STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 08/09/2023, Surveyor conducted 4 complaint investigations at Sunset Ridge Jefferson. Eleven deficiencies were identified; four were repeat deficiencies. All 4 complaints were substantiated. Census: 20	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department when Resident 3's whereabouts were unknown and s/he was returned to the facility by a family member from the facility next door. Repeat deficiency from statement of deficiency (SOD) VZYX11, dated 07/14/2020. Findings include:	N 163		

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
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 163	Continued From page 1 On 08/03/2023 and 08/08/2023, the Department received a complaint related to supervision and Resident 3 eloping from the facility during a severe storm. On 08/09/2023, Surveyor reviewed the provider's electronic facility file; there was no documentation that a self-report had been submitted regarding a resident's whereabouts. The provider is a class CNA (non-ambulatory) community based residential facility able to serve up to 26 adults within the client groups of irreversible dementia/Alzheimer's and advanced age. On 08/09/2023, Surveyor conducted 4 complaint investigations. At 12:15 p.m., Surveyor interviewed Assistant Admin B and asked if the provider had any recent elopements. Assistant Admin B stated yes, that Resident 3 had left the building about 2 weeks ago. Assistant Admin B stated that Resident 3 had left through the garage that's attached to the facility and a family member from the facility next door saw Resident 3 wandering in the parking lot and knew that wasn't right and brought him/her back. Surveyor asked if Assistant Admin B or anyone else and reported to the Department when Resident 3's whereabouts were unknown. Assistant Admin B stated, no, that s/he wasn't aware s/he was required to and, "that's the stuff I'd need to know." Assistant Admin B then called Licensee/Administrator A and asked if s/he reported the incident to the Department. Per Assistant Admin B, Licensee/Administrator A stated s/he did not because Resident 3 never technically left the property, so s/he did not think s/he had to. Surveyor reviewed an incident report dated 07/28/2023 at 8:16 p.m. The report documents, "Resident eloped out of the garage door, resident was found outside the garage between both	N 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 163	Continued From page 2 buildings. Brought [him/her] inside and got [him/her] ready for bed." At 1:05 p.m., Surveyor interviewed Caregiver C, who was the only staff member working on the night of 07/28/2023. Surveyor asked how Resident 3 was able to leave the building on 07/28/2023. Caregiver C stated s/he was the only staff member working and s/he can manage, but some things don't get done and s/he can't be very attentive to all 20 residents when s/he is the cook, house keeper, caregiver, medication passer, everything. Caregiver C stated that Resident 3 will walk around the building but has never left before. Caregiver C stated that s/he went to the facility next door to get food and when s/he returned to the facility s/he heard the doorbell ring and it was a family member from next door returning Resident 3 to the facility. Caregiver C stated that s/he observed that the garage door was wide open, so Resident 3 must have opened it and left. Caregiver C stated that s/he looked over Resident 3's body and got him/her into pajamas. Resident 3 stated s/he was confused but that was his/her baseline. Caregiver C then stated that s/he reported the incident to Assistant Admin B. According to www.weather.gov the temperature in Jefferson, WI on 07/28/2023 was 90 degrees and included an EF-1 tornado touching down in Jefferson county with winds peaking at 95 miles per hour.	N 163		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician	N 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 169	Continued From page 3 when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 3's legal representative when his/her whereabouts were unknown on 07/28/2023. Repeat deficiency from statement of deficiency (SOD) VZYX11, dated 07/14/2020. Findings include: On 08/03/2023 and 08/08/2023, the Department received a complaint related to supervision and Resident 3 eloping from the facility and required notifications. The provider is a class CNA (non-ambulatory) community based residential facility able to serve up to 26 adults within the client groups of irreversible dementia/Alzheimer's and advanced age. On 08/09/2023, Surveyor conducted 4 complaint investigations. At 12:15 p.m., Surveyor interviewed Assistant Admin B and asked if the provider had any recent elopements. Assistant Admin B stated yes, that Resident 3 had left the building about 2 weeks ago. Assistant Admin B stated that Resident 3 had left through the garage that's attached to the facility and a family member from the facility next door saw Resident 3 wandering in the parking lot and knew that wasn't right and brought him/her back.	N 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 169	Continued From page 4 Surveyor reviewed an incident report dated 07/28/2023 at 8:16 p.m. The report documents, "Resident eloped out of the garage door, resident was found outside the garage between both buildings. Brought [him/her] inside and got [him/her] ready for bed." The incident report documents that the assistant administrator was notified at 8:19 p.m. The section of the report that documents "POA (power of attorney) Notified; Doctor Notified; Care WI Notified; Family Notified" were all blank. At 1:05 p.m., Surveyor interviewed Caregiver C, who was the only staff member working on the night of 07/28/2023. Surveyor asked how Resident 3 was able to leave the building on 07/28/2023. Caregiver C stated s/he was the only staff member working and s/he can manage, but some things don't get done and s/he can't be very attentive to all 20 residents when s/he is the cook, house keeper, caregiver, medication passer, everything. Caregiver C stated that Resident 3 will walk around the building but has never left before. Caregiver C stated that s/he went to the facility next door to get food and when s/he returned to the facility s/he heard the doorbell ring and it was a family member from next door returning Resident 3 to the facility. Caregiver C stated that s/he observed that the garage door was wide open, so Resident 3 must have opened it and left. Caregiver C stated that s/he looked over Resident 3's body and got him/her into pajamas. Resident 3 stated s/he was confused but that was his/her baseline. Caregiver C then stated that s/he reported the incident to Assistant Admin B. Caregiver C stated after the event, Resident 3's POA was upset s/he was not notified.	N 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 169	Continued From page 5 At 1:22 p.m., Surveyor interviewed Assistant Admin B and asked what is the provider's protocol for after an elopement happens. Assistant Admin B stated that an incident report should be filled out and the family should be called. Surveyor asked who was responsible for contacting the POA or guardian. Assistant Admin B stated the caregiver. Surveyor asked if Assistant Admin B was aware that Caregiver C did not contact Resident 3's POA after the elopement and s/he believed that Assistant Admin B would. Assistant Admin B stated, "No, and that's the problem."	N 169		
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 provider did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF. Repeat deficiency from statement of deficiency (SOD) L37L11, dated 04/14/2022 and SOD L37L12, dated 10/05/2022. Findings include: On 08/09/2023, the Department conducted 4 complaint investigations at Sunset Ridge Jefferson. All 4 complaints were substantiated; the visit resulted in SOD #61OL11. Eleven deficiencies were issued; four deficiencies were	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 6 recites: 83.12(4)(a) Reporting When Resident's Whereabouts Unknown - repeat 83.12(5)(a) Notification: Incident, Injury, Changes - repeat 83.14(2)(a) Licensee Ensures Facility Complies with Laws - repeat 83.15(3)(b) Administrator Responsible for Staff Training 83.20(2)(a-d) Department Approved Training Courses 83.23 Employee Supervision 83.33(1)(d) Grievance Procedure: Written Summary 83.35(1)(c) Listed Areas for Assessment 83.38(1)(b) Supervision 83.41(2)(c) Nutrition: Menus - repeat 83.43(1) Environment Safe, Clean, And Comfortable On 08/11/2023 at 10:00 a.m., Surveyor interviewed Licensee/Administrator A. Trainings: Licensee/Administrator A stated that s/he is aware that not all the staff are fully trained. Surveyor discussed the systematic concern that Licensee/Administrator A has been issued violations at other facilities s/he owns for not ensuring staff have all required trainings, including Caregiver G, who primarily works at another one of the licensee's facilities and has worked alone at this facility. Licensee/Administrator A acknowledged that staff training is a systematic error and stated that it is hard to find the time to train staff when s/he is also having to work on the floor as a caregiver. Licensee/Administrator A acknowledged that s/he is a department approved trainer for fire safety	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 7	N 196		

