STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 07/06/2023-07/20/2023, Surveyor conducted a standard survey, 3 complaint investigations, 2 self-report reviews and a verification visit at Hilltop Of Pepper, a Community-Based Residential Facility (CBRF) in Wisconsin Rapids, WI. 10 deficiencies identified. Four of the ten deficiencies are repeat deficiencies. Under statutory provision of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 19	{N 000}		
{N 161}	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate an injury that was not observed by any person, the source of the injury could not be adequately explained by the resident and/or the injury to the resident appeared to be suspicious because of the extent of the injury or the location of the injury on the resident for Resident 1. This is a repeat deficiency from Statement of Deficiency (SOD) #9S8811 dated 05/05/2022.	{N 161}		

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
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 161}	Continued From page 1 Findings include: On 07/06/2023-07/20/2023, Surveyor conducted a standard survey, 3 complaint investigations, 2 self-report reviews and a verification visit. On 07/12/2023, the department received a self-report regarding Resident 1. The self-report stated Resident 1 had an incident with injury with a caregiver. The self-report stated Resident 1 had a body assessment to ensure s/he did not have any injuries. While completing the body assessment, Assistant Director B stated Resident 1 had a mark on his/her thigh that looked like scratch that was healing. On 07/20/2023, Surveyor requested to review the documentation/investigation of Resident 1's mark on his/her thigh. On 07/20/2023 at approximately 10:30AM, Director A stated, "[Resident 1] scratches [himself/herself] and staff witness [him/her] doing this. [S/he] pulls up the bottoms of [his/her] pants and scratches [his/her] legs (those are the marks in the front). [S/he] also pulls up [his/her] shorts or pants and hangs onto them. [S/he] digs [his/her] fingers into the fabric and [his/her] legs where [his/her] hands naturally fall. [S/he's] been seen picking at the spot on [his/her] thigh." Surveyor asked Director A if s/he had completed an investigation on this incident since it was not observed by any person and the source of the injury could not be adequately explained by the resident. Director A stated s/he had just talked to some of the care staff about it. Surveyor requested documentation of any investigation conducted on it. Director A stated s/he did not do an investigation or document any conversations	{N 161}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 161}	Continued From page 2 related to the injury. Director A stated moving forward s/he will document this information on the body assessment form.	{N 161}		
N 304	83.28(5) Temporary service plan. Temporary service plan. Upon admission, the CBRF shall develop a temporary service plan as required under s. DHS 83.35(2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop a temporary service plan as required for Resident 1. Findings Include: On 07/06/2023, Surveyor requested to review Resident 1's records. Resident 1 was admitted on 11/18/2022. Resident 1 had comprehensive ISP dated 02/16/2023. On 07/06/2023 at approximately 10:45 AM, Surveyor requested to review Resident 1 and Resident 2's temporary service plan upon admission. Director A stated they do not do temporary service plans for residents. Director A stated they just start with a comprehensive individual service plan (ISP). Director A acknowledged moving forward, each resident should have a temporary service plan upon admission.	N 304		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 389	Continued From page 3 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, interview and observation, the provider did not review one of one resident's Individual Service Plan (ISP) when there was a change in Resident 1's needs, abilities or physical or mental condition. This is a repeat deficiency from Statement of Deficiency (SOD) #4O1R11 dated 12/04/2019. Findings include: On 03/28/2023, the department received a complaint that alleged residents were not receiving the services to meet their needs. On 07/06/2023, Surveyor requested to review Resident 1's record. Resident 1 was admitted to the facility on 11/18/2022 with diagnoses of depression, low back pain and Alzheimer's dementia. At the time of admission, Resident 1 was independent with ambulation and transfers.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 389	Continued From page 4 Resident 1's hospital discharge notes indicated Resident 1 sustained a hip fracture on 02/27/2023. Resident 1 was admitted to the hospital for surgery and rehab from 02/27/2023-03/15/2023. Resident 1's hospital discharge notes stated Resident 1 was being discharged with Home Health Services for physical therapy. Resident 1's progress notes on 03/15/2023 stated, "[Resident 1] returned to facility at 10:00 AM. Was able to bear weight and pivot with assistance, was also taking steps." Resident 1's progress notes on 03/27/2023 stated, "Physical therapy came, walked with [Resident 1]. Please walk with [Resident 1] as much as possible, it is best for [his/her] hip healing." On 07/06/2023, Surveyor requested to review Resident 1's most current ISP. Resident 1's ISP was dated 02/16/2023. Resident 1's ISP stated Resident 1 was ambulatory and needed some assistance with transfers. Resident 1's ISP did not indicate Resident 1 had a fractured hip and did not indicate Resident 1 was receiving physical therapy services and needed assistance with ambulation and transfers. On 07/06/2023 at approximately 2:50 PM, Surveyor reviewed the above concern with Director A. Director A stated s/he did not update Resident 1's ISP with the information after Resident 1 discharged back to the facility.	N 389		
{N 408}	83.37(1)(i) PRN psychotropic medication.	{N 408}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 408}	Continued From page 5 As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN (as needed) psychotropic medication in Resident 2's Individual Service Plan (ISP). This is a repeat deficiency from Statement of Deficiency (SOD) #9S8811 dated 05/05/2022. Findings include: On 07/06/2023, Surveyor requested to review Resident 2's record. Resident 2 was admitted to the facility on	{N 408}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 408}	Continued From page 6 02/01/2023 with diagnoses of dementia, multiple pulmonary emboli, and CHF. Resident 2 had a Physician Order for Lorazepam 0.5 Mg tablet to be taken every 6 hours as needed and Haloperidol 0.5 Mg tablet to be taken every 6 hours as needed. Resident 2's most current ISP was dated 02/01/2023. Resident 2 did not have an ISP that identified s/he was on PRN Lorazepam 0.5 mg and Haloperidol 0.5 mg and did not include a rationale for use nor a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. On 07/06/2023 at approximately 3:00 PM, Surveyor reviewed the above concern with Director A. Director A acknowledged Resident 2's psychotropic PRN medications and/or the rationale for the medication was not listed in the ISP.	{N 408}		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not administer injectables by a registered nurse or a licensed	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 416	Continued From page 7	N 416		

