STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017768	A. BUILDING: _____ B. WING _____	R-C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

(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 10/11/2024, Surveyor conducted a verification visit at The Legacy of Deforest. Two deficiencies were identified. One of 2 deficiencies was a repeat violation (see Statement of Deficiency (SOD) 2YBI12). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 22	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the facility and its operation complied with all laws governing a Community-Based Residential Facility (CBRF). The licensee did not comply with the order to comply with requirements and special orders that were outlined in a Notice and Order letter from the Department. Findings include: The provider received a regular license on 10/19/2019, as a class CNA (nonambulatory) CBRF able to serve up to 25 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and terminally ill. On 10/11/2024, Surveyor conducted a verification	N 196		

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
	0017768	A. BUILDING: _____ B. WING _____	R-C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

(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 196	Continued From page 1 visit which resulted in repeat deficiency: N0431 83.38(1)(g) Health Monitoring. Review of facility records documented previous survey event identified noncompliance, as follows: Statement of Deficiency (SOD) 2YBI12, dated 06/05/2024: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0431 DHS 83.38(1)(g) Health Monitoring SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that The Legacy of DeForest: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The licensee will develop (or review/revise) a procedure(s) to address: Health Monitoring -Including how the facility will: (a) monitor and document changes in the resident's physical or mental health; (b) notify the resident's legal representative and care manager (if any) when a resident experiences a change of condition, accident, injury, or medical emergency; (c) obtain timely medical care (clinical assessments, medications, prompt medical treatment), and (d) provide or arrange services to address each resident's health care needs. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017768	A. BUILDING: _____ B. WING _____	R-C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

(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 196	Continued From page 2 regarding the provider's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request. On 10/11/2024, at approximately 2:30 PM, Surveyor interviewed Executive Director A and Registered Nurse H. Registered Nurse H stated they were not a skilled nursing facility (SNF) and did not need to document when caregivers contacted him/her regarding a resident showing signs and symptoms that were not baseline. Registered Nurse H stated the Surveyor could review his/her phone records to determine if staff had contacted Registered Nurse H regarding resident monitoring. Cross Reference: N0431 DHS 83.38(1)(g) Health Monitoring	N 196		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017768	A. BUILDING: _____ B. WING _____	R-C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

(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 431}	Continued From page 3 Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure changes in 2 of 2 resident's health was communicated to the nursing staff when s/he experienced a change of condition. This is a repeat deficiency. See Statement of Deficiency (SOD) 2YBI12, dated 06/06/2024. Resident 3's oxygen levels were not monitored to determine if they were outside of his/her normal parameters. Resident 4's blood sugar (BS) levels were not monitored to determine if they were outside of	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017768	A. BUILDING: _____ B. WING _____	R-C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

(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 431}	Continued From page 4	{N 431}		

his/her normal parameters.

Findings include:

On 10/11/2024, Surveyor reviewed Resident 3's and Resident 4's record.

Example 1: Resident 3

Resident 3 moved into the facility, 07/17/2020, with diagnoses including psychotic disturbance, mood disturbance, and anxiety.

On 10/11/2024, at approximately 3:00 PM, Surveyor and Executive Director A reviewed Resident 3's October 2024 Medication Administration Record (MAR), dated 10/01/2024 to 10/11/2024, which documented:
"Check oxygen saturations every shift. Update [Registered Nurse H] if <90 (less than) every shift for monitoring. Start Date: 06/21/2024."
Oxygen levels were not documented on the night shift.

Executive Director A stated there were 3 shifts and based on the MAR, staff should have checked Resident 3's oxygen level during the night shift.

Example 2: Resident 4

On 10/11/2024, at approximately 2:00 PM, Surveyor interviewed Executive Director A and Healthcare Coordinator B. Surveyor asked how staff monitored resident BS parameters. Healthcare Coordinator B stated, "We never have parameters for resident BS levels. Our staff know that they are to contact the nurse if a residents BS level goes above 300." Surveyor asked where this communication was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017768	A. BUILDING: _____ B. WING _____	R-C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

(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 431}	Continued From page 5	{N 431}		

documented. Healthcare Coordinator B stated caregivers are not allowed to chart under progress notes, the nurse would document any concerns. Surveyor requested Resident 4's record.

On 10/11/2024, at approximately 2:10 PM, Surveyor interviewed Resident Assistant (RA) I, RA J, and RA K. Surveyor asked how staff determined when a blood sugar level was to be reported to a nurse. RA I stated, "The parameters would be identified in the computer." RA K stated, "Each resident has their own set of numbers, you would have to look at the documentation." RA J stated, "I am not sure if it is not recorded in the computer. I am not sure what a high blood sugar level would be."

Resident 4's individual service plan, dated 09/11/2024, documented:
"Diabetes: Observe for and report to nurse any s/sx (signs/symptoms) of low blood sugar (hypoglycemia): sweating, shakiness (tremor), increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, complaints of hunger, complaints of vision changes, complaints of nausea, vomiting. Observe for and report to the nurse any s/sx of high blood sugar (hyperglycemia): increased thirst and hunger, frequent urination, weight loss, fatigue, warm, dry skin, poor wound healing, muscle cramps, abdominal pain, deep, acetone breath (smells fruity), stupor, coma, complaints of vision changes, complaints of hunger, irritability, complaints of headache, complaints of nausea, vomiting."

Resident 4's October 2024 MAR, dated 10/01/2024 to 10/11/2024, documented:
"Check Blood Sugar twice a day. Start Date:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017768	A. BUILDING: _____ B. WING _____	R-C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

(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 431}	Continued From page 6 07/17/2024. Scheduled at 8:00 AM and 8:00 PM." 10/04 - 8:00 PM - 327 BS 10/05 - 8:00 PM - 355 BS 10/06 - 8:00 PM - Not recorded 10/07 - 8:00 PM - 311 BS The MAR did not document Resident 4's BS parameters. On 10/11/2024, at approximately 3:00 PM, Executive Director A reviewed Resident 4's progress notes to determine if it had been documented that staff had contacted a nurse when Resident 4's BS levels were above 300. Executive Director A stated there was no documentation. Executive Director A called Registered Nurse H to determine where this information would have been documented. Registered Nurse H stated, "This information is not documented, as we are not a skilled nursing facility (SNF). Do you know how many phone calls I get in a day, and you want me to document each time a staff member calls me. I can send you my phone records and you can compare that log to the time stamps on the MAR. Why would you expect this information to be documented." Surveyor reiterated that s/he was asking the provider to explain how resident BS levels were monitored. Registered Nurse H stated, "We monitor when they are outside of their normal parameters." Surveyor asked where these parameters were documented, so that staff had guidelines regarding BS levels. Surveyor did not receive a response. Executive Director A provided Surveyor with a document that read, "Nurse Contact Criteria - Diabetic: BS >450 (greater than) or <60 (or parameters).	{N 431}		