and stated that it is embarrassing on his/her part that staff have not completed that training.

Supervision/Staffing
When Surveyor asked Licensee/Administrator A if s/he was aware of the potential outcomes for not having staff fully trained and working alone. Licensee/Administrator A stated that s/he thought staff had 90 days to complete trainings and was not aware that staff are required to be working with a qualified staff before they are fully trained. Surveyor stated that in SOD L37L11, dated 04/14/2022, Licensee/Administrator A was citing for not having adequate staffing and then in SOD L3712, dated 10/05/2022, Licensee/Administrator A was cited for admitting additional residents while under a no new admission order due to inadequate staffing. In SOD L37L11, Licensee/Administrator A stated that s/he tries for 1 staff to 12 residents but would like it to be 1 staff to 8 residents. Surveyor stated that after reviewing the last 40 days of the staff schedule, there was 43 shifts where 1 caregiver was responsible for all 21 residents; including second shift on 07/28/2023, when Resident 1 eloped during inclement weather. There was also 41 shifts where the only caregiver(s) working had not completed initial training and were not directly supervised by a qualified resident care staff or administrator. Licensee/Administrator A stated s/he is aware of the staffing concern and working on hiring more staff and that the staff s/he does have are trained.

Notification/Investigation
Surveyor discussed the concerns of Resident 1's elopement on 07/28/2023 and the absence of appropriate follow-up after. Surveyor noted that License/Administrator A has previously received a violation for not reporting when a resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 8	N 196		

whereabouts were unknown and for not ensuring the appropriate parties are notified in SOD VZYX11, dated 07/14/2020.
Licensee/Administrator A stated s/he did not think it was a reportable incident because Resident 1 had not left the property. Surveyor asked if s/he was under the impression that Caregiver C knew that Resident 1 was wandering in the parking lot when a family member from the facility next door had brought them back. Licensee/Administrator A stated no. Licensee/Administrator A stated that s/he was not aware that Resident 1's POA was never notified of the incident by the provider and that s/he found out about the elopement a few days later from another resident's family member.
Surveyor asked how Licensee/Administrator A ensured the health, safety and welfare of all 21 residents in the facility when Licensee/Administrator A was made aware that Friend L made an accusation of verbal abuse and neglect against Caregiver K.
Licensee/Administrator A stated that s/he was unaware of what happened but that as far as s/he was aware it was investigated, although s/he cannot find the documentation.
Licensee/Administrator A stated that Previous Assist Admin M stated that s/he did an investigation, so Licensee/Administrator A believed him/her.

Supervision of Day to Day Operations
Throughout the duration of the survey, Assistant Admin B stated s/he was unaware of all DHS chapter 83 requirements and that s/he was "thrown" into the position when Previous Assistant Admin M left. During the survey, Assistant Admin B and Marketing I both attempted to "lead" the survey and gave contradicting statements.
Surveyor asked Licensee/Administrator A who was in charge of the day to day operations at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 9 facility. Licensee/Administrator A stated Assistant Admin B. Surveyor asked Licensee/Administrator A what Assistant Admin B's qualifications are. Licensee/Administrator A stated that s/he was working on getting Previous Assist Admin M through the administrators course but then s/he left and so Assistant Admin B has been filing in and that Licensee/Administrator A is training/overseeing him/her.	N 196		
N 215	83.15(3)(b) Administrator responsible for staff training The administrator shall be responsible for the training and competency of all employees. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 5 of 5 employees had received necessary trainings and were competent in their caregiving role. Findings include: On 07/10/2023, 08/02/2023 and 08/03/2023 the department received complaints with concerns on staff competency and training. On 08/09/2023, at approximately 11:30 a.m., Surveyor entered the facility and observed Caregiver J working. Surveyor requested training records from Assistant Admin B for Caregiver J, D, E, F, and G. The record for Caregiver J, hired 03/14/2023, did not have evidence of training or meeting an exception for client group, challenging behaviors,	N 215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 215	Continued From page 10	N 215		

personal cares or dietary.

