STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011364	A. BUILDING: _____ B. WING _____	R-C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARGONNE	9835 W ARGONNE DR WAUWATOSA, WI 53222

(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 03/25/2025 with information gathered through 03/26/2025, Surveyor conducted a verification visit and two complaint investigations at Argonne, a Community-Based Residential Facility (CBRF) in Wauwatosa, WI. Four deficiencies identified. One of 4 is a repeat deficiency. Two of two complaints unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not send a written report to the Department within 3 working days after any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, welfare or residents or employees for 2 of 2 incidents. The police came	N 164		

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

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N 164	Continued From page 1	N 164		

onsite when Resident 6 called them to report a theft and also when s/he had an altercation with another resident. Staff were aware of the police on site and did not self-report either incident.

Findings include:

On 03/25/2025, Surveyor requested to review any incident reports for Resident 6. Surveyor identified the following:
-"General Event Reports dated 11/08/2024: Describe what happened before the event: [Resident 6] was walking through out [sic] the house, going back and forth outside in the backyard and front yard. Event type: Behavioral issue. Summary: [Resident 6] had been shouting for hours that someone had stolen [his/her] wallet, [s/he] began blaming [his/her] roommate saying that [s/he] was a thief. Staff tried looking for the wallet for the areas that [s/he] had been in and did not find the wallet. [Resident 6] called the police and Wauwatosa PD (police department) showed up and took staff and [Resident 6] statement. [Resident 6] found [his/her] wallet in [his/her] jacket after PD had left."

-"General Event Reports dated 11/10/2024: Describe what happened before the event: [Resident 6] and roommate both was trying to go down the hallway at the same time they bumped each other [Resident 6] went off started yelling even louder than what [s/he] already been doing [Resident 6] been yelling my whole shift about nothing just making noise [Resident 6] walks off go outside while still yelling and calls the police on [his/her] phone stating that [s/he] was getting hit on [sic] when [sic] the cops comes [sic] [s/he] pointed out roommate as the aggressor the cops took all of our info talk to roommate by

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N 164	Continued From page 2 [him/herself] I could here [sic] [s/he] saying I never hit no one the cops told [Resident 6] to not call them again unless it's a medical emergency or they will arrest [him/her] next time [sic] cops leaves [Resident 6] comes in and hit [his/her] roommate I was able to redirect the 2 I separated them the roommate did not hit [him/her] back." On 03/25/2025 at approximately 5:01 PM, Surveyor interviewed Program Director F. Program Director F stated s/he did not believe the facility self-reported when law enforcement was on site. Program Director F stated Area Director B would have been the one to self-report it but s/he was on vacation. On 03/26/2025 at 10:00 AM, Surveyor reviewed facility self-reports for calendar year 2024. Surveyor did not see evidence of a self-report for incident dated 11/08/2024 and incident dated 11/10/2024.	N 164		
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.	N 389		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) was reviewed and updated with changes in needs, abilities or physical or mental condition. Resident 1's ISP was not updated to reflect Resident 1's mobility status, falls, relationship with family members and behaviors.

Findings include:

On 03/25/2025 at approximately 10:30 AM, Surveyor reviewed Resident 1's record and identified the following:

-Resident 1 was admitted to the facility on 05/31/2024 with diagnoses including cerebral palsy, anoxic brain damage, suicidal ideation, and history of sudden cardiac arrest.

-Resident 1's ISP, dated 06/06/2024, stated the following: "[Resident 1] is extremely funny and enjoy cracking jokes. Important to [Resident 1] is [his/her parent]. Being able to speak and have other [sic] listen. [Resident 1] also would like the freedom to smoke [his/her] cigar when ever [sic] [s/he] likes. Keeping [Resident 1] pain levels down is very important to [him/her]. Therefore receiving all [his/her] schedule [sic] medications on time is important. Best way to support [Resident 1] is offer assistants [sic], but when [s/he] refuses still keep watch of [him/her]. [Resident 1] experiences a lot of pain through out [sic] the day. Best way to support [him/her] with [his/her] pain is to administer all of [his/her] scheduled medications on time. And possible offering [him/her] a PRN (as needed medication).

