STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012820	A. BUILDING: _____ B. WING _____	R-C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE ASSISTED LIVING	1320 WISCONSIN ST HUDSON, WI 54016

(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 03/06/2025, Surveyor conducted a verification visit, complaint investigation, and standard licensing survey at Pine Ridge Assisted Living. Data was collected through 03/28/2025. The complaint was substantiated. Ten violations were identified. Two of 10 violations were repeat deficiencies. See Statement of Deficiencies (SOD) 3U2C13, dated 12/21/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 36	{N 000}		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees sampled (Caregiver D and Caregiver E)	N 230		

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

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N 230	Continued From page 1 completed orientation training before performing any job duties. Findings include: On 03/06/2025, Surveyor reviewed employee records. Caregiver D was hired on 11/15/2024. According to interview with Director A on 03/13/2025, Caregiver D began working on the floor on 12/12/2024. Caregiver D's record indicated s/he completed training on recognizing and responding to changes in condition on 01/03/2025. Caregiver E was hired on 12/03/2024. According to interview with Director A on 03/13/2025, Caregiver E began working on the floor on 12/13/2024. Caregiver E's record indicated s/he completed trainings on abuse and neglect and recognizing and responding to changes in condition on 03/02/2025. On 03/13/2025 at 1:45 PM, Surveyor interviewed Director A. Director A stated the provider's human resources (HR) department was responsible for monitoring initial online training and notifying the scheduler when employees completed their online training. Director A stated abuse and neglect training was included in the initial online training. Director A stated that after staff were given the go-ahead by HR, staff were scheduled to work alongside experienced caregivers and scheduled to complete additional training with Registered Nurse (RN) F. Director A said RN F's training covered recognizing and responding to changes in condition. Director A confirmed the provider's system did not ensure staff received this training prior to assuming job responsibilities.	N 230		

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N 230	Continued From page 2 Director A could not explain why Caregiver E completed abuse and neglect training over 90 days after hire because this course should have been completed during the initial online training.	N 230		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure new residents were screened for communicable illness, including tuberculosis (TB). Findings include: On 03/06/2025, Surveyor reviewed the file of 1 newly admitted resident, Resident 2. Resident 2 was admitted to the facility on 01/17/2024. His/her record did not include evidence was screened for TB.	N 302		

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N 302	Continued From page 3 On 03/13/2025 at 1:45 PM, Surveyor interviewed Director A and Registered Nurse (RN) B. Director A stated they did not obtain TB screening or baseline testing for new admissions. Director A and RN B were unaware of this requirement.	N 302		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 3 residents sampled (Resident 1, Resident 3, and Resident 4) were assessed upon changes in condition. Findings include: The provider is licensed to care for 42 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. RESIDENT 1	N 381		

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N 381	Continued From page 4 On 03/06/2025 at approximately 11:35 AM, Surveyor observed Resident 1 in the dining room. Staff were assisting Resident 1 with eating. Resident 1's meal was pureed, and his/her liquid was thickened. Resident 1 was admitted to the facility on 04/01/2019, with diagnoses that included Alzheimer's disease. Resident 1's progress notes indicated s/he was admitted to hospice services on 11/01/2024. Resident 1's shift notes (referred to as the 24-hour sheets) indicated s/he had the following fall interventions: "Floor mat when in bed... Floor alarm in bed/recliner." Resident 1's record included an assessment dated 04/01/2024. The assessment, signed by Registered Nurse (RN) G on 08/30/2024, read, "...continues on hospice services... minced and moist foods, moderately thick liquid." The assessment indicated s/he was not a fall risk, and it did not include any fall interventions. On 03/06/2025 at approximately 3:15 PM, Surveyor interviewed Director A and RN B. Director A stated residents should be assessed upon admission and whenever there was a change in condition. Director A stated s/he provided Surveyor Resident 1's (and Resident 3's) most recent assessments. Director A stated Resident 1 had changes in condition since his/her last assessment that should have triggered a new assessment. Director A stated that since Resident 1's last assessment, s/he had graduated and re-admitted to hospice, fallen, and experienced a change in	N 381		