The record for Caregiver D, hired 06/28/2023, did not have evidence of training or meeting an exception for fire safety, medications, client group, challenging behaviors, personal cares or dietary.

Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver D worked with Caregiver E, who is not fully trained, on 07/01/2023, 07/02/2023, 07/08/2023, 07/09/2023, 07/15/2023; second and third shift, 07/16/2023; second and third shift, 07/22/2023; second and third shift, 07/23/2023; second and third shift, 07/29/2023; second and third shift, 07/30/2023; second and third shift, 08/05/2023, and 08/06/2023; second and third shift.

The record for Caregiver E, hired 06/28/2023, did not have evidence of training or documentation of Caregiver E meeting an exception for fire safety, medications, client group, challenging behaviors, personal cares or dietary.

Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver E worked with Caregiver D, who is not fully trained, on 07/01/2023, 07/02/2023, 07/08/2023, 07/09/2023, 07/15/2023; second and third shift, 07/16/2023; second and third shift, 07/22/2023; second and third shift, 07/23/2023; second and third shift, 07/29/2023; second and third shift, 07/30/2023; second and third shift, 08/05/2023, and 08/06/2023; second and third shift.

The record for Caregiver F, hired 07/21/2023, did not have evidence of training or meeting an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 215	Continued From page 11	N 215		

exception for client group and challenging behaviors.

Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver F was trained by Caregiver G, who is not fully trained, on 07/25/2023, 07/26/2023 and 07/31/2023. Caregiver F worked alone on 08/01/2023, 08/02/2023, 08/03/2023, 08/08/2023 and 08/09/2023.

The record for Caregiver G, hired 02/14/2023, did not contain evidence of training or evidence of meeting an exemption for department approved training in fire safety, medications and first aid and choking.

Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver G worked alone on third shift on 07/27/2023 and worked 3rd shift on 07/25/2023 and 07/26/2023 training Caregiver F.

At 12:37 p.m., Surveyor asked Assistant Admin B who was responsible for staff trainings. Assistant Admin B stated s/he guesses s/he is responsible for everything in the building now and that it was something s/he was "thrown into" and there is still things s/he does not know. Assistant Admin B stated that it is hard to do administrative tasks when s/he is also a primary caregiver on the floor.

On 08/11/2023 at 10:00 a.m., Surveyor interviewed Licensee/Administrator A in regards to staff training. Licensee/Administrator A stated that s/he is aware that not all the staff are fully trained. Surveyor noted that Licensee/Administrator A has been issued violations at other facilities s/he owns for not ensuring staff have all required trainings,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 215	Continued From page 12 including Caregiver G. Licensee/Administrator A acknowledged that s/he is a department approved trainer for fire safety and that it is embarrassing on his/her part that staff have not completed that training. Licensee/Administrator A stated that s/he will be contracting with a consulting company to ensure trainings are being completed. Cross Reference: N1096 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0239 DHS 83.20(2)(a-d) Department Approved Training Courses N0251 DHS 83.23 Employee Supervision	N 215		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 239	Continued From page 13 administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver G obtained all department approved training as required. Caregiver G did not have training in fire safety within 90 days after starting employment. Caregiver G did not have training in first aid and choking within 90 days after starting employment. Findings include: On 08/09/2023, Surveyor conducted a review of 3 employees who had been employed for over 90 days to verify compliance with department approved training requirements. Surveyor requested training records from Assistant Admin B for Caregiver G. Fire Safety The record for Caregiver G, hired 02/14/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 08/09/2023, at approximately 12:55 p.m., Surveyor interviewed Marketing I. Marketing I confirmed that Caregiver G has still not completed or met an exemption for fire safety training. First aid and Choking The record for Caregiver G, hired 02/14/2023, did	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 239	Continued From page 14 not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 08/09/2023, at approximately 12:55 p.m., Surveyor interviewed Marketing I. Marketing I confirmed that Caregiver G has still not completed or met an exemption for first aid and choking training. On 08/09/2023, Surveyor verified Caregiver G was not on the Community-Based Care and Treatment training registry for fire safety or first aid and choking. On 08/11/2023 at 10:00 a.m., Surveyor interviewed Licensee/Administrator A in regards to staff training. Licensee/Administrator A stated that s/he is aware that not all the staff are fully trained. Surveyor noted that Licensee/Administrator A has been issued violations at other facilities s/he owns for not ensuring staff have all required trainings, including Caregiver G. Licensee/Administrator A acknowledged that s/he is a department approved trainer for fire safety and that it is embarrassing on his/her part that staff have not completed that training. Licensee/Administrator A stated that s/he will be contracting with a consulting company to ensure trainings are being completed. Cross Reference: N1096 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0215 DHS 83.15(3)(b) Administrator Responsible for Staff Training N0251 DHS 83.23 Employee Supervision	N 239		
N 251	83.23 Employee supervision.	N 251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 251	Continued From page 15 Employee supervision. Until an employee has completed all required training, the employee shall be directly supervised by the administrator or by qualified resident care staff. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 5 of 5 caregivers who had not completed initial training, were directly supervised by a qualified resident care staff or administrator. Findings include: On 07/10/2023, 08/02/2023 and 08/03/2023 the department received complaints with concerns on staff competency and training. On 08/09/2023, at approximately 11:30 a.m., Surveyor entered the facility and observed Caregiver J working. Surveyor requested training records from Assistant Admin B for Caregiver J, D, E, F, and G. Example 1 - Caregiver J The record for Caregiver J, hired 03/14/2023, did not have evidence of training or documentation of Caregiver J meeting an exception for client group, challenging behaviors, personal cares or dietary. At 12:55 p.m., Surveyor interviewed Marketing I and asked if there was documentation of Caregiver J receiving training in client group, challenging behaviors, personal cares or dietary. Marketing I stated that s/he was no longer in management at the facility was Caregiver J was re-hired, so s/he was not sure if it was not in Caregiver J's record. At 1:07 p.m., Surveyor interviewed Caregiver J	N 251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 251	Continued From page 16	N 251		

