STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019416	A. BUILDING: _____ B. WING _____	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYCAMORE LODGE SENIOR LIVING LUXEMBI	409 3RD STREET LUXEMBURG, WI 54217

(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 10/02/2025 with additional information gathered through 10/07/2025, Surveyor conducted a standard survey at Sycamore Lodge Senior Living Luxemburg. As a result, 5 deficiencies were identified. Census: 18	N 000		
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 observation, record review and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 2) individual service plans (ISPs) were updated when there was a change in their needs or ensure all ISPs were signed by their legal representatives acknowledging their involvement in, understanding of and agreement with the plan. Resident 1's ISP was not updated to reflect his/her needs related to mobility, transferring and	N 389		

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

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N 389	Continued From page 1	N 389		

toileting. Resident 1 was a pivot transfer, self-propelled using a wheelchair, had occasional incontinence and used incontinence products.

Resident 2's ISP was not updated to reflect his/her needs related to mobility, transferring and toileting. Resident 2 required the use of a mechanical lift for transfers, utilized a Broda chair, had occasional incontinence and used incontinence products.

Findings include:

On 10/02/2025, Surveyor conducted a standard survey at the facility. A sample of residents was selected including the records of Resident 1 and Resident 2.

RESIDENT 1:

On 10/02/2025, Surveyor reviewed Resident 1's record and the following was identified:

Resident 1 admitted to the facility on 11/11/2022 with diagnoses to include but not limited to, epilepsy, left foot drop, dysphagia, hemiplegia affecting left nondominant side, back pain, tremor and depression. Resident 1 had a legal guardian and managed care organization (MCO). The last signed ISP located in Resident 1's record was dated 12/07/2022.

Resident 1's ISP provided was the current ISP in place as of 10/02/2025. The ISP was unsigned and read in part:

-- "Mobility and Transferring: Independent with ambulation. Independent with positioning. Resident has been identified as a fall risk. Resident requires staff assistance to complete

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N 389	Continued From page 2 transfers." -- "Toileting: Resident requires staff to monitor and document bowel movements. Resident requires partial assistance from staff to complete toileting tasks." On 10/02/2025 at 2:45 PM, Surveyor interviewed Administrator (ADM) A who verified Resident 1 self-propels him/herself using a manual wheelchair, is a pivot transfer, is continent with occasional accidents and uses incontinence products. ADM A reported Resident 1 communicates his/her toileting needs to staff and will often change his/her own incontinence products. ADM A acknowledged there were no signatures on Resident 1's ISP. ADM A stated s/he communicates frequently with Resident 1's legal guardian and updates his/her ISP as needed. While Surveyor discussed Resident 1's ISP and explained the importance of including resident specific information, ADM A began updating Resident 1's ISP. S/he stated s/he will review Resident 1's ISP with his/her legal guardian and have him/her sign it. Surveyor note: Resident 1's ISP did not reflect his/her need for the use of a manual wheelchair, independence with self-propelling, assistance with pivot transfers and the use of incontinence products due to occasional incontinence. Resident 1's ISP was not specific to his/her individual care needs. RESIDENT 2: On 10/02/2025 at 12:35 PM, Surveyor observed Resident 2 sitting in a Broda chair in the dining room. Surveyor attempted to interview Resident 2, but was not successful.	N 389		

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N 389	Continued From page 3 On 10/02/2025, Surveyor reviewed Resident 2's record and the following was identified: Resident 2 admitted to the facility on 12/02/2024 with diagnoses to include Parkinson's Disease. Resident 2 was on hospice care and had an activated power of attorney (POA). Resident 2's ISP provided was the current ISP in place as of 10/02/2025. The ISP was unsigned and read in part: -- "Mobility and Transferring: Resident requires full assistance from staff to ambulate. Resident requires staff assistance with all positioning needs. Resident has been identified as a fall risk. At all times resident needs alarm placed under them, at HS [sic] bed needs to be in lowest position, with fall mat placed, and alarm in bed. Hourly checks must be done. Resident requires staff assistance to complete transfers." -- "Toileting: Resident requires full assistance from staff to complete toileting needs." On 10/02/2025 at 2:25 PM, Surveyor interviewed Administrator (ADM) A who verified Resident 2 uses a Broda chair, a Sit-to-Stand lift for transfers, is continent with occasional incontinence and uses incontinence products. ADM A also reported Resident 2 is able to communicate his/her toileting needs, but requires reminders from staff. ADM A acknowledged Resident 2's ISP is not signed, but stated s/he will review with his/her activated POA and have him/her sign it. While Surveyor discussed Resident 2's ISP and explained the importance of including resident specific information, ADM A began updating Resident 2's ISP.	N 389		

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N 389	Continued From page 4 Surveyor note: Resident 2's ISP did not reflect his/her need for the use of a Broda chair, a Sit-to-Stand lift for transfers, reminders for toileting and the use of incontinence products due to occasional incontinence. Resident 2's ISP was not specific to his/her individual care needs. On 10/07/2025 at 12:40 PM, Surveyor interviewed ADM A who acknowledged Surveyor's concerns Resident 1 and Resident 2's ISPs were not updated when there was a change in their needs and they were not signed by their legal representatives. ADM A stated s/he has already updated all resident's ISPs and will also ensure they are signed by all parties involved in their care.	N 389		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not test facility smoke detectors bimonthly as required. There were no documented internal smoke detector tests in facility records for 2023 or 2024.	N 535		