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N 381	Continued From page 5 diet. On 03/13/2025 at 1:45 PM, Surveyor interviewed Director A and RN B. Director A shared that the previous RN, RN G, was responsible for all aspects of resident care, including assessments. Director A stated s/he began getting complaints from family members in November 2024 and found that RN G was not performing his/her duties. Director A stated RN F was brought in to mentor RN G. The mentorship was not successful, and RN G was terminated. Director A stated RN F performed an internal audit after RN G left and s/he found many concerns. According to documentation provided by Director A on 03/13/2025, RN G's last day was 02/18/2025. The provider did not assess Resident 1 when s/he experienced changes in condition. RESIDENT 3 On 03/06/2025 at 11:15 AM, Surveyor observed Resident 3 in his/her room. Resident 3 was in bed. There was a motion detector alarm on the floor. At noon, Surveyor interviewed Caregiver H. Caregiver H stated Resident 3 had recently experienced a change in condition. Resident 3 had stopped eating and remained in bed most of the day. Caregiver H stated Resident 3 was on hospice and they believed s/he was transitioning. Surveyor reviewed Residents 3's record. Resident 3 was admitted to the facility on 05/09/2022, with a dementia diagnosis. Resident 3's 24-hour sheets indicated s/he	N 381		

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refused the majority of his/her meals for the past 2 weeks.

Resident 3's record included 2 fall reports for 2025. Resident 3 fell on 01/03/2025 at 2:00 AM and on 03/07/2025 at 7:05 AM.

Resident 3's last assessment, dated 04/26/2024, was not complete. The assessment form was signed by RN G on 09/09/2024. The following sections of the form were blank: general health, recurring illness, physical disabilities, dressing, grooming, oral care, bathing, toileting. The assessment indicated Resident 3 was not at risk for falls and did not have fall interventions.

The provider did not assess Resident 3 upon changes in condition.

RESIDENT 4
On 03/19/2025, Surveyor requested Resident 4's record to review from Director A.

Between 03/19/2025 and 03/28/2025, Surveyor reviewed Resident 4's record.

Resident 4 was admitted to the facility on 02/15/2022 with diagnoses that included Alzheimer's disease. S/he was sent to the emergency department on 01/31/2025 due to unresponsiveness. Resident 4 was admitted to the hospital and discharged to a skilled nursing facility on 02/04/2025.

Resident 4's was last assessed on 02/15/2024. The assessment form was signed by Director A on 08/19/2024. The assessment rated Resident 4's health as "fair," indicating s/he had no recurring illnesses, short-term illnesses, or regular pain issues. The assessment did not

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indicate Resident 4 had a history of skin breakdown. The assessment indicated Resident 4 ambulated and transferred independently and that s/he sometimes used his/her walker, but most often forgot it. Resident 4 was identified as a fall risk, and interventions included, "Encourage the walker, make sure shoes and socks are on."

Resident 4 had 5 falls since s/he was last assessed:
- On 06/16/2024, s/he fell and fractured his/her ribs. Resident 4 was hospitalized. Resident 4 returned with orders for tramadol for pain.
- On 07/20/2024, s/he had an unwitnessed fall in his/her room and reported increased pain.
- On 07/21/2024, s/he was found on his/her face down in the living room. The incident report referenced his/her floor alarm not working properly.
- On 11/21/2024, s/he was found on the floor of the shower calling out in pain.
- On 11/22/2024, s/he had an unwitnessed fall in his/her room.

An incident report dated 11/27/2024, indicated staff found a skin tear on Resident 4's shin that they believed was from his/her wheelchair pedal bracket.

Surveyor reviewed staff charting from November 2024 through February 2025. Resident 4's 24-hour sheets identified the following conditions/needs that were not reflected on his/her last assessment:
- Resident 4 required a floor alarm whenever s/he was in his/her recliner.
- S/he experienced hallucinations on 12/10/2024.
- On 12/18/2024, s/he was changed to a "finger food diet."
- On 12/31/2024, s/he required transfer