and asked if s/he received training in the provider's client group, challenging behaviors, personal care or dietary. Caregiver J stated that s/he was a rehire and s/he didn't know if s/he had ever received those trainings during his/her first or second time of employment.

Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver J worked alone on 07/01/2023, 07/02/2023, 07/06/2023, 07/07/2023, 07/15/2023, 07/16/2023, 08/04/2023, and 08/07/2023.

Example 2 - Caregiver D
The record for Caregiver D, hired 06/28/2023, did not have evidence of training or documentation of Caregiver D meeting an exception for fire safety, medications, client group, challenging behaviors, personal cares or dietary.

At 12:55 p.m., Surveyor interviewed Marketing I and asked if there was documentation of Caregiver D receiving training in fire safety, medications, client group, challenging behaviors, personal cares or dietary. Marketing I was on the phone with Licensee/Administrator A and relayed that s/he stated no because Caregiver D has not been employed for 90 days.

Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver D worked with Caregiver E, who is not fully trained, on 07/01/2023, 07/02/2023, 07/08/2023, 07/09/2023, 07/15/2023; second and third shift, 07/16/2023; second and third shift, 07/22/2023; second and third shift, 07/23/2023; second and third shift, 07/29/2023; second and third shift, 07/30/2023; second and third shift, 08/05/2023, and 08/06/2023; second and third shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 251	Continued From page 17 At 1:10 p.m., Assistant Admin B confirmed that Caregiver D has worked without qualified supervision without completing all trainings. Example 3- Caregiver E The record for Caregiver E, hired 06/28/2023, did not have evidence of training or documentation of Caregiver E meeting an exception for fire safety, medications, client group, challenging behaviors, personal cares or dietary. At 12:55 p.m., Surveyor interviewed Marketing I and asked if there was documentation of Caregiver E receiving training in fire safety, medications, client group, challenging behaviors, personal cares or dietary. Marketing I was on the phone with Licensee/Administrator A and relayed that s/he stated no because Caregiver E has not been employed for 90 days. Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver E worked with Caregiver D, who is not fully trained, on 07/01/2023, 07/02/2023, 07/08/2023, 07/09/2023, 07/15/2023; second and third shift, 07/16/2023; second and third shift, 07/22/2023; second and third shift, 07/23/2023; second and third shift, 07/29/2023; second and third shift, 07/30/2023; second and third shift, 08/05/2023, and 08/06/2023; second and third shift. At 1:10 p.m., Assistant Admin B confirmed that Caregiver E has worked without qualified supervision without completing all trainings. Example 4- Caregiver F The record for Caregiver F, hired 07/21/2023, did not have evidence of training or documentation of	N 251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 251	Continued From page 18	N 251		

Caregiver F meeting an exception for client group and challenging behaviors.

At 12:55 p.m., Surveyor interviewed Marketing I and asked if there was documentation of Caregiver F receiving training in client group and challenging behaviors. Marketing I was on the phone with Licensee/Administrator A and relayed that s/he stated no because Caregiver F has not been employed for 90 days.

Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver F was trained by Caregiver G, who is not fully trained, on 07/25/2023, 07/26/2023 and 07/31/2023. Caregiver F worked alone on 08/01/2023, 08/02/2023, 08/03/2023, 08/08/2023 and 08/09/2023.

At 1:10 p.m., Assistant Admin B confirmed that Caregiver F has worked without qualified supervision without completing all trainings.

Example 5 - Caregiver G

The record for Caregiver G, hired 02/14/2023, did not contain evidence of training or evidence of meeting an exemption for department approved training in fire safety, medications and first aid and choking. At 12:55 p.m., Surveyor interviewed Marketing I and asked if there was documentation of Caregiver F receiving training or meeting an exemption for fire safety, medications, first aid and choking, client group and challenging behaviors. Marketing I was on the phone with Licensee/Administrator A and relayed s/he is aware Caregiver G has not received all required trainings.

On 08/09/2023, Surveyor verified Caregiver G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 251	Continued From page 19 was not on the Community-Based Care and Treatment training registry for fire safety or first aid and choking. Surveyor reviewed the staffing schedule for July and August 2023 which documented that Caregiver G worked alone on third shift on 07/27/2023 and worked 3rd shift on 07/25/2023 and 07/26/2023 training Caregiver F. At 1:10 p.m., Assistant Admin B confirmed that Caregiver G has worked without supervision and trained other caregivers without completing all trainings. On 08/11/2023 at 10:00 a.m., Surveyor interviewed Licensee/Administrator A in regards to staff training. Licensee/Administrator A stated that s/he is aware that not all the staff are fully trained. Licensee/Administrator A acknowledged that s/he is a department approved trainer for fire safety and that it is embarrassing on his/her part that staff have completed that training. Licensee/Administrator A stated that s/he will be contracting with a consulting company to ensure trainings are being completed. Cross Reference: N1096 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0215 DHS 83.15(3)(b) Administrator Responsible for Staff Training N0239 DHS 83.20(2)(a-d) Department Approved Training Courses	N 251		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the	N 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 362	Continued From page 20	N 362		

grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that a written summary of the grievance, the findings and the conclusion and any actions taken was provided to Resident 1's legal guardian after Friend L filed a grievance in regards to alleged abuse and neglect from Caregiver K to Resident 1.

