STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110522	A. BUILDING: _____ B. WING _____	C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANE COUNTY CARE CENTER	300 FEMRITE DR MONONA, WI 53716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 10/01/2025, Surveyors conducted a self-report investigation at Dane County Care Center. One deficiency was identified. Census: 19	N 000		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide or arrange services adequate to meet the behavioral needs of Resident 2 and his/her documented hypersexuality towards peers and staff. Findings include: On 08/29/2025, the Department received a self-report documenting a sexual assault that had been reported. On 10/01/2025, Surveyors conducted a self-report investigation. Surveyor reviewed a Client Involved Adverse	N 433		

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

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N 433	Continued From page 1 Incident Reporting Form dated 08/27/2025 documenting that around 8:00 a.m., the provider received a call from Family Member D alerting them that Resident 1 had called him/her this morning from the unit bathroom stating that other clients on the unit have been sexually inappropriate towards Resident 1. Family Member D reported that Resident 1 was not feeling safe and asked what corrective action was going to be taken. Resident 1 then reported s/he had moved into a room with Resident 2 and that Resident 2 allowed Resident 3 into their room and stated Resident 1 and Resident 3 should "be together". Resident 1 reported that Resident 2 made comments about Resident 3's genitalia and encouraged Resident 1 to feel it and that the situation escalated from there. Surveyor reviewed the record of Resident 2. Resident 2 was admitted to the provider on 07/29/2025 with diagnoses including unspecified psychosis and unspecified schizophrenia spectrum and other psychotic disorder. Surveyor reviewed Resident 2's progress notes which documented: - 8/10/2025; Resident 2 has exhibited symptoms of the pseudobulbar effect, signs of responding to internal stimuli. Resident 2 presented with compulsive decluttering. a/v (audio/visual) hallucinations and delusions. Resident 2 expressed symptoms of inappropriate closeness and hypersexuality expressing to staff comments staff's body and "liking writer's body" and "we could fall in love sometime". -08/17/2025; Staff had to remind Resident 2 to be appropriate and keep (his/her) hands to themselves and not touch anyone. Staff had concerns other than Resident 2 making sexual advances towards staff and other client's	N 433		

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N 433	Continued From page 2	N 433		

conversation with supervisors may need to take place.
-08/20/2025; Resident 2 continues to need reminders to respect physical boundaries with staff and peers.
-08/20/2025; Resident 2 was overly sexual with staff and residents. Resident 2 was talked to multiple times about this behavior throughout the day.
-08/22/2025; Resident 2 required several reminders to be mindful of healthy communication and respectful of personal boundaries with staff and peers.
-08/24/2025; Resident 2 demonstrates poor boundaries and often needs to be reminded but is redirectable.
-08/25/2025; Resident 2 required several reminders to be mindful of healthy communication and respectful of personal boundaries with staff and peers. Resident 2 seemed to reflect and apologize each time.
-08/26/2025; "[Resident 2] displayed a labile affect today as they quickly switched from angry to happy to flirtatious to euphoric and back. [Resident 2] went into the case managers office and grabbed their case manager by the end and kissed their face which was met with stern disapproval from the case manager and staff. [Resident 2] has been talked to many times about their flirtatious behavior but client does not seem to be able to resist impulses as they arise to act out sexually or overly affectionately."

Surveyor reviewed Resident 2's progress note for discharge, dated 08/27/2025, that documented: "Discharge Type: Administrative discharge (initiated by the agency)

Reason for (administrative discharge type): Violation of Program Rules...

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N 433	Continued From page 3 Metal Status at the time of discharge: Not stable... Presenting Concern: [Resident 2] was referred to Dane County Care Center from law enforcement for the purpose of connection to resources, medication stabilization, mental health services, psychiatric stabilization and respite. This stay was precipitated due to presentation of psychiatric symptoms such as angry, anxious, depressed (lacks hope, energy, ect.), suicidal thoughts of actions. Client presented with organized thought process, attending to internal stimuli and delusions. Progress in Treatment: ...Minimal change was seen and [Resident 2] started displaying hypersexual behaviors. Prescriber increased Lexapro to help with [his/her] hypersexual to 10mg 3 times daily and the risperidone was discontinued and changed to start Aripiprazole at 10mg. [Resident 2] continued to decompensate on unit was seen throwing a full cup of milk at another client and became slightly aggressive with other clients and was hard to redirect. Prescriber then used the Apipiprazole dosage to 15mg on Monday. Since the change in medication [Resident 2] did not improve with any medication changes, [Resident 2] had kissed multiple other clients on unit made sexual comments to them asking them to get in [his/her] bed, as well engaging in sexual intercourse with another client [Resident 3] on unit last night which is also not tolerated on unit. ..." Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the facility on 08/26/2025 with diagnoses including substance use disorder and depression.	N 433		

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N 433	Continued From page 4 Surveyor reviewed Resident 1's intake progress note, dated 08/26/2025 at 10:54 p.m., which documented, "Client was respective of being here, despite [his/her family] wishes. [S/he] realized [s/he] needs help and is open to talking about [his/her] concerns but needs direction on how to get it." Surveyor reviewed Resident 1's progress note of the client rights incident, dated 08/27/2025, that documented, "[Family Member D] called the unit around 8 a.m. and informed writer that [Resident 1] was involved in an incident...[Resident 1] appeared distressed evidenced by some tears. Writer immediately contacted program supervisor and client rights officer." Surveyor reviewed Resident 1's progress note for discharge, dated 08/27/2025 at 9:00 a.m., that documented that Resident 1 had moved into Resident 2's room upon admission the night prior. Resident 2 had invited Resident 3 into their shared room and encouraged Resident 1 and Resident 3 to "be together." Resident 2 stated that Resident 1 and Resident 3 could use Resident 2's bed and then grabbed Resident 1's hand to feel Resident 3's genitalia. Resident 1 stated s/he did not consent to this or the sexual assault that occurred after. Resident 1 reported feeling uncomfortable and no longer feeling safe at the facility. Resident 1's discharge also documented, "Progress in Treatment: [S/he] arrived in the evening of 8/26/25. In the morning of 8/27/25, [s/he] reported being sexually assaulted by another client. [S/he] requested to press charges. [S/he] was taken to outpatient to be with the Director of Client Rights and to be away from the	N 433		

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N 433	Continued From page 5 unit. Police were called, and [s/he] made a report. [S/he] was taken to [Hospital G] via police for a SANE (sexual assault nurse exam) exam. Staff drove [him/her] back to [facility] and coordinated an admission to [Facility H] as [s/he] no longer felt safe at the care center. [S/he] was accepted into [Facility H]. [His/her] [family] picked [him/her] up and planned to drive [him/her] to [Facility H]." On 10/01/2025 at approximately 10:30 a.m., Surveyors reviewed the above concerns with Program Supervisor A, Facilities Director B, and Dir of Emergency Srvs C. Surveyor reviewed the census of 19 with a facility capacity of 38 and asked if there were other available rooms Resident 1 could have admitted into besides Resident 2's room. Program Supervisor A stated yes. Surveyor asked what type of behavioral management interventions were in place for Resident 2, with his/her documented behavior of impulse control and hypersexual behavior, to insure Resident 1's safety as his/her new roommate. Program Supervisor A stated that Resident 2 was seeing his/her prescriber twice a week for medication changes. Program Supervisor A stated that no other interventions or safety plans were in place besides verbal redirection and standard checks on residents.	N 433		