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N 381	Continued From page 8 assistance via sit-to-stand. - Resident 4 had significant skin breakdown. On 12/28/2024, staff wrote, "Has a really red bottom that is shedding blood." On 01/16/2025, staff wrote, "Bottom needs medical attention." According to wound consultation, dated 01/31/2025, Resident 4 first experienced skin breakdown in July 2024. On 03/26/2025 at 7:11 AM, Surveyor received an email from Director A confirming the provider did not have a more recent assessment for Resident 4. Resident 4 was assessed on 02/15/2024. S/he experienced a significant change in condition after this date. The provider failed to assess Resident 4 upon changes in condition.	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	N 386		

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N 386	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 residents sampled, (Resident 1, Resident 3, and Resident 4) had a comprehensive individualized service plan (ISP). Findings include: On 03/06/2024 at 1:55 PM, Surveyor requested to review 3 resident ISPs. At approximately 3:15 PM, Surveyor interviewed Director A and Registered Nurse (RN) B. Surveyor requested the resident ISPs again. Director A asked for clarification because s/he was unclear what Surveyor was requesting. Surveyor provided technical assistance and Director A stated s/he did not believe they had a document for each resident that included their needs, services and frequency of services, goals, and who was responsible for delivering care. RN B, who was new to the role, stated s/he had created ISPs at other places of employment in the past, and s/he believed s/he had found some within the provider's records. RN B stated s/he was realizing things were not completed as they should have been. At 3:37 PM, RN B stated s/he was able to find an ISP for one of the 3 residents Surveyor sampled. On 03/13/2025 at 1:45 PM, Surveyor interviewed Director A and RN B. Director A discussed needing to revise the provider's systems. Director A stated resident needs were broken down on shift care plans. The shift care plans were more of a quick reference guide that included all residents. Director A stated the "care plans" were changed as needed, sometimes updated daily, but the provider did not date the plans or identify	N 386		

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N 386	Continued From page 10 when changes were made. The plans did not include goals, frequency of services, or desired outcomes. Director A stated the plans were not shared with residents or legal representatives. The provider did not have ISPs for Resident 1 or Resident 4. On 03/14/2025, the Department received a complaint related to resident care. On 03/19/2025, Surveyor requested records for Resident 3 from Director A, including his/her ISP. On 03/25/2025, Director A provided Surveyor with the shift care plan in place when Resident 3 was at the facility. The document indicated Resident 3 was a 1-assist with cares and wheelchair mobility, required transfer assistance via sit-to-stand or 1-assist pivot transfers, required peri care, and could be combative at times. Director A guessed Resident 3's section of the shift care plan was updated sometime in January 2025. Resident 3 did not have a comprehensive ISP.	N 386		
{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	{N 389}		

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{N 389}	Continued From page 11 with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident individual service plans (ISP) reviewed (Resident 2's) was updated when Resident 2's needs changed. Resident 2's legal representative was not involved in the planning, and s/he did not sign the ISP, acknowledging involvement and agreement with the plan. This is a repeat deficiency. See Statement of Deficiencies (SOD) 3U2C13, dated 12/21/2023. Findings include: On 03/06/2024 at 1:55 PM, Surveyor requested to review 3 resident ISPs. At approximately 3:15 PM, Surveyor interviewed Director A and Registered Nurse (RN) B. Surveyor requested the resident ISPs again. Director A ask for clarification because s/he was unclear what Surveyor was requesting. RN B, who was new to the role, stated s/he had created ISPs at other places of employment in the past, and s/he believed s/he had found some within the provider's records. RN B stated s/he was realizing things were not completed as they should have been. At 3:37 PM, RN B stated s/he was able to find an ISP for 1 of the 3 residents Surveyor sampled. On 03/06/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 01/17/2024 with diagnoses that included vascular dementia. Resident 2 was hospitalized on	{N 389}		

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{N 389}	Continued From page 12 02/27/2025 after a fall. As of 03/06/2025, Resident 2 remained at the hospital for medication adjustments. Resident 2's record indicated s/he had a legal representative. Resident 2's initial assessment with his/her primary care physician, date of service 06/12/2024, indicated Resident 2 had a long history of pain related to his/her arthritis. The pain was believed to be the source of agitation and resistance to cares. Staff shift notes indicated Resident 2 had behaviors that included physical aggression toward staff and residents, wandering, and resisting cares. Staff charting on 02/08/2025 referenced Resident 2's floor alarm. An incident report dated 01/17/2025, indicated Resident 2 had an unwitnessed fall in his/her room. The intervention added to prevent further falls read, "...will leave bathroom light on at noc (overnight shift)." An undated document within the staff charting binder contained a list of all residents' dietary preferences, interests, and past employment/careers. This document indicated Resident 2 required finger foods; that his/her medications needed to be crushed, added to jelly, and spread on his/her toast; and "no silverware to be given to [him/her]." This document also read, "[Resident 2] spits a lot and that has been disruptive in some activities as [s/he] has spit on other residents when they are too close in proximity. You have to gauge the activity." Resident 2's medication administration record	{N 389}		