Findings include:

On 07/10/2023 the department received a complaint alleging caregiver neglect and verbal abuse.

On 08/09/2023, Surveyor conducted 4 complaint investigations. At approximately 2:30 p.m., Surveyor interviewed Assistant Admin B and asked if s/he was aware of any grievances that have been filed. Assistant Admin B stated yes, s/he was aware that Friend L had filed a grievance against Caregiver K a few weeks ago. Surveyor asked who followed-up with the grievance. Assistant Admin B stated that s/he believes that Licensee/Administrator A conducted an investigation and did the required follow-up.

At 3:17 p.m., Surveyor interviewed Caregiver K. Caregiver K stated s/he was aware that Friend L filed a grievance against him/her after an altercation in the facility. Caregiver K provided Surveyor with a provider complaint form that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 362	Continued From page 21 documents that Friend L filed a grievance with the provider on 06/29/2023 about an interaction with Caregiver K on 06/27/2023. The document states, "What actions, if any, were taken to resolve the concern? Nothing yet." Surveyor asked if Caregiver K was aware of an investigation or any follow-up or actions taken after the grievance was filed. Caregiver K stated that s/he provided a written statement of the event after it happened on 06/27/2023 and that s/he saw a text from Part Owner N stating s/he was glad Caregiver K was able to keep his/her cool in the situation. Caregiver K stated that moving forward s/he will not provide cares for Resident 1 while Friend L is in the facility. On 08/11/2023 at 10:00 a.m., Surveyor interviewed Licensee/Administrator A in regards to Friend L's grievance. Licensee/Administrator A stated s/he was aware of Friend L's concerns and that Friend L has also talked to him/her about it. Surveyor asked if an investigation was completed. Licensee/Administrator A stated as far as s/he knows, yes, but s/he can't find any documentation of it. Licensee/Administrator A stated that as far as s/he knew, the previous assistant administrator had conducted an investigation and that s/he is not aware that anything was done for follow-up but s/he believes the previous assistant administrator had talked with Resident 1's legal guardian.	N 362		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health,	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 383	Continued From page 22 physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess Resident 3 for risks including elopement after his/her whereabouts were unknown and s/he was found in the parking lot. Findings include: On 08/03/2023 and 08/08/2023, the Department received a complaint related to supervision and Resident 3 eloping from the facility. The provider	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 383	Continued From page 23	N 383		

is a class CNA (non-ambulatory) community based residential facility able to serve up to 26 adults within the client groups of irreversible dementia/Alzheimer's and advanced age.

On 08/09/2023, Surveyor conducted 4 complaint investigations. At 12:15 p.m., Surveyor interviewed Assistant Admin B and asked if the provider had any recent elopements. Assistant Admin B stated yes, that Resident 3 had left the building about 2 weeks ago. Assistant Admin B stated that Resident 3 had left through the garage that's attached to the facility and a family member from the facility next door saw Resident 3 wandering in the parking lot and knew that wasn't right and brought him/her back.

Surveyor reviewed an incident report dated 07/28/2023 at 8:16 p.m. The report documents, "Resident eloped out of the garage door, resident was found outside the garage between both buildings. Brought [him/her] inside and got [him/her] ready for bed."

At 1:05 p.m., Surveyor interviewed Caregiver C, who was the only staff member working on the night of 07/28/2023. Surveyor asked how Resident 3 was able to leave the building on 07/28/2023. Caregiver C stated s/he was the only staff member working and s/he can manage, but some things don't get done and s/he can't be very attentive to all 20 residents when s/he is the cook, house keeper, caregiver, medication passer, everything. Caregiver C stated that Resident 3 will walk around the building but has never left before. Caregiver C stated that s/he went to the facility next door to get food and when s/he returned to the facility s/he heard the doorbell ring and it was a family member from next door returning Resident 3 to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 383	Continued From page 24 Caregiver C stated that s/he observed that the garage door was wide open, so Resident 3 must have opened it and left. Caregiver C stated that s/he looked over Resident 3's body and got him/her into pajamas. Resident 3 stated s/he was confused but that was his/her baseline. Caregiver C then stated that s/he reported the incident to Assistant Admin B. At 1:22 p.m., Surveyor interviewed Assistant Admin B and asked if Resident 3 was assessed for elopement after s/he left on 07/28/2023. Assistant Admin B stated no, s/he wasn't aware s/he had to.	N 383		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all 20 residents were provided adequate supervision on 07/28/2023 when Caregiver C left the facility. On the same day, Resident 3 had left the facility and was brought back by another resident's family member.	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 426	Continued From page 25 Findings include: On 08/03/2023 and 08/08/2023, the Department received a complaint related to the supervision of the facility and Resident 3 eloping from the facility during a storm. The provider is a class CNA (non-ambulatory) community based residential facility able to serve up to 26 adults within the client groups of irreversible dementia/Alzheimer's and advanced age. On 08/09/2023, Surveyor conducted 4 complaint investigations. At 12:15 p.m., Surveyor interviewed Assistant Admin B and asked if the provider had any recent elopements. Assistant Admin B stated yes, that Resident 3 had left the building about 2 weeks ago. Assistant Admin B stated that Resident 3's room is next to an exit door that leads into the facility's garage. Around 8:00 p.m. Resident 3 had walked out the exit door to the garage and the staff members had left the garage door open, so Resident 3 was found wandering outside in the parking lot and brought back by another family member. Surveyor asked what the staffing patterns are for each shift. Assistant Admin B stated ideally it would be 2 staff on first shift, 2 staff on second shift and 1 staff on third shift, but that the provider is trying to hire more caregivers because a lot of the time there is only 1 staff. Surveyor reviewed an incident report dated 07/28/2023 at 8:16 p.m. The report documents, "Resident eloped out of the garage door, resident was found outside the garage between both buildings. Brought [him/her] inside and got [him/her] ready for bed." Surveyor reviewed the facility staff schedule	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 426	Continued From page 26	N 426		

