SSD E brought in a copy of what she indicated was the invalid POAHC paperwork that is signed on 3/15/24. SSD E indicated that R32's wife passed away in January 2025, so it was probably March when she tried to talk to R32 about updating his POAHC. Surveyor asked SSD E if she should have reapproached again. SSD E indicated, probably, I mean yeah.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure care plans were reviewed and/or revised for 2 of 16 (R8 and R9) residents reviewed. Facility staff did not revise R8's care plan to address his hospice status and did not have the hospice agency care plan available for facility staff. R9's comprehensive care plan does not include a focus, goal or interventions for depression. Evidenced by: The facility policy titled, “Comprehensive Care Plan,” indicates, in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment…Policy Explanation and Compliance Guidelines: …5. The comprehensive care plan will be reviewed and revised as appropriate by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) assessment, and as needed with changes in condition. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed… Example 1: On 8/6/25 Surveyors reviewed R8's profile tab in his electronic health record which indicated a hospice organization was involved in R8's care. On 8/6/25 at 9:54 AM, Surveyor reviewed R8's hospice binder. A tab labeled Plan of Care (POC) does not contain any documents, and surveyor was unable to locate a hospice POC anywhere in the binder. Of note, R8 was on hospice prior to 7/7/25. Surveyors reviewed R8's comprehensive care plan and was not able to locate a hospice care plan. Surveyors did note the following under R8's nutrition at risk care plan: Focus: At risk for nutritional status change…Potential for wt loss r/t reduced oral intake, hospice care…Goal: Palliative Care… On 8/7/25 at 8:50 AM, Surveyor interviewed LPN J (Licensed Practical Nurse). During the interview, LPN J indicated if someone is on hospice it will show in their profile under external facilities. Surveyor asked LPN J if the facility utilized the hospice care plan separate from the facility care plan or if they are combined. LPN J indicated they put it on their care plan that the resident is on hospice. Surveyor asked LPN J where she would find the actual hospice care plan. LPN J indicated she truly didn't think she had ever seen one of hospice's care plans. Surveyor asked how they combine the care plans if she can't review it. LPN J indicated we talk and communicate then discuss it in care conferences. LPN J indicated that she does not put in the care plan and typically that is done by MDS (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinator K (Minimum Data Set), DON B (Director of Nursing), or ADON D (Assistant Director of Nursing). LPN J indicated she utilizes the facility care plan for information. Surveyor and LPN J reviewed R8's facility care plan and LPN J indicated the only place she could locate any hospice information was under the nutrition at risk care plan. Surveyor asked LPN J if she would expect to see a hospice care plan. LPN J indicated, yes. On 8/7/25 at 9:15 AM, Surveyor interviewed ADON D and asked what the process is for care planning hospice. ADON D indicated, we have care conferences with hospice and combine cares. Surveyor asked ADON D if they combine care plans or keep them separate. ADON D indicated she was not sure if that was the process and referred surveyor to MDS Coordinator K. On 8/7/25 at 9:18 AM, Surveyor interviewed MDS Coordinator K. During the interview MDS Coordinator K indicated that she assists with making care plans. Surveyor asked MDS Coordinator K to review the hospice care planning process. MDS Coordinator K indicated they open the original baseline care plan, if it's a brand new patient, open that and answer all the questions and if you tell the care plan that the resident had a fall, for example, it will trigger a fall care plan. We go through all the diagnoses and ensure we have a care plan for everything and if they are on hospice they get a hospice care plan. Surveyor asked MDS Coordinator K how they incorporate the hospice agency care plan into the facility care plan. MDS Coordinator K indicated in their focus for care plans they have actual pain/hospice/palliative care and we can pick if they will be hospice. I compare the hospice care plan to ours and add what is needed. Surveyor asked MDS Coordinator K where they get the hospice care plans. MDS Coordinator K indicated there are books up front. Surveyor showed MDS Coordinator K R8's hospice binder, which she indicated was the book she was referring to, and MDS Coordinator K reviewed the binder and agreed there was not a hospice POC present. Surveyor