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{N 389}	Continued From page 13 (MAR) and physician orders indicated s/he was prescribed lorazepam for anxiety and agitation on 08/26/2024. On 12/11/2024, Resident 2's physician ordered an additional as-needed (PRN) dose to Resident 2's regimen. On 02/20/2025, Resident 2's physician added "trazodone HCL, give 12.5mg 30 to 60 minutes prior to bathing to help with agitation." Resident 2's ISP, dated 02/11/2025, read: "Pain... Care staff will report any new complaint of pain...report any changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to care which may be indicative of pain." The ISP did not include interventions for pain or desired outcomes or goals related to pain. "Falls... Is at risk for falls ... poor safety awareness, often getting up and ambulating without walker... Requires Reminders for: ... use of walker." The ISP did not include reference to other fall interventions such as a floor alarm or need to keep the light in his/her bathroom on at night. The ISP did not include desired outcomes or goals related to falls. "Behaviors... Goal...will be able to identify factors/interventions that help to prevent/minimize inappropriate behaviors...will not act out in a way that is harmful to self or others... Interventions... Care staff will report any changes from baseline behaviors." The ISP did not provide details on Resident 2's behaviors (i.e. wandering, spitting, physical aggression toward staff and residents), did not indicate what Resident 2's baseline behaviors were, and it did not provide interventions to help prevent, control, or manage Resident 2's behaviors.	{N 389}		

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{N 389}	Continued From page 14 "Eating/Meals/Nutrition... Goal... Will be able to meet eating/meals [sic] needs with assistance... Interventions... set up... encourage food consumption and fluids... Care Staff will report any changes in ability to eat or drink... Weight monthly or as per MD orders." The ISP did not reference Resident 2's need for finger foods or needs related to utensils. "Bathing... Goal... Will be able to meet bathing/showering needs with assistance... Interventions... Requires Assistance for: (specify: transferring in/out; steadying; washing self; drying self; shampooing/rinsing/drying hair; applying lotion; toenail and fingernail care)... Schedule preference: AM preferred (specify: days of the week)... Schedule preference: PM preferred (specify: days of the week)... Care staff will report any changes in ability to bath/shower [sic]." The ISP form contained the original form prompts and was not individualized for Resident 2's needs. The ISP did not reference Resident 2's need to receive tramadol 30-60 minutes prior to his/her bath/shower, the frequency in which Resident 2 was to receive the service, or Resident 2's baseline ability so staff could determine a change in ability. Resident 2's ISP did not include reference to his/her PRN psychotropic medications used to assist with anxiety and agitation, or Resident 2's preference to receive his/her medications crushed and added to his/her food in the morning. Resident 2's ISP was not complete. The following sections did not include desired outcomes or goals: dressing/undressing, personal hygiene/oral care, bladder/bowel needs, cognition, or transfer needs. The following sections contained the	{N 389}		

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{N 389}	Continued From page 15 original form prompts instead of Resident 2's individualized needs: - "Elopement Risk... Triggers for wandering/eloping are (SPECIFY). The wandering behaviors decrease when we (SPECIFY)." - "Evacuation... Requires Assistance for: Evacuation from the building in the event of an emergency (specify: community specific information)" - "Vitals Monitoring... Assistance with: (specify vitals and frequency)." - "Toileting... Requires Assistance for: (specify: toileting activity, to and from toilet; peri-care; adaptive device i.e. grab bars, raised toilet, commode at night or bed pan; negotiate clothing after toileting)... Incontinence Products: Requires Assistance for: (pull-up, liner, brief). Supply and disposal managed by (resident/staff)." - "Transferring... Independent with: (specify: able to get in and out of bed, chair, car, etc.)" Resident 2's ISP was not signed by Resident 2 or his/her legal representative. Cross reference: N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan	{N 389}		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall	N 407		

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N 407	Continued From page 16	N 407		

be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a pharmacist, practitioner, or registered nurse assessed residents' scheduled psychotropic medication usage quarterly. Two of 2 residents sampled (Resident 1 and Resident 2) were not assessed at least quarterly between 2024 and 2025.

