STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017383	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY AT NOEL MANOR (THE)	435 PRAIRIE OAKS BLVD VERONA, WI 53593

(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 06/04/2025, Surveyor conducted a standard survey at Legacy at Noel Manor, a CBRF in Verona. Four deficiencies were identified. Three deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 1IUL11, dated 12/30/2022 and SOD 1IUL12, dated 06/01/2023. Census: 30	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 caregivers reviewed had documentation of a background check following the procedures in s. 50.065, Stats., and ch. DHS 12. Caregiver B and Caregiver C did not have complete background checks in their employee file.	N 219		

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

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N 219	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) 1IUL11, dated 12/30/2022 and SOD 1IUL12, dated 06/01/2023. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 06/04/2025 at approximately 9:15 a.m., Surveyor requested Caregiver B and Caregiver C's record from RN A. On 06/04/2025 at approximately 10:00 a.m., Surveyor reviewed documentation, which indicated the following: - Caregiver B was hired on 07/03/2024. Caregiver B's record did not include a DOJ or IBIS. - Caregiver C was hired on 09/25/2024. Caregiver C's record did not include a BID. On 06/04/2025 at 12:10 p.m., Surveyor reviewed concern with RN A that Caregiver B and Caregiver C's documentation of background checks were incomplete. RN A acknowledged Surveyor's concern and stated his/her coworker was unable to locate documentation of the missing background checks.	N 219		

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N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employees reviewed, who required continuing education, had received at least 15 hours of continuing education per year. Caregiver D did not receive 15 hours of training in 2023 or 2024. Findings include: On 06/04/2025 at approximately 9:15 a.m., Surveyor requested Caregiver D's record, including 2023 and 2024 continuing education, from RN A. On 06/04/2025 at approximately 10:00 a.m., Surveyor reviewed documentation, which indicated Caregiver D was hired on 12/01/2016. Caregiver D's record indicated s/he had received the following continuing education in the past 2 years:	N 277		

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N 277	Continued From page 3 - 01/24/2023: Attendance and Punctuality (1 hour) - 03/14/2023: Annual Inservice Meeting (1 hour) - 06/20/2024 1:30 p.m.: "Annual Training" that included medication administration, skills refresher, nurse call system, incident reports and "RA" quick reference. *No documentation regarding the length of this training. On 06/04/2025 at 10:50 a.m., Surveyor reviewed concern with RN A that Caregiver D did not complete 15 hours of continuing education in 2023 or 2024. RN A replied, "You're correct. [S/he] didn't have much." RN A stated the provider began using an electronic continuing education program in 2025, which should hopefully resolve concerns related to continuing education.	N 277		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the	N 389		

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N 389	Continued From page 4	N 389		

provider did not ensure 1 of 3 residents reviewed had his/her individual service plan (ISP) updated when there was a change in his/her needs. Resident 2's ISP was not updated to include his/her risk of elopement.

This is a repeat deficiency. See Statement of Deficiency (SOD) 1IUL11, dated 12/30/2022.

Findings include:

On 06/04/2025 at approximately 7:00 a.m., Surveyor reviewed the department's facility record, which included the following self-reports:

- 04/19/2025: Resident 2 was found, by a staff member that had gone out on break, walking toward a gas station. When staff checked Resident 2's room, staff observed the window screen had been pushed out and the window was open. Intervention was to place an alarm between the screen and window.
- 04/22/2025: Resident 2 was observed walking outside the facility. When staff checked Resident 2's room, staff observed the window screen had been pushed out and the window was open. Intervention was to complete 15-minute checks and have family hire an individual to accompany Resident 2 on daily walks.
- 04/26/2025: At approximately 11:55 a.m., staff were unable to locate Resident 2. Resident 2's family contacted Resident 2 via cell phone and learned s/he was walking back to the facility from a restaurant approximately 1 mile from the facility. Cameras indicated Resident 2 exited the facility through the front door after a staff member had walked in and turned the other way before the front door lock (delayed egress) had engaged. Intervention was for medication changes, re-education regarding 15-minute checks,

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N 389	Continued From page 5 ensuring entrance doors were fully locked before leaving the area and reiterating the importance with Resident 2 to not leave the facility unattended. On 06/04/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 2's record, provided by RN A. Resident 2 was admitted to the provider's facility on 01/20/2025 with diagnosis of frontotemporal dementia. Resident 2's ISP, dated 03/18/2025, did not identify that s/he was an elopement risk and did not include interventions to prevent elopements. On 06/04/2025 at 11:25 a.m., Surveyor shared concern with RN A that Resident 2's ISP was not updated to include his/her needs related to his/her elopement risk. RN A reviewed Resident 2's record and responded, "You are correct."	N 389		
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	N 431		