asked MDS Coordinator K if she remembered if she compared the hospice care plan to the facility's and used it to update the care plan. MDS Coordinator K indicated, I honestly do not recall. Surveyor asked MDS Coordinator K how the nurses would know how to care for R8 without a hospice care plan. MDS Coordinator K indicated, they would come to us if they had questions and most of our hospice patients are cared for based on what we have in house and hospice is an added service. Surveyor asked MDS Coordinator K if R8 should have had a separate hospice care plan on the facility comprehensive care plan. MDS Coordinator K indicated, yes, and I fixed it yesterday. MDS Coordinator K indicated DON B came to her about it and R8's just got missed. MDS Coordinator K indicated he had one under nutrition but it needed to be more elaborate, it needed to be this is hospice, this is what he has. Example 2: R9 was admitted to the facility on [DATE] with diagnoses that include Major Depressive Disorder, Recurrent, Moderate and Mild Cognitive Impairment of Uncertain or Unknown Etiology. R9's most recent Minimum Data Set (MDS) Assessment, dated 4/24/25, indicates R9's Brief Interview for Mental Status (BIMS) score was 11 out of 15, indicating that R9 has mild cognitive impairment. R9's Physician Orders include, in part: --Paxil Oral Tablet 20 MG (Paroxetine HCl). Give 0.5 tablet by mouth one time a day for Depression, unspecified. Start Date: 6/26/25 --risperidone Oral Tablet (Risperidone) Give 0.5 mg (milligram) by mouth two times a day related to (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Other Symptoms and Signs involving Cognitive Functions and Awareness. Start Date 5/28/25 R9's Comprehensive Care Plan indicates: Focus: At risk for behavior symptoms. Date Initiated: 4/25/25. Revision on: 4/25/25. Goal: Will accept care and medications as prescribed. Date Initiated: 4/25/25. Target Date: 10/22/25. Will reduce risk of behavioral symptoms. Date Initiated: 4/25/25. Target Date: 10/22/25. Interventions: Behavior 1 rejection of care. Intervention #1: active listening for reason for rejection. Intervention #2: try again later. Intervention #3: try another caregiver. Of note, nowhere in R9's comprehensive care plan does it include that R9's has a diagnosis of depression, nor does it include resident specific goals or interventions. R9's Certified Nursing Assistant (CNA) Kardex Report indicates, in part: Mood/Behavior: *Behavior 1 rejection of careIntervention #1: active listening for reason for rejectionIntervention #2: try again laterIntervention #3: try another caregiver. Monitoring: *Monitor/Document/Report PRN (as needed) for following adverse effects of SEDATIVE/HYPNOTIC therapy: day time drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness. Resident Care: *Administer SEDATIVE/HYPNOTIC medications as ordered by physician. Monitor side effects and effectiveness Q-SHIFT (every shift). On 8/4/25 at 11:39 AM, Surveyor interviewed R9 and asked her if she ever felt sad or depressed. R9 stated that she did sometimes. Surveyor asked R9 if she ever refused the staff to assist her with cares. R9 stated that she never refused cares. Surveyor asked R9 if she ever refused medications. R9 stated that she never refused to take her medication. On 8/7/25 at 9:45 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) and asked her what kind of behaviors that R9 displayed. CNA F stated that she didn't see R9 having any behaviors. Surveyor asked CNA F if R9 ever refused cares. CNA F stated that R9 would sometimes refuse to eat lunch if she ate a big breakfast, but that she never refused cares. Surveyor asked CNA F if R9 ever displayed signs of depression. CNA F stated that R9 liked to stay in her room and watch TV. Surveyor asked CNA F what side effects of R9's medication she would be monitoring for. CNA F stated she would have to check with the nurse. On 8/7/25 at 10:04 AM, Surveyor interviewed CNA G and asked her what kind of behaviors that R9 displayed. CNA G stated that R9 doesn't really have any behaviors, but that she prefers to stay in her room and at times will only eat one meal per day. Surveyor asked CNA G if R9 ever refused cares. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA G stated no, she did not think that R9 ever refused cares. Surveyor asked CNA G if R9 ever displayed signs of depression. CNA G stated the isolation and refusal of meals that she had previously mentioned. Surveyor asked CNA G what kind of interventions worked for R9. CNA G indicated that she would offer R9 a snack if she refused lunch. Surveyor asked CNA G what side effects of R9's medication she would be monitoring for. CNA G stated she didn't know because the nurses are the ones that do that. On 8/7/25 at 10:31 AM, Surveyor interviewed RN H (Registered Nurse) and asked her what kind of behaviors that R9 displayed. RN H stated that at times R9 would refuse cares and refuse to come out of her room. RN H stated that R9 just liked to stay in her room and didn't like to be around other people, especially at mealtimes. Surveyor asked RN H what kind of interventions worked for R9. RN H indicated attempting redirection. Surveyor asked RN H what kind of side effects of R9's medication were they monitoring for. RN H stated that R9 took quite a list of behavioral medications so she would be watching for mental status changes and things like constipation. On 8/7/25 at 10:43 AM, Surveyor interviewed DON B (Director of Nursing) about monitoring R9's depression, medications, and interventions. DON B stated that they do a lot of redirection with R9, try to get her to come to activities and meals but that she is resistive to that and wants to hang out in her room by herself. Surveyor asked DON B how staff monitor for side effects of R9's medications. DON B stated the nurses watch every shift and note any behavior and monitor for depression symptoms. DON B indicated that the CNAs should monitor for any changes and notify the nurse. Surveyor asked DON B if a diagnosis of depression should be on R9's comprehensive care plan. Surveyor asked DON B how often interventions are reviewed for effectiveness. DON B stated that she reviews interventions at care plan review meetings quarterly and annually, and that she checks in with each resident twice per week or at least once per month to make sure their care plans match their needs. DON B stated yes, depression should be on R9's care plan. On 8/7/25 at 11:13 AM, ADON D (Assistant Director of Nursing) provided Surveyor with a history of changes made to R9's comprehensive care plan, which indicated that on 7/24/25, R9's depression focus, goals, and interventions had been resolved/cancelled. On 8/7/25 at 12:47 PM, Surveyor interviewed SSD E (Social Services Director) and asked her about R9's depression care plan being resolved. SSD E stated she had no idea why she would have done that, as she knows that R9 has a diagnosis of depression. SSD E indicated that sometimes she goes into a resident's care plan and updates the target behaviors but that she would not have intentionally deleted it. SSD E stated she had no clue how or why that happened and was not aware that she had deleted R9's depression care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525352	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Health Services	1350 S Madison St Lancaster, WI 53813

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors in 29 opportunities that affected 2 out of 7 supplemental residents (R23 & R25) included in the medication pass task, which resulted in an error rate of 6.9%. R23 received insulin from an insulin pen that had not been primed prior to use. R25 did not receive the correct dose of Vitamin D3. Evidenced by: The facility policy entitled, Medication Administration General Guidelines, dated 1/2025, states, in part: .Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices. Procedures:. Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. 9. Verify medication is correct three (3) times before administering the medication. a. When pulling medication package from med cart. b. When dose is prepared. c. Before dose is administered. Manufacturers' guidelines for insulin pen, entitled, Instructions for Use Humalog Kwik Pen injection for subcutaneous use 3 mL single-patient-use-pen (100 units per mL), revised 7/2023, manufactured by [NAME] Lily and Company, states, in part: . Priming your Pen: Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Example 1: R23 was admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (a chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), Long Term (current) use of insulin, and weakness. R23's Physician Orders include, in part: Humalog Injection Solution (Insulin Lispro). Inject 3 unit subcutaneously three times a day for inject before meals. Start Date: 4/8/25. No end date. R23's Medication Administration Record (MAR) for August 2025 indicates, in part:Humalog Injection Solution (Insulin Lispro). Inject 3 unit subcutaneously three times a day for inject before meals. Start Date: 4/8/25. On 8/5/25 at 8:06 AM, Surveyor observed LPN I (Licensed Practical Nurse) administer R23's insulin. LPN I did not prime the insulin pen before administering the insulin to R23. Surveyor asked LPN I if she had primed the insulin pen. LPN I stated that she primed the needle when the pen was first opened. LPN I stated she was taught to prime the pen to 2 units the first time it is used and after that it didn't need to be primed