STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020445	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERLEAF MEMORY CARE OF SCHOFIELD	1404 LILI LANE SCHOFIELD, WI 54476

(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 09/24/2024, Surveyor conducted a standard licensure survey and complaint investigation (x3) at Copperleaf Memory Care of Schofield. Data collection continued through 10/01/2024. One of 3 complaints was substantiated. Two deficiencies were identified. 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 to the department within 3 working days after an incident or accident resulting in Resident 2 receiving emergency room treatment. Findings include: On 09/10/2024, the Department received a complaint alleging concerns about a resident who fell on 09/06/2024. The facility is licensed to serve up to 22 residents in the client groups emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's disease, and advanced	N 165		

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

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N 165	Continued From page 1 aged. On 09/24/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 05/02/2023. According to observation notes, dated 09/06/2024, Resident 2 was found on the floor of his/her room and was transferred to the hospital and admitted. The observation note indicated, "Determined [s/he] had suffered a CVA (cerebral vascular accident) and possible Type 2 NSTEMI (non-ST-segment elevation myocardial infarction)." According to medical records, Resident 2 was admitted to the hospital on 09/06/2024 for an "acute CVA" and "was treated with aggressive fluid resuscitation." On 10/01/2024 at approximately 4:45 PM, Surveyor interviewed Director A and Regional Manager (RM) B. Director A verified completing a "Fall Report" for Resident 2 on 09/06/2024. Director A confirmed that Resident 2 was admitted to the hospital on 09/06/2024 and treated for a CVA. Surveyor asked Director A and RM B if a self-report was submitted to the department. Director A and RM B stated that a self-report was not submitted to the department because they did not view Resident 2's fall as reportable (Thought Resident 2's fall was not caused by an accident that resulted in a serious injury).	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	N 352		

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N 352	Continued From page 2 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 Resident 1 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Findings include: On 08/02/2024, the Department received a complaint alleging a resident ran out of his/her psychotropic medications in July 2024. The facility is licensed to serve up to 22 residents in the client groups emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's disease and advanced aged. On 09/24/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/19/2024. According to Resident 1's medication administration record (MAR), Resident 1 was prescribed Quetiapine Fumarate 100 MG TAB (take 1 tablet by mouth once daily at bedtime) on 05/09/2024. According to Resident 1's June 2024 MAR, Resident 1's Quetiapine Fumarate 100 MG was not available from 06/05/2024 to 06/21/2024 because the provider was "Waiting on Pharmacy" for the medication. According to Resident 1's July 2024 MAR, Resident 1 went without Quetiapine Fumarate 100 MG from 07/20/2024 to 07/25/2024 because the provider was "Waiting on Pharmacy." On 10/01/2024 at approximately 4:45 PM, Surveyor interviewed Director A via telephone. Director A confirmed that Resident 1 did not have	N 352		

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N 352	Continued From page 3 his/her Quetiapine Fumarate 100 MG TAB available between 06/05/2024 to 06/21/2024 and from 07/20/2024 to 07/25/2024. Director A reported that Resident 1's [daughter/son] was made aware that the Quetiapine Fumarate was running out and Resident 1 needed to be seen by a physician/psychiatrist to get the Quetiapine Fumarate 100 MG Tab prescription refilled.	N 352		