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[Resident 1] is very familiar with all of [his/her] medications. [Resident 1] has protective placement and has a guardian. [Resident 1] relies on [his/her parent] for information. When [s/he] is not feeling well or not getting the attention [s/he] wants. [S/he] will call [his/her parent]. [Resident 1] needs reassurances that [facility] staff is here to support [him/her]."

-Resident 1's General Event Report (GER), dated 11/24/2024 at 11:09 AM, stated the following: "[Resident 1] was on [his/her] way out to the kitchen area trying to bring trash from out of [his/her] room and [s/he] fell down and hit [his/her] back up against the wall. [Resident 1] said that [s/he] can get up from the floor but [his/her] back was red and had a little scratch on there looking like its [sic] going to bruise later on. [Resident 1] was asked if [s/he] wanted to be seen by paramedics or hospital and [s/he] said no. Corrective actions: Encourage [Resident 1] to use walker."

-Resident 1's GER, dated 12/19/2024 at 8:09 PM, stated the following: "[Resident 1] had just arrived home from being with [his/her parent] all day for [his/her] bday (birthday). [Resident 1] knocked on the door and writer and other staff approached the door to open it. Writer informed [Resident 1's parent] that [s/he] wasn't allowed to come in and that staff will help [Resident 1] getting settled in. [Resident 1's parent] threw a fit and got aggressive. [Resident 1's parent] started cussing at staff and telling staff that [s/he] wanted [his/her] coffee pot, coffee and sugar back due to manage removing it from [his/her] room. Due to [his/her] behavior staff let [him/her] know that [s/he] will receive it when management is at the location. [Resident 1's parent] then stormed off to [his/her] car to grab [his/her] things. Writer let

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[him/her] to please leave out the entry way so writer can close the door so things wouldn't escalate. [Resident 1's parent] then pushed [Resident 1] down to the floor. Staff asked [him/her] why would [s/he] do that. [S/he] started cussing again and staff told [him/her] the police will be called before and [s/he] left. [Resident 1] was laying on the floor and didn't want staff to help [him/her] and denied that [his/her parent] pushed [him/her]. Staff took picture for proof. Staff called the pd but didn't get an answer and then called [Resident 1's] guardian. After the guardian heard about what happened [s/he] told staff that [Resident 1's parent] can't come back at all."

-Resident 1's GER, dated 02/19/2025 at 4:15 PM, stated the following: "[Resident 1] made some coffee for [him/herself] and staff assisted [him/her]. [Resident 1] goes outside on the porch for awhile and [s/he] comes back in. [Resident 1] ask staff who drank my coffee and the staff member told [him/her] another resident might have drink some of [his/her] coffee. Staff goes and ask the client and [s/he] said [s/he] did. [Resident 1] starts screaming yelling out of frustration and [s/he] was yelling at everyone, staff politely asked [him/her] to calm down and we can make more coffee. [Resident 1] was still frustrated, [Resident 1] goes in the dining room and starts yelling at the resident who drank [his/her] coffee."

-Resident 1's GER dated 03/24/2025 at 10:30 AM stated the following: "[Resident 1] was trying to rush out doors [sic] to go smoke [his/her] cigarette and went to lean against the wall in the hallway by [his/her] bed room and fail [sic] to the floor. Corrective action: Assist [Resident 1] get up off the floor. Reminded [him/her] to use