again with each use. On 8/7/25 at 10:41 AM, Surveyor interviewed DON B (Director of Nursing) and asked her if she would expect staff to prime an insulin pen before administering to ensure the correct dose is given. DON B stated yes, it was her expectation that insulin pens be primed at least 2 units each time. DON B indicated that she had provided education about priming insulin pens to LPN I and the other nurses. Example 2: R25 was admitted to the facility on [DATE] and has diagnoses that include Multiple Sclerosis, Primary Osteoarthritis, and Weakness. R25's Physician Orders include, in part: Vitamin D3 Tablet MCG (micrograms) 1000 unit (Cholecalciferol). Give 2 tablet by mouth one time a day for supplement. Start Date: 3/17/22. No end date. R25's Medication Administration Record (MAR) for August 2025 indicates, in part:Vitamin D3 Tablet MCG (micrograms) 1000 unit (Cholecalciferol). Give 2 tablet by mouth one time a day for supplement. Start Date: 3/17/22. On 8/5/25 at 7:48 AM, Surveyor observed LPN I administer medication to R25 which included Vitamin D3. Surveyor asked LPN I if she was giving one tablet or two. LPN I stated she was administering one tablet of Vitamin D3 to R25. On 8/5/25 at 8:47 AM, Surveyor reconciled medications that were administered to R25 to R25's MAR to find the Vitamin D3 was ordered for two tablets. Surveyor had observed the medication pass and confirmed with LPN I that she was giving one tablet of Vitamin D3. On 8/5/25 at 9:47 AM, Surveyor interviewed LPN I and asked about the Vitamin D3 that she had administered to R25. Surveyor showed LPN I R25's physician orders and asked LPN I if she had administered one tablet or two of Vitamin D3. LPN I indicated she thought she had given two. Surveyor asked LPN I if giving the (continued on next page)

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	525352	A. Building B. Wing	08/19/2025

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Lancaster Health Services	1350 S Madison St Lancaster, WI 53813

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wrong dose would be considered a medication error and LPN I indicated yes, that would be a medication error. On 8/7/25 at 10:41 AM, Surveyor interviewed DON B and informed her of the medication observation errors. DON B indicated she would expect medications to be administered according to physician orders.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure they followed standards of practice for an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 (R21) of 8 supplemental residents reviewed for antibiotic stewardship. R21 was diagnosed with a urinary tract infection. The physician ordered the antibiotic Bactrim DS (trimethoprim/sulfamethoxazole). The urine culture and susceptibility indicated the bacteria causing R21's urinary tract infection was resistant to Bactrim DS. After this result, R21's ordered antibiotic was not changed. Evidenced by: The facility's Antibiotic Stewardship Program policy, dated 11/18/22, states, in part: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.4. The program includes antibiotic use protocols and a system to monitor antibiotic use . b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness . R21 was admitted to the facility on [DATE] and has diagnoses that include: congestive heart failure (heart does not adequately pump blood), weakness, and type 2 diabetes. On 7/7/25, a urinalysis was collected from R21 for new or marked increase in incontinence, urgency, and frequency. The urinalysis resulted on 7/8/25, and a physician ordered Bactrim DS for R21. On 7/9/25, a urine culture and susceptibility resulted showing greater than 100,000 CFU (Colony Forming Units) of Escherichia coli (bacteria). The susceptibility indicated this bacterium was resistant to Bactrim DS, the antibiotic ordered to treat this infection. On 8/6/25 at 2:40 PM, Surveyor interviewed ADON D (Assistant Director of Nursing). Surveyor referenced R21 being ordered on Bactrim DS on 7/7/25, Surveyor asked ADON D what symptoms R21 was experiencing. ADON D indicates, altered mental status, urinary frequency, and restlessness. Surveyor asked ADON D if the infectious organism found in R21's urine culture was resistant to Bactrim DS. ADON D reviewed the culture and susceptibility results and states, yes. Surveyor asked ADON D if any discussions were had with the ordering physician regarding R21's resistance to this antibiotic. ADON D indicates that the culture and susceptibility was sent to him, but there are no notes regarding any discussion. Surveyor asked ADON D why it is important to use a different antibiotic if the bacteria is found to be resistant to the ordered antibiotic. ADON D indicates, so the antibiotic actually kills the bacteria.