STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510311	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE MANOR	508 E MONROE AVE BARRON, WI 54812

(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 07/14/2025, Surveyors conducted a standard survey, complaint investigation, and self-report investigation at Monroe Manor. Data was collected through 07/15/2025. Three of 3 complaints were unsubstantiated. Three new violations were identified. One is a repeat deficiency. See Statement of Deficiency (SOD) YMCL11, dated 05/05/2021. Census: 65.	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 staff sampled were screened for communicable disease, including tuberculosis (TB), upon hire. Findings include:	N 220		

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

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N 220	Continued From page 1 The provider is licensed to care for 82 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced aged. On 07/14/2025, Surveyor reviewed 4 staff files. Caregiver A was hired 06/02/2023. Caregiver A's file did not contain evidence s/he was tested for TB within 90 days before hire. Caregiver B was hired 06/30/2023. Caregiver B's file did not contain evidence s/he was screened for communicable, disease including TB, within 90 days before hire. Caregiver C was hired 02/19/2025. Caregiver C's file did not contain evidence s/he was screened for communicable disease within 90 days of hire. On 07/15/2025, from 2:15 PM to 3:14 PM, Surveyor interviewed Administrator D, who stated Finance Director (FD) E knew communicable disease screens and TB tests were completed upon hire but was unable to find the documentation. Administrator D stated the Human Resources Director (HRD) F was responsible for communicable disease, including TB, but s/he had been terminated on 07/10/2025. The provider did not ensure all staff were screened for communicable disease, including TB, upon hire.	N 220		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF	N 404		

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N 404	Continued From page 2 employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a physician, pharmacist, or registered nurse (RN) conducted an annual onsite review of the provider's medication administration and medication storage systems. Findings include: The provider is licensed to care for 82 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/14/2025 at approximately 9:40 AM, Surveyors requested the annual medication regimen reviews for 2023 and 2024. Administrator D was able to provide a 2023 annual medication regimen review but stated s/he	N 404		

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N 404	Continued From page 3 wasn't sure where the 2024 review was. At approximately 9:40 AM, Surveyors interviewed Administrator D. Administrator D stated the provider had switched pharmacies in 2025, and that the 2024 medication review could be on file at the old pharmacy. S/he contacted the pharmacy, which was also unable to provide documentation of the review. Administrator D stated a staff member who no longer worked at the provider had filed the 2024 review and that s/he would continue to search for it. On 07/15/2025 at approximately 12:03 PM, Administrator D stated s/he was unable to provide an annual medication regimen review for 2024. The provider did not ensure an annual medication administration was completed.	N 404		
N 636	83.59(1)(f) Exit passageways, stairways: width maintained All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit passageways and stairways to outside exits shall be at least 36 inches in width and maintained clear and unobstructed at all times. Exit passageways and stairways to outside exits shall be at least 32 inches in width in facilities licensed on or before the effective date of this section. In existing large facilities, the minimum corridor width shall be at least 4 feet. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 636		

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N 636	Continued From page 4	N 636		

did not ensure all exits were unobstructed. The exit stairwell on the southwest hall of the main floor had a Velcro netting barrier and artificial tree blocking it.

This is a repeat violation. See Statement of Deficiencies (SOD) YMCL11, dated 05/05/2021.

Findings include:

The provider is licensed to care for 82 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced aged.

On 07/14/2025, at approximately 9:06 AM, during a tour of the facility, Surveyors observed an artificial tree blocking the stairwell of the southwest exit on the upper floor. Surveyors also observed a netted, Velcro barrier placed across the doorway. The barrier was placed approximately waist high and was approximately 1 foot tall. The barrier displayed a stop sign graphic. Surveyors observed that the stairwell's light was not on.

Surveyors reviewed the provider's exit map posted throughout the facility. The map indicated the blocked exit was a designated emergency exit.

On 07/14/2025 at approximately 9:40 AM, Surveyors shared findings with Administrator D. Administrator D stated the artificial tree was not supposed to be blocking the exit but the barrier was there to discourage residents from using the stairwell and exit.

On 07/15/2025 at approximately 2:15 PM, Surveyor interviewed Administrator D, who stated

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N 636	Continued From page 5 the barrier had been in place for over a year. The provider did not ensure that a stairway to an outside exit was maintained clear and unobstructed at all times.	N 636		