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	0017501	A. BUILDING: _____ B. WING _____	C 05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON HOUSE SENIOR LIVING INC	W76 N629 WAUWATOSA RD CEDARBURG, WI 53012

(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 05/02/2025, Surveyor conducted a complaint investigation at Hamilton House Senior Living Inc. Two deficiencies were identified. The complaint was substantiated. Census: 27	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents were safeguarded from environmental hazards. Resident 1 eloped from the facility and staff could not hear the provider's alarm. Findings include: The provider is licensed to care up to 28 residents in the following client groups: advanced age and irreversible dementia/Alzheimer's. On 03/13/2025, the Department received a complaint alleging concerns with a resident elopement.	N 358		

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

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N 358	Continued From page 1 On 05/02/2025, Surveyor reviewed Resident 1's record and identified the following: Surveyor reviewed Cedarburg Police Department incident report #25-003272 dated 03/09/2025. This report documented: " On March 9, 2025, a resident at [provider's name], [Resident 1], did leave the memory care unit and make it down to Casey's Gas Station approximately ½ mile away before personnel at [provider's name] noticed that [s/he] was gone. On Sunday, March 9, 2025, at approximately 7:09 PM, dispatched to the area of Wauwatosa/Western Rd. for a report of an elderly [man/woman] walking down the road way who did not appear to be dressed appropriately ....The calling party stated that [Resident 1] was just walking down the road way southbound and appeared confused. [S/he] was not wearing a jacket and did not have shoes on. [S/he] was also not very verbal. While there, [Caregiver B] along with a carload of other workers from [provider's name], stopped out stating that they knew who this individual was and it was [Resident 1], a resident at the [provider's name], where [s/he] works and [s/he] would take [him/her] back. I [Officer D] then followed [Caregiver B] along with [Resident 1] in [his/her] vehicle back to [provider's name]. I [Officer D] spoke to the worker who was in charge of [his/her] room, [Caregiver C] who stated that [s/he] is a CNA. [Caregiver C] stated that there are 3-4 workers working at a time and they have to go into rooms to help other patients and when they go into the rooms they are unable to hear the alarm of someone leaving. [Caregiver C] stated that there are two doors which they can leave out of and when they attempt to leave there is about a 15 second delay before they can get out and then the alarm in the hallway goes off beeping. [Caregiver C] stated [s/he] was in	N 358		

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another room and could not hear the alarm and when [s/he] had come out [s/he] heard it, cleared it, and was about to check to see who had set it off or could be missing when [s/he] received a phone call from [Caregiver C] stated that they had found [Resident 1]. I [Officer D] to the facility director by phone [Executive Director A] and [s/he] stated that one of the problems with [Resident 1] is that [s/he] does not take [his/her] medication and they cannot force [him/her] and [s/he] believes that is one of the problems as [s/he] keeps trying to leave."

Resident 1 was admitted to the facility on 07/19/2024. Resident 1 is under 70 and had diagnosis of dementia and bipolar disorder. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 04/23/2025 documented: "Behavior observation: Behavior exhibited: Resident paces throughout the day and night. Will be resistive with ADLs, Will follow staff around. Interventions: Never argue. Door cover ordered to place on the door [s/he] exits. Re-approach if needed. Anticipate needs. Keep resident engaged with activities that [s/he] enjoys during wake hours. Sit and chat and talk about [his/her] condo or family. Offer to call [his/her] [wife/husband] or [son/daughter] as [s/he] often needs reassurance and hearing their voice helps [him/her] Offer to sit and do a puzzle. Take outside for a walk on the memory care patio if weather permits. Offer a hand held snack/liquid. The community to provide assistance to monitor reactive behaviors in a supportive environment."

Resident 1's progress notes documented: "02/18/2025: Resident has been following staff around the building. Resident has set off door alarm four times since the start of the shift.

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N 358	Continued From page 3 Resident has been redirected multiple times, has been given snacks and something to drink even offered to be toilet. Resident has refused." "02/20/2025: Resident is setting off door alarms back entrance. " "03/02/2025: Resident is very hard redirecting behavior of going to the back exit door, when staff not looking [s/he's] pushing on the door sounding the alarm tryna (sic) get out the building. Going behind the kitchen counter getting all the snacks from the cabinet." "03/04/2025: [Resident 1] has paranoia and will push the door but has not attempted to go out the door. [S/he] stops when the alarm sounds. NP is aware of paranoia. Able to redirect [Resident 1] but having [him/her] watch me make [his/her] plate of food for breakfast and [s/he] sat down to eat." "03/05/2025 @ 10:47 AM: Very aggressive tryna (sic) fight staff. @7:58 PM: Resident kept going door to door and setting off the alarms. @ 9:55 PM: Resident had elopement tonight. Resident was brought in by another aid on third shift. Resident was setting the alarm off at least a dozen times since 2 o'clock when for second shift came in. [S/he] did it all the way till 10:00 PM. @ 11:21 AM: ...[Resident 1] is exit seeking and has been triggering the door alarm every two minutes throughout the evening, raising safety concerns. Appears this was the case the last 2 evenings as well. While on the phone [s/he] was able to exit the building. [Resident 1] does not sleeping but paces and walks in circles and is not responding to [his/her] current medications." "03/09/2025: HHA called that resident had eloped unsure of exact time. [S/he] made it out of the facility to the gas station. One of the staff were able to get the resident back into the facility. Police were involved. The HHA states has done this multiple times today and exhibiting unsafe	N 358		