provided by Assistant Admin B which documents that Caregiver C was the only caregiver working on 07/28/2023 on second and third shift.

At 1:05 p.m., Surveyor interviewed Caregiver C and asked how many staff work on his/her scheduled shifts. Caregiver 3 stated a lot of the time s/he is the only staff in the building. Surveyor asked if Caregiver C has ever left the facility while s/he was the only staff working, specifically on 07/28/2022. Caregiver C stated yes, that s/he went to the facility next door to get food, leaving the building without a qualified resident care staff. Caregiver C stated that s/he did not know s/he could not leave the building, but s/he takes responsibility for that and that Licensee/Administrator A let him/her know that a resident care staff is not to leave the building unattended. Surveyor then asked about Resident 3 unknowingly leaving the building on 07/28/2023. Caregiver C stated s/he can usually manage being the only staff in the building, but some things don't get done and s/he can't be very attentive to all 20 residents when s/he is the cook, house keeper, caregiver, medication passer, everything. Caregiver C stated that Resident 3 will walk around the building but has never left before. Surveyor asked Caregiver C when s/he was made aware that Resident 3 had left the building. Caregiver C stated when s/he was brought back by a family member from next door.

When Caregiver C left the facility on 07/28/2023, there was not at least one qualified resident care staff present for the 20 residents in need of supervision; including residents with risk of elopement, some who have dementia and some who are unable to evacuate in under 4 minutes and are a point of rescue. At approximately 8:00 p.m. on 07/28/2023, Resident 3 was not provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 426	Continued From page 27 appropriate supervision to meet his/her needs when s/he was found in the parking lot unattended. According to www.weather.gov the temperature in Jefferson, WI on 07/28/2023 was 90 degrees and included an EF-1 tornado touching down in Jefferson county with winds peaking at 95 miles per hour.	N 426		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not have a weekly menu available to residents at the time of the survey. Repeat deficiency from statement of deficiency (SOD) L37L11, dated 04/14/2022. Findings include: On 08/02/2023, the Department received a complaint alleging that mealtimes are chaotic and residents do not get menus. On 08/09/2023, Surveyor conducted 4 complaint investigations. At approximately 12:00 p.m., Surveyor observed	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 450	Continued From page 28 residents eating lunch. Surveyor did not see a menu posted in or around the dining room or kitchen. At 1:50 p.m., Surveyor interviewed Resident 2 about the facility food and menus. Resident 2 stated that the provider used to hand out a weekly menu, and that was nice, but that hasn't happened in quite some time. Resident 2 stated that the residents find out what is being served when they get to the dining room. At 2:00 p.m., Surveyor interviewed Cook H, who was in the kitchen preparing food for dinner. Surveyor asked Cook H if there was a weekly menu available for residents. Cook H pointed to a menu on the refrigerator, that was not accessible to residents, and stated s/he was not aware that a weekly menu is required to be available for residents and that s/he just found out this morning. Cook H stated s/he will ensure each resident gets a weekly menu moving forward.	N 450		
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: Based on record review and interview, the provider did not ensure that a safe, comfortable and homelike environment for all 20 residents,	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 29	N 481		

including Resident 1 by being aware that Friend L was verbally aggressive to staff in Resident 1's room and common living spaces.

Findings include:

On 07/10/2023 the department received a complaint alleging caregiver neglect and verbal abuse.

On 08/09/2023, Surveyor conducted 4 complaint investigations. At approximately 2:30 p.m., Surveyor interviewed Assistant Admin B and asked if s/he was aware of any grievances that have been filed. Assistant Admin B stated yes, s/he was aware that Friend L had filed a grievance against Caregiver K a few weeks ago after a verbal altercation. Assistant Admin B stated that Friend L has been causing issues with staff since Resident 1 moved in and said that Resident 1 is very sweet and this behavior doesn't reflect him/her and his/her needs.

At 3:17 p.m., Surveyor interviewed Caregiver K. Caregiver K stated s/he got into a disagreement with Friend L about the placement of Resident 1's leg bag. S/he stated that Friend L became verbally aggressive, stated Caregiver K had to listen to Friend L and that Caregiver K kept trying to leave the conversation because s/he was uncomfortable that it was taking place in front of Resident 1. Caregiver K stated that Friend L would push Resident 1's call button to get Caregiver K back in there and then followed Caregiver K into the hallway and was yelling at him/her while s/he was heading to the dining room for breakfast. Surveyor asked if there were residents in the dining room at that time. Caregiver K stated yes, it was in the morning so everyone was in the dining room for breakfast.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 30	N 481		

Surveyor asked if Caregiver K notified anyone of the situation. Caregiver K stated that Previous Assist Admin M was made aware of the situation as soon as it happened. Surveyor asked what was done about it. Caregiver K stated that s/he filled out an incident report but that Licensee/Administrator A is aware and allows Friend L to treat caregivers that way.