Findings include:

On 03/06/2024 at 1:55 PM, Surveyor requested resident records, including medication reviews for the past 6 months. At approximately 2:50 PM, Director A provided Surveyor with psychotropic medication reviews for Resident 1 and Resident 2. Director A stated s/he was aware the reviews were not occurring as required.

On 03/06/2025, Surveyor reviewed resident records.

Resident 1 was admitted to the facility on 04/01/2019. According to Resident 1's medication record, s/he was prescribed lorazepam 0.25 mg, give twice a day (BID) for rigidity, on 04/03/2024; risperidone 0.25, give BID for agitation, on 11/20/2024; and gabapentin 300 mg, give 1 capsule BID for Alzheimer's disease, on 02/14/2025. Resident 1's record included 2 psychotropic medication review forms, dated 08/30/2024 and 02/17/2025. The review forms did not provide evidence that the medications were

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N 407	Continued From page 17 reviewed. Resident 1's medications were inserted into the form, but the sections of the form related to effectiveness and side effects/adverse reactions were blank. Resident 2 was admitted to the facility on 01/17/2024. According to Resident 2's medication record, s/he was prescribed lorazepam 0.5 mg, give 1 tablet BID for agitation, on 08/26/2024. Resident 2's record included 2 psychotropic medication review forms, dated 09/09/2024 and 01/21/2025. The review forms did not provide evidence that Resident 2's medication was reviewed. Resident 2's medication was inserted into the form, but the sections of the form related to effectiveness and side effects/adverse reactions were blank. On 03/13/2025 at 1:45 PM, Surveyor interviewed Director A and Registered Nurse (RN) B. Director A stated the previous RN had not completed medication assessments as required. RN B stated s/he would be assessing residents with scheduled psychotropic medications on a quarterly basis.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not	N 408		

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N 408	Continued From page 18	N 408		

limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 3 of 3 residents sampled with as-needed (PRN) psychotropic medication (Resident 1, Resident 2, and Resident 3) were assessed monthly. The provider did not ensure individual services plans (ISP) for the 3 of 3 residents sampled included a rationale for use and a detailed description of the behaviors warranting the use of the PRN psychotropic medication.

Findings include:

On 03/06/2024 at 1:55 PM, Surveyor requested to review 3 resident records, including medication reviews for the last 6 months. At approximately 2:50 PM, Director A informed Surveyor that the provider did not do monthly PRN psychotropic medication reviews.

On 03/06/2025, Surveyor reviewed resident records.

Resident 1 was admitted to the facility on 04/01/2019. According to Resident 1's medication record, s/he was prescribed lorazepam 0.5 mg, give 1 tablet by mouth every 2 hours PRN for

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N 408	Continued From page 19 anxiety/sleep/severe nausea, on 11/24/2023. Resident 1's record did not include an ISP. Resident 2 was admitted to the facility on 01/17/2024. According to Resident 2's medication record, s/he was prescribed lorazepam 0.5 mg, give 1 tablet by mouth every 4 hours as needed for anxiety and agitation, on 12/11/2024. Resident 2's ISP, dated 02/11/2025, did not include reference to Resident 2's PRN psychotropic medication. Resident 3 was admitted to the facility on 05/09/2022. According to Resident 3's medication record, s/he was prescribed lorazepam 0.5 mg, give every 4 hours for anxiety or restlessness, on 05/24/2024. S/he was also prescribed Seroquel 25 mg, give daily PRN for agitation, on 12/18/2024. Resident 3's record did not include an ISP. On 03/13/2025 at 1:45 PM, Surveyor interviewed Director A and Registered Nurse (RN) B. Director A stated the previous RN had not completed monthly medication assessments as required. RN B stated s/he would be assessing resident PRN psychotropic usage on a monthly basis. Cross references: 0386 Comprehensive Individualized Service Plan 83.35(3)(a) 0389 Service Plans Updated Annually Or On Changes 83.35(3)(d)	N 408		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications,	N 416		

