STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525655	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fond Du Lac Lutheran Home	244 N Macy St Fond Du Lac, WI 54935

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to discuss risks versus benefits and obtain informed consent for the use of psychotropic medication for 1 resident (R) (R4) of 3 sampled residents. The deficient practice had the potential to cause a psychosocial decline in R4's mental status. Findings include: Review of the facility's undated Standard Psychoactive Medication Protocol policy revealed: .Individual is prescribed a psychotropic medication .Nursing: .Review and obtain signature for informed consent with individual or responsible party. Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, human immunodeficiency virus (HIV), dementia, and type 2 diabetes mellitus. R4 had a Guardian who was R4's Responsible Party (RP). Review of an Order Entry, dated 11/4/25, revealed an order for Depakote Extended Release (ER) (an anticonvulsant and mood stabilizer medication) 250 milligrams (mg) daily for sexually inappropriate behavior. Review of R4's Medication Administration Record (MAR) for November 2025 revealed an order for Depakote ER 250 mg daily with a start date of 11/5/25. The medication was documented as administered on 11/5/25. There was no documentation as to whether the 11/6/25 dose was administered. The medication was held and not administered from 11/7/25 until it was discontinued on 11/10/25. Review of the Miscellaneous tab of R4's electronic medical record (EMR) revealed there was not a signed informed consent form for the Depakote that was administered on 11/5/25. Review of R4's comprehensive record revealed nothing to indicate a discussion was had with R4's RP regarding the Depakote order, risks versus benefits, or informed consent prior to the administration of the medication on 11/5/25. Review of a Nurse's Note, dated 11/7/25, revealed: Depakote: Order in EMAR (electronic MAR) put on hold. POA (Power of Attorney) wants to speak (with) dialysis before she will consent to (medication). Review of an Incident Note, dated 11/10/25 and written by the Director of Nursing (DON), revealed: (R4) was ordered Depakote to help with sexually inappropriate behavior reduction as it does not interact with (R4's) HIV medication effectiveness. The NP (Nurse Practitioner) gave the order after recommendations were given from the pharmacist. Staff did not update (R4's) POA on the new medication and administered a dose after receiving the order. Later, (R4's) POA was informed and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525655	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fond Du Lac Lutheran Home	244 N Macy St Fond Du Lac, WI 54935

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wanted the medication to be held until she could talk to dialysis for safety reasons. (R4's) POA asked what medications (R4) had today and it was noted that a dose was missing on (11/5) as given. There (were) no adverse effects noted the day of the dose being given but the order has been discontinued and all appropriate people updated as (R4's) POA does not consent to use of this medication. Review of R4's Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/6/26, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderately impaired cognition. The MDS assessment indicated R4 had no behaviors in the 7-day look-back period and did not receive any psychotropic medication. During an interview on 5/13/26 at 2:35 PM, Registered Nurse (RN)1 stated she spoke with R4's RP regarding the new medication and informed R4's RP the first dose had been administered. RN1 stated R4's RP stated she wanted to talk to the dialysis facility before the next dose was given to ensure it would not have an adverse effect with dialysis. RN1 stated she asked R4's RP to come back or call the facility after she spoke with the dialysis center to relay the information she received. RN1 stated she never heard back from R4's RP. During an interview on 5/14/26 at 11:45 AM, the DON stated R4's medications were reviewed by the pharmacist and the provider for the most effective medication that would not interact with dialysis or any other medications R4 received. The DON stated the order for Depakote was entered in the EMAR, and one dose was given on 11/5/25 before R4's RP was updated and informed consent was obtained. The DON stated she expected nursing staff to obtain consent before entering a new order for a psychotropic medication.