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N 431	Continued From page 6 CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of 1 of 3 residents reviewed was monitored and documented in the resident's record. Resident 1's blood sugar (BS) was not rechecked as ordered and Resident 1's physician was not notified as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) 1IUL11, dated 12/30/2022. Findings include: On 06/04/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/30/2023 with diagnoses including diabetes and vascular dementia. Resident 1's physician orders and Medication Administration Record (MAR), dated 05/01/2025 to 06/04/2025, identified the following concerns with diabetic management and monitoring: Blood Sugar <70: Resident 1' s physician orders included an order dated, 01/30/2025, that instructed staff to hold	N 431		

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N 431	Continued From page 7	N 431		

insulin for a BS less than 70, recheck 20 minutes after corrective action had been taken and administer insulin if BS was then greater than 100.

Resident 1's MAR documented the following dates when his/her BS was below 70, indicating corrective action should have taken place and a repeat BS taken after 20 minutes:

- 05/06/2025 at 4:00 p.m. BS 42 *Glucose chew tablet administered at 3:59 p.m. No recheck documented.
- 05/07/2025 at 2:00 a.m. BS 63 *No corrective action or recheck documented.
- 05/07/2025 at 8:00 a.m. BS 64 *No corrective action or recheck documented.
- 05/07/2025 at 4:00 p.m. BS 64 *No corrective action or recheck documented.
- 05/10/2025 at 4:00 p.m. BS 31 *No corrective action or recheck documented.
- 05/12/2025 at 2:00 a.m. BS 43 *No corrective action or recheck documented.
- 05/12/2025 at 12:00 p.m. BS 57 *No corrective action or recheck documented.
- 05/13/2025 at 2:00 a.m. BS 59 *No corrective action or recheck documented.
- 05/14/2025 at 12:00 p.m. BS 55 *No corrective action or recheck documented.
- 05/16/2025 at 5:00 p.m. BS 68 *No corrective action or recheck documented.
- 05/22/2025 at 5:00 p.m. BS 51 *No corrective action or recheck documented.
- 05/26/2025 at 8:00 a.m. BS 64 *No corrective action or recheck documented.
- 05/30/2025 at 12:00 p.m. BS 60 *No corrective action or recheck documented.

Blood Sugar >450:

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N 431	Continued From page 8 Resident 1' s physician orders included an order dated, 01/30/2025, that instructed staff to give insulin as ordered and update RN for a BS over 450, recheck in 4 hours and contact RN and Endocrinology clinic to report if BS remained over 450 (Start Date: 01/30/2025). Resident 1's MAR documented the following occurrences when his/her BS was greater than 450: - 05/03/2025 at 8:00 p.m. BS 510 - 05/04/2025 at 8:00 a.m. BS 546 - 05/14/2025 at 4:00 p.m. BS 459 - 05/14/2025 at 8:00 p.m. BS 600 - 05/15/2025 at 8:00 a.m. BS 467 - 05/20/2025 at 8:00 a.m. BS 515 - 05/21/2025 at 12:00 p.m. BS 549 - 06/04/2025 at 8:00 a.m. BS 503 Resident 1's record did not include documentation indicating the RN was updated or that a recheck occurred to determine whether Resident 1's physician needed to be updated of the BS. Recheck with Glucose PRN Administration: Resident 1 had a physician order, dated 10/27/2023, to take 1 Glucose chewable tablet for BS under 50, recheck BS 15 minutes later, take another tablet if BS remained 50-70, recheck BS 15 minutes later and repeat steps until BS was above 70. The MAR, dated 05/01/2025 to 06/04/2025, documented the following administrations of Glucose chewable tablets with no follow up BS check documented:	N 431		

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N 431	Continued From page 9 - 05/10/2025 at 4:00 p.m. BS 31 - 05/12/2025 at 2:00 a.m. BS 43 On 06/04/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 1's physician orders and resident record with RN A. RN A explained that staff were to complete corrective action, such as PRN administration, for a BS of approximately 30-40, but that a corrective action for a BS in the 50-70 range was not specified. Surveyor requested a physician order for clarification. RN A then explained that there was not a physician order clarifying the corrective action for a BS in the 50-70 range. RN A read Resident 1's physician orders, confirmed staff should be completing rechecks based on the order and confirmed Resident 1's record did not include documentation of rechecks. RN A stated s/he would reach out to Resident 1's physician to obtain more specific orders related to Resident 1's diabetic management.	N 431		