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N 416	Continued From page 20 treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure unlicensed staff were delegated by a registered nurse (RN) prior to administering medications or treatments via injection, nebulizer, stomal/enteral routes, or vaginal/rectal routes. Four of 4 caregivers (Caregiver J, Caregiver K, Caregiver L, and Caregiver M) did not complete delegation. Findings include: On 03/06/2025, Surveyor reviewed Caregiver J's and Caregiver K's records. Both staff were identified as medication passers. The records did not include evidence of delegation. On 03/06/2025 at 11:15 AM, Surveyor observed Caregiver L administer medications. Caregiver M was training Caregiver L during the observation, but Caregiver L was performing the tasks. Caregiver L stated s/he had already administered Resident 6's nebulizer treatment prior to Surveyor joining the medication pass. Surveyor observed Caregiver L administer insulin subcutaneously to Resident 5. On 03/13/2025, Surveyor received an email from Director A that read, "I was talking to our nurse educator on the request for 'Please send evidence of RN delegation for [Caregiver J, Caregiver K, Caregiver L, and Caregiver M].' [S/he] is wondering if [s/he] can get clarification	N 416		

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N 416	Continued From page 21 on exactly what you're looking for, if possible." On 03/13/2025 at 1:45 PM, Surveyor interviewed Director A and RN B. Director A stated the provider's nurse educator, RN F, was working on reviewing medication competency with all medication passers, but RN F had not completed any delegations with staff. Director A stated s/he was unsure if the previous nurse, RN B (terminated on 02/18/2025), delegated staff to perform nursing tasks.	N 416		
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. 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	N 431		

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N 431	Continued From page 22 status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor Resident 4's health when it failed to communicate and record Resident 4's changes in condition. Resident 4 became unresponsive on 01/31/2025, was sent to the emergency department (ED), and discharged to a higher level of care on 02/04/2025. Hospital staff found Resident 4 to have significant skin breakdown which had not been communicated to the healthcare provider or Resident 4's legal representative. Findings include: On 03/14/2025, the Department received a complaint regarding resident care and treatment. Between 03/19/2025 and 03/28/2025, Surveyor reviewed Resident 4's provider record and hospital records. Resident 4 was admitted to the facility on 02/15/2022 with diagnoses that included Alzheimer's disease. Resident 4 was sent to the emergency department on 01/31/2025 due to unresponsiveness. Resident 4 was hospitalized and discharged to a skilled nursing facility with hospice care on 02/04/2025.	N 431		

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N 431	Continued From page 23 The provider last comprehensive assessment on Resident 4, dated 02/15/2024, indicated Resident 4 did not have regular pain concerns, his/her health was "fair," and s/he did not have recurring or short-term illnesses. The assessment did not indicate Resident 4 had issues with skin breakdown. Emergency Department (ED) and hospital records, dated 01/31/2025 through 02/04/2025 read, " "Presents via EMS (emergency medical services) cot from memory care unit. EMS reports that [s/he] has norovirus-like symptoms. Had an episode of vomiting and diarrhea last night with an episode of diarrhea today. [S/he] has had a suppressed appetite and is more fatigued. Normally wheelchair bound. [Power of Attorney (POA) C] arrived to provide further history which included an acute change in [Resident 4's] mental status. [POA C] states the patient would normally recognize [him/her] and interact, however the patient has been less responsive to verbal stimuli." The ED record indicated they did not complete a full physical exam due to Resident 4's somnolence and baseline dementia. Resident 4 was admitted to the hospital at approximately midnight on 02/01/2025. Registered Nurse (RN) I wrote, "Getting ready to straight cath (catheter) this patient we discovered massive amounts of inflammation, erythema, and open skin all over perineum. [She] is experiencing severe amounts of pain in the area and is shaking uncontrollably when we try to clean [him/her] up. Response: PRN (as needed) IV (intravenous) Dilaudid and PRN hydrocortisone orders ... Evidence of potential neglect from care facility related to condition of patient's perineum and lack of	N 431		

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communication and coordination of care with activated healthcare agent" Resident 4 was diagnosed with sepsis, acute encephalopathy, vomiting and diarrhea "most likely culprits include UTI (urinary tract infection) (in setting of diarrhea) and PNA (pneumonia) (aspiration in setting of vomiting)," perineum and sacral skin breakdown, and a stage 2 pressure injury of the sacral region.