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N 389	Continued From page 6 [his/her] walker. Plan of Future Corrective Actions: Continue to encourage [him/her] to use [his/her] walker." On 03/25/2025 at approximately 11:30 AM, Surveyor interviewed Program Manager F and Area Manager G. Program Manager F stated Resident 1 is supposed to use his/her walker but s/he refuses to use it and that is why s/he has falls. Program Manager F stated Resident 1's parent has visiting restrictions due to his/her behavior and Resident 1 being protectively place and having a corporate guardian due to history of potential abuse or misappropriation from Resident 1's parent. Program Manager F stated Resident 1 can tell staff what s/he needs but his/her parent can be very manipulative, and Resident 1 is constantly on the phone with his/her parent which can sometimes cause behaviors in the facility with other residents but usually Resident 1 is very pleasant. Program Manager F and Area Manager G acknowledged Resident 1's ISP was not very specific to his/her needs and should have been updated due to his/her refusal of his/her walker, behaviors with other residents at times, and his/her relationship with his/her parent.	N 389		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed	N 415		

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N 415	Continued From page 7 by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 1 of 1 resident (Resident 6). Findings include: On 03/25/2025 at 2:00 PM, Surveyor reviewed Resident 6's November 2024 MAR. Resident 6's MAR had a total of 54 blank entries for administering his/her medications. Resident 6's MAR states that Resident 6 is on the following medications: -"Aspirin 81 milligrams (mg) chewable tablet 1 time daily at 8:00 AM -Atorvastatin 20 mg tablet 1 time daily at 8:00 AM -Baclofen 10 mg tablet two times daily at 8:00 AM and 8:00 PM -Dalfampridine extended release (ER) mg tablet two times daily at 8:00 AM and 8:00 PM -Depakote ER 500 mg tablet 1 time daily at 8:00 PM -Docusate Sodium 100 mg tablet 1 time daily at 8:00 AM -Eliquis 5 mg tablet two times daily at 8:00 AM and 8:00 PM	N 415		

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N 415	Continued From page 8 -Olanzapine 15 mg tablet 1 time daily at 8:00 PM -Omeprazole DR 20 mg tablet 1 time daily at 8:00 AM -Senna 8.6 mg tablet 1 time daily at 8:00 AM -Vitamin D2 50 micrograms (mcg) 1 time daily at 8:00 AM" Resident 6's MAR had missing entries on the following dates: 11/02/2024 at 8:00 AM (9 entries), 11/02/2024 at 8:00 PM (5 entries), 11/03/2024 at 8:00 AM (9 entries), 11/12/2024 at 8:00 AM (9 entries), 11/14/2024 at 8:00 AM (9 entries), 11/15/2024 at 8:00 AM (9 entries) and 11/15/2024 at 8:00 PM (4 entries). On 03/26/2025 at 11:30 AM, Surveyor interviewed Program Director F about missing entries on Resident 6's MAR. Program Manager F confirmed Resident 6 required staff to administer his/her medications at all times. Program Manger F stated the internet was most likely down so the staff did not document on the MAR. Program Manager F stated they do have a paper copy for back up. Surveyor requested to review the back up paper copy. Program Manager F stated s/he did not have one.	N 415		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by:	{N 481}		

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{N 481}	Continued From page 9 Based on observation and interview, the provider did not ensure 4 of 4 residents were provided a living environment that was safe, clean, comfortable, and homelike. The dining room floor contained a heaving of the subfloor/underlayment which has caused the floor to buckle. The floor was coming apart and was a trip hazard. This is a repeat deficiency. See Statement of Deficiency (SOD) 2TX611, dated 07/29/2024. Findings include: On 03/25/2025, Surveyor toured the facility and observed the following: -Dining room: The floor was buckling and coming apart under and around the kitchen table. There were floorboards coming up and spaces between them. The span was approximately 6 feet by 4 feet. On 03/25/2025 at approximately 10:30 AM, Surveyor interviewed Program Director F and Area Director G. Program Director F stated there was a resident who had an electric wheelchair in the home, and it made the floor buckle. Area Director G stated it was a trip hazard and needed to be fixed right away. Area Director G stated s/he would be contacting their office to get someone out to do a quote and get something approved as soon as possible to fix the floor.	{N 481}		