Caregiver K provided Surveyor an incident report s/he filled out regarding his/her and Friend L's interactions on 06/27/2023. The incident report documents, "I was in [Resident 1's] room and in the process of switching [his/her] catheter bag from the night back to the day bag. (Which [s/he] refused until I told [him/her] that [s/he] has a visitor here to see [him/her] and that we needed to switch it) I noticed that the top strap of [his/her] leg bag was dirty, so I made a mental note to find a new strap and throw the old one away. Before I could even get started changing [his/her] bag, [Friend L] walked into the room, looked at the bag and said very aggressively, 'Really? You are going to put that [expletive] covered thing on [him/her]? That's [expletive] disgusting.' Then [s/he] went to the bathroom and brought out the new strap and threw it on the bed. I changed the bag and the strap and I didn't say anything. The whole time I felt very uncomfortable and threatened because [Friend L] not only essentially was swearing at me but was standing with [his/her] arms crossing glaring at me at the end of the bed. I felt too uncomfortable to even ask [him/her] to leave the room so I could complete my cares. I emptied [Resident 3's] night bag in the bathroom and came back into the room and asked [him/her] if [s/he] needed help with anything else, [s/he] did not. In the process of changing [his/her] bag, a little pee got on the side of [his/her] sheets and I told [him/her] I needed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 31	N 481		

change them but [s/he] did not want to get up. I knew [s/he] would be getting up for breakfast within the next hour so I told [him/her] that I would come back and change them for [him/her] at that time. Being that the urine was on THE SIDE of [his/her] bed and therefore not touching [his/her] skin/clothing and [s/he] refused. I went to leave [his/her] room and [Friend L] told me to come back by them. [S/he] then started telling me how to put the leg bag on correctly. I said, 'I know they are typically up higher but [Resident 1] does not like when the bag is placed up higher because it digs into the back of [his/her] knee. [S/he] prefers that it is placed near [his/her] ankle so that's why it's down lower.' [S/he] responded with, 'I don't care if [s/he] likes it there or not, and I honestly don't care what [s/he] says, YOU need to put it here.' I said, 'If [s/he] doesn't like it up there I am not going to put it there, I am going to put it where it is comfortable for [him/her] especially when [s/he] prefers to not wear the leg bag at all.' [Friend L] said something along the lines of, 'You have no idea what you are doing, and if you aren't going to do your job right, don't do it at all.' To which I responded with, 'Okay, you do it then.' Being that I was uncomfortable with the way I was being talked to, I asked [Resident 1] if [s/he] needed anything else and left the room. Later, [Resident 1's] button was pushed and [other caregiver] was assisting another resident. Because in my mind the situation was done and over with, I went to answer [his/her] light. I walked into [his/her] room and [Friend L] was making [his/her] bed and before I could even ask what [Resident 1] needed [Friend L] said, 'Now you little [girl/boy] are going to listen to me. If I am telling you do to something, you are going to do it.' I interrupted [him/her] and said, 'I am sorry but No I am not going to listen to you. [Resident 1] do you need anything from me?

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 32	N 481		

Was there a reason you pushed your button?' [S/he] shook [his/her] head no, so I went to leave the room. As I was exiting [his/her] room, [Friend L] was still raising [his/her] voice at me, which I was ignoring in hopes that the situation would not escalate further. I left [Resident 1's] room and was followed by [Friend L]. At this point I was shaking because I was so uncomfortable and [s/he] just kept going and would not leave me alone. When [Friend L] came into the hallways [s/he] said something like, 'I have been doing this for 35 years, so if I tell you something is done incorrectly, you are going to listen to me and you are going to fix it. If I tell you to do something you are going to do it. And if I say that you need to listen to me, then you are going to listen to me.' I said, '[Friend L] you are not my boss, and I am not going to sit here and listen to you when you are being disrespectful to me and making me feel uncomfortable. I don't really care how long you have done this for, I am not going to listen to you say to me that 'I am terrible at my job and I have no idea what I am doing just because I placed [his/her] leg bag where [S/HE] wanted it. I am sorry that you did not like the placement of [his/her] bag but you are not my boss and I don't have to do something a certain way just because you told me to. If you have a problem with my ability to provide care to these residents, you can go to [Assistant Admin B] or [Previous Assist Admin M) to express your concerns' and I continued to walk down the hallway. [S/he] then said something like, 'You DO have to listen to me. I am the boss. Whether you like it or not, I am the boss of you and EVERYONE ELSE when it comes to [Resident 1]. I am the boss. So you DO have to listen to me. [his/her] leg bag goes behind the knee and if you can't do your job right, then don't even do it at all. If you aren't going to listen to me or do what I tell you to do, then I am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 33	N 481		