Surveyor reviewed Resident 4's progress notes for 06/14/2024 through 02/03/2025. The first documented concern related to skin breakdown occurred on 01/03/2025. RN G wrote, "Resident's bottom/peri area red raw, had wound consultant look with this writer to come up with a treatment plan. will [sic] trial antifungal ointment topped with barrier cream."

Based on Resident 4's task administration record (TAR) and medication administration record (MAR), this treatment was not added to Resident 4's regimen until 01/31/2025.

A physician notification, dated 12/04/2024, indicated Resident 4 no longer had redness to his/her groin. Resident 4's physician ordered nystatin cream as needed. This was the last documented communication between the provider and Resident 4's physician regarding Resident 4's skin changes.

Resident 4's January 2025 TAR indicated Resident 4 had orders for peri care that were initiated on 10/23/2024, suggesting there were skin concerns in October. The order from 10/23/2024 read, "1) Use personal care washcloths, wet with water 2) Dab/Pat as much as possible rather than wiping 3) Pat dry with personal care wash cloths 4) Apply orange tube barrier cream after 5) Do NOT worry about wiping

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all ointment off from previous time. Being gentle to area is more important than scrubbing 6) DO NOT USE TENA WIPES or NYSTATIN ... Start Date 10/23/2024 ... D/C (discontinued) Date 01/13/2025." On 01/13/2025, step 4 changed to "apply BLUE tube barrier cream."

Based on the staff communication record, this treatment was ordered by RN G on 01/10/2025, 3 days before it was added to the TAR.

Surveyor reviewed the provider's staff communication record (i.e. 24-hour sheets) for dates 11/01/2024 through 01/28/2025. The following skin concerns were identified:
- 12/28/2024, "Has a really red bottom that is shedding blood, I've packed it with skin protector and [s/he] still pulls [his/her] brief off, [s/he] will need a lien [sic] change"
- 01/4/2025, "Bottom is bleeding ... STOP PUTTING PULL UPS ON."
- 01/10/2025, "Nurse ([Registered Nurse (RN) G]) checked out sores. Switch to silicone blue barrier cream."
- 01/13/2025, "Bottom is VERY sore, bleeding & lots of breakdown!"
- 01/16/2025, "Bottom needs medical attention"

Staff did not document concerns related to Resident 4's skin after 01/16/2025. The provider did not retain the 24-hour sheets for dates 01/29/2025 through 01/31/2025.

Resident 4's record contained a wound assessment dated 01/31/2025. The assessment read: "Wound #1 Sacral including coccyx is a chronic Full Thickness Irritant Contact Dermatitis (MASD) acquired on 07/08/2024 and has received a status of Not Healed. Initial wound encounter measurements are 7cm length x 7cm

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PINE RIDGE ASSISTED LIVING	1320 WISCONSIN ST HUDSON, WI 54016

(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 26	N 431		

width x 0.1cm depth, with an area of 49 sq cm and a volume of 4.9 cubic cm ... Wound bed has 76-100% bright red, granulation; no slough, eschar and no epithelialization present ... many topical creams have been tried to resolve the skin breakdown, full area includes [his/her] posterior thighs, perianal, perineal and medial upper thighs recommended to cover sacrum area and treat the rest with perineal cleanser and af (antifungal) barrier paste (with) q (every) incontinence episode ...

Wound Orders: ...
Cover wound with A6197 Bordered Super Absorbent Sacral 7" x 6.75" Every day for 30 days ...Cleanse eroded area with soap and water and pat dry. Apply sacral superabsorbent dressing. Change daily. Ok for outside of dressing to get soiled in between incontinence episodes."