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behaviors. HHA expressed concerns about not being able to monitor resident effectively with the increased behaviors. HHA states they think the resident needs to go into the hospital to be evaluated. HHS states [s/he] talked to [Executive Director A] , it was suggested the resident may need a medication adjustment. The police officer took the phone and wanted to understand the plan for a resident when this happens. This writer explained I would want to make sure the resident is safe. HHA noted while writer was speaking to police officer the resident attempted to elope again ...."

The providers self-report for Resident 1's elopement on 03/14/2025 documented: "[Resident 1] ...Dx: Bi-polar and Dementia. [S/he] received assistance with bathing, dressing, meal reminder, and medication administration, among others. [S/he] ambulates and transfer with no staff assistance nor assistive devices. [Resident 1] has a history of refusing staff assistance including medication administration. On March 14th, 2025, at approximately 3:50 am, [Caregiver E] responded to properly alarmed egress door to see [Resident 1] outside of the community in pajamas and house slippers."

On 05/02/2025 from 9:40 AM to 10:00 AM, Surveyor interviewed Executive Director A and observed the provider's memory care unit. Executive Director A confirmed Resident 1 eloped on 03/09/2025 and reported staff was in another resident's room when the alarm signaled. Executive Director A reported when the backdoor alarm activates, the alarm signals a noise which has to be shut off by staff. Executive Director A reported staff carry a facility phone during their shifts, but their current system does not send any messages to their phone indicating what door

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alarm had been activated. Surveyor questioned the volume level of the back door alarm once activated, since Caregiver B indicated in the police report s/he could not hear the alarm when Resident 1 eloped. Executive Director A acknowledged staff could not hear the alarm when in some resident rooms, but noted an amplifier had been added to make the alarm louder. Surveyor observed the back door entrance/exit where Resident 1 had successfully eloped. Surveyor observed Executive Director A open the door, the door alarm sounded, requiring Executive Director A to silence the alarm. The door opened up to a staff parking lot.. Executive Director A reported after Resident 1's increase exit seeking, s/he started on hospice services, had a 1:1 staff for 4 hours/day for 2 weeks, and medication changes until behavior minimized. At 11:30 AM, Surveyor expressed concern the provider's alarm system could not be heard throughout the facility and with current systems in place no notifications were sent to staff when exit doors were opened. Executive Director A acknowledged an understanding of the Surveyor's concerns and stated its something we need to look into.

On 05/02/2025 at 11:05 AM, Surveyor interviewed Memory Care Coordinator F. Memory Care Coordinator F confirmed Resident 1 had an increase in elopements in March 2025. Memory Care Coordinator F stated s/he was called at home when Resident 1 eloped on 03/09/2025 and the incident was handled by Executive Director A. Memory Care Coordinator F confirmed staff reported they could not hear the alarm when Resident 1 eloped on 03/09/2025. Surveyor asked if an amplifier had been added to the alarm system since the 03/09/2025 incident. Memory Care Coordinator F stated s/he did not

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know. Memory Care Coordinator F explained each care staff carried a phone during their shift, and with their current systems ability, it could not send notifications to the staff when the back door was opened, they only could rely on the alarm going off. At 11:15 AM to 11:25 AM, Surveyor tested the volume of the provider's egress back door alarm with Memory Care Coordinator F. Surveyor stood inside room M25 (adjacent to the exit) while Memory Care Coordinator F signaled the alarm. The alarm could be heard very loud with the door shut. Surveyor stood inside room M10 (halfway from the exit to the back of the facility) while Memory Care Coordinator F signaled the alarm. The alarm could be heard with the door shut but the volume of the alarm was softer. Surveyor stood inside room M21 (farthest point from back exit) while Memory Care Coordinator F signaled the alarm. The alarm could not be heard at all with the door shut. Rooms M18, M19, M20, and M22 were all farthest from the back exit and the alarm could not be heard. Surveyor expressed concern the provider's alarm system could not be heard throughout the facility and with current systems in place no notifications were sent to staff when exit doors were opened. Memory Care Coordinator F acknowledged an understanding of the concerns and noted the alarm should be louder.