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N 535	Continued From page 5 Findings include: The facility is licensed to provide services for up to 20 residents who may have irreversible dementia/Alzheimer's, be physically disabled, advanced aged and/or terminally ill. On 10/02/2025 at 1:15 PM, Surveyor reviewed facility records provided by Administrator (ADM) A. The records did not include documentation of smoke detector testing for calendar year 2023 or 2024. On 10/02/2025 at 2:30 PM, Surveyor interviewed ADM A who acknowledged s/he did not have documentation of bimonthly smoke detector testing. S/he reported the smoke detectors are tested during their fire drills and they are also inspected annually by a certified company. On 10/07/2025 at 12:40 PM, Surveyor interviewed ADM A who confirmed s/he did not have any documentation of bimonthly smoke detector testing for 2023 or 2024. Surveyor explained to ADM A that DHS 83 requires the facility to conduct internal testing bimonthly. ADM A stated s/he will implement a process going forward to ensure this is completed. Cross Reference: N0550 DHS 83.48(6)(a) Integrated Heat Detector in Kitchen N0553 DHS 83.48(6)(d) Integrated Heat Detector in Furnace Room N0554 DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room	N 535		

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N 550	Continued From page 6	N 550		
N 550	83.48(6)(a) Integrated heat detector in kitchen. CBRFs shall have at least one heat detector integrated with the smoke detection system at all of the following locations or in accordance with the heat detector manufacturer ' s specifications: Kitchen. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not have a heat detector in the kitchen as required. Findings include: The facility is licensed to provide services for up to 20 residents who may have irreversible dementia/Alzheimer's, be physically disabled, advanced aged and/or terminally ill. On 10/02/2025 at 3:30 PM, Surveyor conducted a tour of the facility accompanied by Administrator (ADM) A. Surveyor did not observe a heat detector in the kitchen. ADM C acknowledged Surveyor's concern and stated s/he did not know why a heat detector was not in the kitchen. On 10/02/2025 at 4:00 PM, Surveyor reviewed the most recent fire detection system inspection dated 02/20/2025. The report did not identify any heat detectors in the kitchen. On 10/03/2025 at 7:40 AM, Surveyor interviewed Fire Alarm Testing Manager B who confirmed they completed the fire detection system inspection on 02/20/2025 and there are no heat detectors in the kitchen. On 10/06/2025 at 10:55 AM, Surveyor interviewed ADM A who verified after speaking	N 550		

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N 550	Continued From page 7 with their fire alarm inspection contractor there are no heat detectors in the building in the required areas. The provider did not ensure a heat detector was installed in the kitchen. Cross Reference: N0553 DHS 83.48(6)(d) Integrated Heat Detector in Furnace Room N0554 DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room	N 550		
N 553	83.48(6)(d) Integrated heat detector in furnace room. CBRFs shall have at least one heat detector integrated with the smoke detection system at all of the following locations or in accordance with the heat detector manufacturer ' s specifications: Furnace room. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure a heat detector that is integrated with the smoke detection system was in the furnace room. Findings include: The facility is licensed to provide services for up to 20 residents who may have irreversible dementia/Alzheimer's, be physically disabled, advanced aged and/or terminally ill. On 10/02/2025 at 3:30 PM, Surveyor conducted a tour of the facility accompanied by Administrator (ADM) A. Surveyor observed 2 furnaces in the basement of the facility. Surveyor was unable to	N 553		

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N 553	Continued From page 8 determine if the detector located on the ceiling was heat or smoke. Surveyor asked ADM A if s/he knew if the detector was heat or smoke and s/he stated s/he did not know. On 10/02/2025 at 4:00 PM, Surveyor reviewed the most recent fire detection system inspection dated 02/20/2025. The report identified there were no heat detectors in the basement, only smoke detectors. On 10/03/2025 at 7:40 AM, Surveyor interviewed Fire Alarm Testing Manager B who confirmed they completed the fire detection system inspection on 02/20/2025 and the basement only contains smoke detectors and no heat detectors. On 10/06/2025 at 10:55 AM, Surveyor interviewed ADM A who verified after speaking with their fire alarm inspection contractor there are no heat detectors in the building in the required areas. The provider did not ensure a heat detector was installed in the basement where 2 furnaces were located. Cross Reference: N0550 DHS 83.48(6)(a) Integrated Heat Detector in Kitchen N0554 DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room	N 553		
N 554	83.48(6)(e) Integrated heat detector in laundry room. CBRFs shall have at least one heat detector integrated with the smoke detection system at all of the following locations or in accordance with	N 554		

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N 554	Continued From page 9 the heat detector manufacturer ' s specifications: Laundry room. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 laundry rooms were equipped with a heat detector as required. Findings include: The facility is licensed to provide services for up to 20 residents who may have irreversible dementia/Alzheimer's, be physically disabled, advanced aged and/or terminally ill. On 10/02/2025 at 3:30 PM, Surveyor conducted a tour of the facility accompanied by Administrator (ADM) A. Surveyor observed a laundry room located on the main level of the facility. Surveyor was unable to determine if the detector located on the ceiling was heat or smoke. Surveyor asked ADM A if s/he knew if the detector was heat or smoke and s/he stated s/he did not know. On 10/02/2025 at 4:00 PM, Surveyor reviewed the most recent fire detection system report dated 02/20/2025. The report identified there was only a smoke detector in the laundry room and no heat detectors. On 10/03/2025 at 7:40 AM, Surveyor interviewed Fire Alarm Testing Manager B who confirmed they completed the fire detection system inspection on 02/20/2025 and the laundry room did not have a heat detector, only a smoke detector. On 10/06/2025 at 10:55 AM, Surveyor interviewed ADM A who verified after speaking	N 554		

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N 554	Continued From page 10 with their fire alarm inspection contractor there are no heat detectors in the building in the required areas. The provider did not ensure 1 of 1 laundry rooms had the required heat detectors installed. Cross Reference: N0550 DHS 83.48(6)(a) Integrated Heat Detector in Kitchen N0553 DHS 83.48(6)(d) Integrated Heat Detector in Furnace Room	N 554		