On 03/26/2025, Surveyor received an email from Director A confirming staff last documented skin concerns on 01/16/2025 in the 24-hour sheets. Director A wrote, " ...there is no documentation I can find stating there was a new concern that prompted the wound consultant that recommended the antifungal ointment and barrier cream on 1/31 ...I no longer have access to [RN G's] emails so I cannot answer if the family was notified."

On 03/28/2025 at 1:30 PM, Surveyor interviewed Power of Attorney (POA) C. POA C voiced concern with the provider's lack of communication. Surveyor asked if the provider had notified him/her in January that Resident 4 had skin breakdown. POA C replied, "Nope. Not at all. I wasn't aware at all that [s/he] had skin breakdown prior to the hospitalization." POA C

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N 431	Continued From page 27 stated s/he was aware that Resident 4 had redness about a month prior, but s/he was not aware s/he had bleeding or open areas. POA C stated s/he was not aware Resident 4 had a wound assessment on 01/31/2025. The provider did not document Resident 4's skin changes between July 2024 through January 2025. Records indicated treatments were not initiated for days to weeks after they were ordered. The provider did not retain documentation between Resident 4's physician regarding Resident 4's skin changes. Cross references: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0454 DHS 83.42(1) Resident Record Maintained	N 431		
{N 454}	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and	{N 454}		

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{N 454}	Continued From page 28	{N 454}		

resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually

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{N 454}	Continued From page 29 spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident records were maintained. The provider utilized a paper charting system to communicate resident changes, incidents, etc., to oncoming shifts. The information recorded in the communication record was not consistently transferred to the residents' individual records. The communication records were not retained for dates 01/29/2025 through 01/31/2025. Resident 4's record did not include documentation that accurately described Resident 1's change in condition or interventions. This is a repeat deficiency. See Statement of Deficiencies (SOD) 3U2C13, dated 12/21/2023. Findings include: On 03/06/2025 at 12:07 PM, Surveyor interviewed Director A. Director A discussed the changes the provider made since the previous survey. Director A said the provider no longer discarded the staff daily communication record (i.e. 24-hour sheets). Surveyor asked if the information on the 24-hour sheets was transferred to the resident's record. Director A stated anything related to concerns, changes in conditions, or incidents communicated on the 24-hour sheets should added to the resident's progress notes.	{N 454}		

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{N 454}	Continued From page 30 On 03/19/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 02/15/2022 with diagnoses that included Alzheimer's disease. Resident 4's progress notes included 3 entries for January 2025: - 01/03/2025: "Resident's bottom/peri area red raw, had wound consultant look with this writer to come up with a treatment plan." - 01/31/2025 at 11:09 AM: "LATE ENTRY - Resident started to have D/V (diarrhea/vomiting) this AM." - 01/31/2025 at 6:10 PM: "Resident sent to ER (emergency room) d/t (due to) unresponsiveness." On 03/25/2025, Surveyor received Resident 4's 24-hour sheets for November 2024 through January 2025 from Director A. There were no 24-hour sheets for the 3 days leading up to Resident 4's hospitalization; staff charting from 01/29/2025, 01/30/2025, and 01/31/2025 was missing. Director A stated at 3:02 PM, "I do not have 24-hour sheets for those dates. [RN B] and I searched. It's possible staff accidentally tossed them, but I don't know for sure." Surveyor reviewed the 24-hour sheets. The document included all residents, so it could not be added to each resident's record without violating confidentiality. Incidents, changes in condition, and concerns identified on the 24-hour sheets were not consistently added to Resident 4's progress notes per the provider's policy. For example, staff recorded the following concerns on the 24-hour sheets in January: - 01/01/2025, "Keeps taking off depends" - 01/03/2025, "Keeps pulling depends down... appears anxious... very bad mood before bed.	{N 454}		

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{N 454}	Continued From page 31 Refusing cares and meds (medications)." - 01/04/2025, "Bottom is bleeding" - 01/10/2025, "Nurse ([RN G]) checked out sores. Switch to silicone blue barrier cream." - 01/13/2025, "Bottom is VERY sore, bleeding and lots of breakdown!" - 01/16/2025, "Bottom needs medical attention." - 01/19/2025, "Powder seems to be helping [his/her] body" - 01/27/2025, "Agitated after dinner" Cross reference: N0431 DHS 83.38(1)(g) Health Monitoring	{N 454}		