On 05/02/2025 at 12:18 PM, Surveyor interviewed Caregiver G regarding Resident 1 elopements. Caregiver G reported s/he was working on 03/09/2025 when Resident 1 eloped to the nearby gas station. Caregiver G reported s/he was providing cares to another resident when Resident 1 eloped and s/he did not hear the alarm going off. Caregiver G reported when coming out of the others resident room, s/he saw police at the facility and learned about Resident

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N 358	Continued From page 7 1's elopement. Cross Reference: N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 358		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plans (ISP) reviewed was updated when there was a change in the resident's needs, abilities or physical or mental condition. Resident 1's was not updated to include his/her elopement risk and paranoia behavior. Findings include: On 05/02/2025, Surveyor reviewed Resident 1's record and identified the following:	N 389		

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N 389	Continued From page 8 Resident 1 was admitted to the facility on 07/19/2024 with diagnosis of dementia and bipolar disorder. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 02/27/2025 did not identify his/her elopement risk or paranoia behavior. Resident 1's progress notes documented: "02/18/2025: Resident has been following staff around the building. Resident has set off door alarm four times since the start of the shift. Resident has been redirected multiple times, has been given snacks and something to drink even offered to be toilet. Resident has refused." "02/20/2025: Resident is setting off door alarms back entrance. " "03/02/2025: Resident is very hard redirecting behavior of going to the back exit door, when staff not looking [s/he's] pushing on the door sounding the alarm tryna (sic) get out the building. Going behind the kitchen counter getting all the snacks from the cabinet." "03/04/2025: [Resident 1] has paranoia and will push the door but has not attempted to go out the door. [S/he] stops when the alarm sounds. NP is aware of paranoia. Able to redirect [Resident 1] but having [him/her] watch me make [his/her] plate of food for breakfast and [s/he] sat down to eat." "03/05/2025 @ 10:47 AM: Very aggressive tryna (sic) fight staff. @7:58 PM: Resident kept going door to door and setting off the alarms. @ 9:55 PM: Resident had elopement tonight. Resident was brought in by another aid on third shift. Resident was setting the alarm off at least a dozen times since 2 o'clock when for second shift came in. [S/he] did it all the way till 10:00 PM. @ 11:21 AM: ...[Resident 1] is exit seeking and has been triggering the door alarm every two minutes	N 389		

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throughout the evening, raising safety concerns. Appears this was the case the last 2 evenings as well. While on the phone [s/he] was able to exit the building. [Resident 1] does not sleeping but paces and walks in circles and is not responding to [his/her] current medications."

On 05/02/2025 at 10:00 AM Executive Director A confirmed Resident 1 had an increase in exit seeking behavior in March 2025. Executive Director A reported after Resident 1's increase exit seeking, s/he started on hospice services, had a 1:1 staff for 4 hours/day for 2 weeks, and medication changes until behavior minimized. Surveyor questioned why Resident 1's ISP was not updated until after 03/09/2025 incident when the record and interviews indicated Resident 1 had exit seeking and paranoia behaviors prior to the above date. At 10:49 AM, Executive Director A reported Resident 1's first elopement was not until 03/05/2025, up until then s/he was a safe wanderer, and did not become fixated on the back exit door until March. At 11:30 AM, Executive Director A confirmed the provider did not update Resident 1's ISP to identify his/her elopement risk or paranoia behavior prior to 03/09/2025, as the above behaviors had just started. Surveyor expressed concern Resident 1's record and interviews with staff identified above behaviors starting at the beginning of 2025. Surveyor noted Resident 1's ISP did not include documentation of elopement risk or paranoia behavior or interventions for staff to utilize in mitigating risk prior to 03/09/2025 elopement. Executive Director A acknowledged an understanding of the Surveyor's concerns.

On 05/02/2025 at 12:50 PM, Surveyor interviewed Caregiver H regarding Resident 1's behaviors. Caregiver H reported s/he started in

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N 389	Continued From page 10 September 2024 and did not start seeing exit seeking behavior until the beginning of 2025. Caregiver H reported Resident 1 would pace the hallway then push on the delayed egress door until the alarm activated. Caregiver H stated these behaviors were very hard to manage and s/he was not sure if Resident 1's ISP was updated prior to increase in elopements from March 2025. Caregiver H reported Resident 1 experienced paranoia tendencies especially around medications, and noted if s/he did not see staff prepare the medication, Resident 1 would follow us around making comments about "why are you making me take these?" and be aggressive with staff. Caregiver H reported if Resident 1 did not see staff prepare a cup of water or food, s/he would not accept it. On 05/02/2025 at 12:30 PM, Surveyor interviewed Caregiver I regarding Resident 1's behaviors. Caregiver I reported s/he started in November 2024 and did not start seeing exit seeking behavior until after Christmas. Caregiver I stated Resident 1 would go to the back door from the moment s/he woke up until bed. Caregiver I noted Resident 1 would set off the alarm, wait until staff were out of sight and continue to exit seek. Caregiver I reported s/he noticed paranoia behavior around medication pass and Resident 1 would follow staff around asking, "Why did you give me that?" Caregiver I stated since Resident 1 started receiving Haldol injections his/her behavior had decreased dramatically. Resident 1's ISP was not updated to include his/her elopement risk and paranoia behavior. Cross Reference: N0358 83.32(3)(n) Rights of Residents: Safe	N 389		

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