going to make it so that you cannot go into [his/her] room at all, and you can't help [him/her] at all. You left [him/her] laying in a piss and [expletive] bed so clearly you don't know how to do your job correctly.' I responded with, 'If you want to do that, do it then. It's one less thing that I have to do at night. I have my CNA and have been doing this kind of work for a couple of years and I know very well that I do my job and I do it right. Since you've been doing this for so long, you should know that these residents have rights and if [Resident 1] does not want [his/her] leg bag behind the knee, I am not going to put it there. I am going to put it where [s/he] wants it because [s/he] has the right to make that decision for [him/herself]. That is [his/her] right. And yes [Friend L], [s/he] did have a pee spot on the side of [his/her] bed but [his/her] bed was not soaked with piss. And [s/he] did not want to get out of bed, which is [his/her] right. The pee wasn't touching [him/her] nor [his/her] clothing, so I can't/won't force [him/her] to get up. [S/he] and everyone else here have rights and it doesn't matter who you are or how long you have been doing this kind of work, we have to respect their rights. So if [s/he] wants [his/her] bag a certain way, I am going to put it that way. If s[/he] does not want to get out of bed earlier, I am not going to force [him/her]. I am no longer going to continue to argue with you and since [Resident 1] did not need anything I am leaving now.' As I was walking away (I was turning the corner to go to the dining room) [s/he] shouted, 'Oh, you can do your job and get [him/her] breakfast.' I said, 'No, I am not allowed in there, you can do it or I will find someone else to do it.' Then I gave [him/her] a thumbs up as I turned the corner and then had someone else take [Resident 1 his/her] breakfast. I went right away to [Previous Assist Admin M] and notified [him/her] about the incident. I did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 34	N 481		

go back into [Resident 1's] room until after [Friend L] left and when [s/he] pushed [his/her] button. When I went into [his/her] room the next time, I did apologize to [Resident 1] for my actions regarding the situation. [S/he] stated, 'it wasn't your fault.' I told her, 'My fault or not, right or wrong, the situation shouldn't have happened and that I am really sorry that your morning started like this.' Lastly, I do want to add that this is not the first time that [Friend L] has spoken disrespectfully to me and others."

Caregiver K was aware that Friend L filed a grievance about the interaction and provided Surveyor with the 'Family Complaint Form' Friend L filed on 06/29/2023. The complaint states, "Walked into room 10 - Resident was in bed - staff [Caregiver K] was switching over [his/her] cath bag to a leg bag. I stated you're not putting them straps on [his/her] when they are full of [expletive] - (staff said nothing). I went into the bathroom and found a clean strap - put it on Resident's bed and stated [s/he] could use this. Staff continued to do [his/her] thing - stated to Resident that [s/he] would have to change [his/her] bed later - emptied [his/her] bag in bathroom - I went over to get Resident up and asked staff to come here - I then tried to explain the proper way to put on a leg bag - staff informed me and I was not her boss and walked out of Rm. While I got Resident up I notified that [his/her] bed was soaked with urine. Took care of Resident and put [his/her] call light on - while I waited for staff to answer [his/her] call light, I stripped [his/her] bed and put clean linen on. Staff [Caregiver K] came in asked [Resident 1] what [s/he] wanted (very rude)- I stated that I would like [his/her] breakfast and then I state that [s/he] doesn't have to be so rude once again. [Caregiver K] told me that I wasn't [his/her] boss,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 35	N 481		

and that [s/he] went to school for [his/her] job - and I knew nothing about [his/her] job or Resident's Rights. Then I told [him/her] that [s/he] left the resident laying in a wet bed, which was not exceptable [sic] - and asked [him/her] how [s/he] would like it. Again [s/he] told me that I was not [his/her] boss and started out the door and down the hallway. I told [him/her that if [s/he] wanted to talk so smart and rude that [s/he] didn't need to come back to [Resident 1's] Rm. While [s/he] was walking down the hall - [s/he] flipped me off with [his/her] hand in the air and stated to me that would be fine - that [s/he wouldn't check [Resident 1] at all when [s/he] worked pms. I came back that evening on 06/27/2023 and spoke with [Assistant Admin B] and explained what happened."

At 3:27 p.m., Surveyor interviewed Caregiver C. Caregiver C stated that what happened with Friend L and Caregiver K is how Friend L usually acts to the caregivers and that nothing has been done about it. Surveyor asked Caregiver C if s/he has had any interactions with Friend L. Caregiver C stated yes, many times. That just the other week Friend L came into the medication room and harassed Caregiver C about his/her new position stating that it was not a good choice and s/he should not be in management. Caregiver C stated that Licensee/Administrator A has told him/her to ignore Friend L and that there is nothing s/he can do. Surveyor asked if there were any residents present when this happened. Caregiver C stated yes, that Friend L was raising his/her voice and the medication room is attached to the dining room, where residents were sitting. Caregiver C stated that s/he told Friend L that s/he was not allowed into the medication room and asked him/her to leave and then shut the door. Caregiver C stated that s/he shouldn't have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016540	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE JEFFERSON	826 REINEL STREET JEFFERSON, WI 53549

(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 481	Continued From page 36	N 481		

to be harassed by a resident's friend every time s/he comes to work.

At 4:10 p.m., Surveyor interviewed Resident 1. Surveyor asked Resident 1 if s/he has any visitors. Resident 1 stated that his/her [family member] comes and Friend L comes every afternoon. Surveyor asked if there have been any issues with guests coming. Resident 1 stated, "I don't know." Surveyor asked if Resident 1 had any concerns with the caregivers at the facility and how they interact and provide cares for him/her. Resident 1 stated no, that the staff take good care of him/her.

On 08/11/2023 at 10:00 a.m., Surveyor interviewed Licensee/Administrator A. Surveyor asked Licensee/Administrator A if s/he was aware of the way caregivers state that Friend L interacts with them. Licensee/Administrator A stated yes, I am completely aware of that. Surveyor asked what actions have been taken to ensure a safe, comfortable and homelike environment for the residents if Friend L is using aggressive language in Resident 1's room and in coming areas where other residents are present.
Licensee/Administrator A stated s/he doesn't think anything was done for follow-up.
Licensee/Administrator A stated that s/he did not know there was anything s/he could do and that moving forward s/he will have a conversation with Friend L and let him/her know that s/he is not to interact with staff and that if s/he has any concerns that s/he can come to me.