STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008499	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSALIA GARDENS	519 FLIGHT RD ANTIGO, WI 54409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 03/10/2025, Surveyor conducted an abbreviated licensure survey, complaint investigation and self-report investigation at Rosalia Gardens. Data collection continued through 03/11/2025. The complaint was unsubstantiated. The self-report was closed. Two deficiencies were identified. Census: 34	N 000		
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 adequate supervision to meet the needs of Resident 1. Findings include: The provider is licensed to care for up to 43 residents in the following client groups:	N 426		

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

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N 426	Continued From page 1 Irreversible dementia/Alzheimer's disease and advanced aged. On 12/02/2024, the Department received a self-report indicating Resident 1 eloped on 11/24/2025. Resident 1 fell outside the facility and was hospitalized. Resident 1 died at the hospital on 11/26/2024. On 03/11/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 02/08/2022. Resident 1 died on 11/26/2024. Resident 1's diagnoses included Lewy body dementia with behavioral disturbance. According to an AM progress note, dated 11/24/2024, staff noted: "PRN Alprazolam given for agitation and restlessness. Very little effectiveness. Did not try to elope today but lots of 1:1 with staff. Packing room. Refused to change out of pjs (pajamas). According to a PM progress note, dated 11/24/2024, staff noted: "Ate in DR (dining room). As soon as supper was over [sic] res [sic] was gathering clothes & jackets from room & exit seeking, Med RA (resident assistant) went to MC (memory care) to administer insulin and res (resident) eloped, ended up falling outside on sidewalk by medical building. 911 called & res went to ER (emergency room), update is they're admitting [him/her] with a severe brain bleed." According to a facility self-report, dated 11/24/2024 (time of incident: 5:46 PM), Clinical Consultant (CC) A noted, "Resident, ... with progressive lewy [sic] body dementia who eloped from the facility on 11/24/2024 and then sustained an unwitnessed fall. Day of the elopement [sic] [s/he] was described as restless and agitated. Prior to the event [sic] staff making attempts to calm and redirect [him/her]. Resident was exit seeking and staff had ensured that all of the exit	N 426		

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N 426	Continued From page 2	N 426		

doors on the unit were locked to promote safety. During this time [sic] resident then went to the locked front door of the facility and was able to open the door by triggering the fire release mechanism by holding down the door handle for 15 seconds. The resident then eloped. The wander guard sounded, a resident assistant responded to the alarm and went outside to look for the resident. The response time from the patient exiting the building to the staff exiting to follow [him/her] was 49 seconds. Resident was found by staff outside on the ground, fall was not witnessed by staff. Staff immediately called 911 and patient was transported to the emergency room." CC A noted, "Investigation also revealed that resident did not receive [his/her] bedtime dose of Seroquel from Thursday [sic] 11/21/2024 [sic] until [s/he] fell and was hospitalized on Sunday, 11/24/2024."

According to a "Root Cause Analysis (RCA) - Action Plan," dated 11/27/2024, about Resident 1's elopement, the provider noted, "Contributing Factor Statement: Medication omission/Resident missed the bedtime dose of scheduled Seroquel on 11/21/2024, 11/22/2024 and 11/23/2024. As patients [sic] were experiencing an escalation of behavior at time of the fall question of [sic] if this missed dose could have contributed (to) the behaviors and exit seeking."

On 03/11/2025 at approximately 12:45 PM, Surveyor interviewed CC A via telephone. Surveyor asked CC A about Resident 1's elopement on 11/24/2024. CC A confirmed Resident 1 eloped on 11/24/2024 and staff did not see Resident 1 go outside on 11/24/2024. CC A also confirmed Resident 1 did not receive Seroquel as prescribed on 11/21/2024, 11/22/2024 and 11/23/2024.

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N 426	Continued From page 3 The provider did not ensure adequate supervision for Resident 1. Cross Reference N0432 DHS 83.38(1)(h) Medication Administration	N 426		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration 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 medication administration to meet the needs of Resident 1. Findings include: The provider is licensed to care for up to 43 residents in the following client groups: Irreversible dementia/Alzheimer's disease and advanced aged. On 12/02/2024, the Department received a self-report indicating Resident 1 eloped on 11/24/2025. Resident 1 fell outside the facility and was hospitalized. Resident 1 died at the hospital	N 432		

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N 432	Continued From page 4 on 11/26/2024. On 03/11/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 02/08/2022 and died on 11/26/2024. Resident 1's diagnoses included Lewy body dementia with behavioral disturbance. According to Resident 1's medication administration record (MAR), dated 09/04/2024, Resident 1 was prescribed Quetiapine (Seroquel) Fum 50 Mg Tab (Take 1 and 1/2 Tablets [75 MG] By Mouth at Bedtime). According to a facility self-report, dated 11/24/2024 (time of incident: 5:46 PM), Clinical Consultant (CC) A noted, "Resident, ... with progressive lewy [sic] body dementia who eloped from the facility on 11/24/2024 and then sustained an unwitnessed fall. Day of the elopement [sic] [s/he] was described as restless and agitated. Prior to the event [sic] staff making attempts to calm and redirect [him/her]. Resident was exit seeking and staff had ensured that all of the exit doors on the unit were locked to promote safety. During this time [sic] resident then went to the locked front door of the facility and was able to open the door by triggering the fire release mechanism by holding down the door handle for 15 seconds. The resident then eloped. The wander guard sounded, a resident assistant responded to the alarm and went outside to look for the resident. The response time from the patient exiting the building to the staff exiting to follow [him/her] was 49 seconds. Resident was found by staff outside on the ground, fall was not witnessed by staff. Staff immediately called 911 and patient was transported to the emergency room." CC A further noted, "Investigation also revealed that resident did not receive [his/her] bedtime dose of Seroquel from Thursday [sic] 11/21/2024 [sic] until [s/he] fell and was	N 432		

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N 432	Continued From page 5 hospitalized on Sunday, 11/24/2024." According to a "Root Cause Analysis (RCA) - Action Plan," dated 11/27/2024, about Resident 1's elopement, the provider noted, "Contributing Factor Statement: Medication omission/Resident missed the bedtime dose of scheduled Seroquel on 11/21/2024, 11/22/2024 and 11/23/2024. As patients [sic] were experiencing an escalation of behavior at time of the fall [sic] question of [sic] if this missed dose could have contributed the behaviors and exit seeking." On 03/11/2025 at approximately 12:45 PM, Surveyor interviewed CC A via telephone. Surveyor asked CC A about Resident 1's elopement on 11/24/2024. CC A confirmed Resident 1 eloped on 11/24/2024. CC A confirmed Resident 1 did not receive Seroquel as prescribed on 11/21/2024, 11/22/2024 and 11/23/2024. The provider did not ensure medication administration for Resident 1. Cross Reference N0426 DHS 83.38(1)(b) Supervision.	N 432		