practical nurse within the scope of the license. Medication administration described under sub. (2)(e) was not delegated to non-licensed employees pursuant to s.N6.03(3).

Findings include:

On 07/06/2023 at approximately 11:50 AM, Surveyor observed Caregiver C's noon medication pass. Caregiver C prepped 1 unit of insulin for Resident 3 and injected insulin into Resident 3's abdomen. Caregiver C went back to the medication cart, documented insulin given, removed gloves and sanitized hands.

On 07/06/2023 at approximately 2:15 PM, Surveyor interviewed Director A and Assistant Director B and asked if all staff were medication delegated by an RN. Director A and Assistant Director B stated yes they were and three of the residents receive insulin.

On 07/06/2023, Surveyor requested to review Caregiver C's employee file. Caregiver C was hired 03/21/2023. Surveyor did not observe RN delegation records for Caregiver C.

On 07/06/2023 at approximately 2:20 PM, Director A stated that s/he could not locate Caregiver C's RN delegation. Director A asked Assistant Director B if Caregiver C had been delegated to. Assistant Director B stated s/he must not have been since s/he had started and had all his/her approved certifications. Director A told Assistant Director B to put Caregiver C on the list for when the consulting RN comes back to conduct delegations. Director A did not indicate when this would be.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 427	Continued From page 8	N 427		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure a daily activity program to meet the interests and capabilities of the residents. While present at the facility from approximately 8:30 AM to 3:00 PM, Surveyor did not observe residents engaged in activities. Findings include: The provider is licensed to serve up to 22 residents with diagnoses of advanced age and irreversible dementia/Alzheimer's. On 07/06/2023, Surveyor conducted a standard survey, 3 complaint investigations, 2 self-report reviews and a verification visit. Surveyor requested a copy of the provider's activity schedule and made observations. While present at the facility from approximately	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 427	Continued From page 9 8:30 AM to 3:00 PM., Surveyor did not observe activity programs taking place. Surveyor observed residents sitting in the dining room, walking around the facility and spending time in their own rooms watching television or sleeping. At approximately 10:00 AM, Surveyor interviewed Caregiver C. Surveyor asked about the daily activity programing. Caregiver C stated that there was an activities calendar posted by the dining room but the activity person had been out for the last few weeks. Surveyor asked if caregivers were to perform the activities while the activity person was out. Caregiver C stated that if there isn't an activity person then they were supposed to do activities between cares, passing meds and housekeeping which typically they don't have time to do. On 07/06/2023 at approximately 11:00 AM, Surveyor toured the facility and interviewed Resident 4. Resident 4 was sitting in his/her room with the lights off. Surveyor asked Resident 4 how things were going. Resident 4 stated, "Not very good," and stated s/he was very depressed. Surveyor asked Resident 4 what types of things s/he liked to do. Resident 4 stated s/he liked word puzzles. Surveyor asked Resident 4 if s/he did word puzzles or other activities with staff. Resident 4 stated no and that s/he usually just does word puzzles in his/her room by him/herself. Surveyor asked Resident 4 if s/he would like to see more activities done and if s/he would engage in them. Resident 4 stated, "That sounds good to me." On 07/06/2023 at approximately 1:00 PM, Director A provided Surveyor with a schedule labeled "July 2023." There was only one activity listed on each day. The calendar stated the	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 427	Continued From page 10 following: 07/01/2023: Polka Party 99.9 FM 9 AM-Noon 07/02/2023: Movie Time 1 PM-3 PM 07/03/2023: Coloring 07/04/2023: Celebrate 4th of July 07/05/2023: Beach Ball Toss 07/06/2023: Music 1:30 PM 07/07/2023: Coloring 07/08/2023: Play Polka 9 AM-noon On 07/06/2023 at 2:30 PM, Surveyor reviewed the concern regarding a lack in activities for residents to engage in daily with Director A. Director A stated there was music in the afternoon. Surveyor explained there had been no activities during the day prior to the 1:30 PM scheduled music. Director A acknowledged observations and stated s/he would take a look at their activities program.	N 427		
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 prepare a weekly written menu and make menus available to the residents. Findings include: On 07/06/2023, Surveyor conducted a standard	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 11 survey, 3 complaint investigations, 2 self-report reviews and a verification visit. While touring the facility at approximately 11:30 AM, Surveyor observed the following menu in the dining room: "Lunch: BLTs, chips, cookie" On 07/06/2023 at approximately 11:30 AM, Surveyor interviewed Cook D. Cook D stated s/he will cook most of the meals but the Head Chef at the main building made the menus and did all the shopping for food. Cook D stated some meals were made at the main building and brought over to them. S/he stated it depends what was on the menu for the day. Surveyor asked Cook D if s/he had a weekly menu. Cook D stated s/he had only been working there for a little while so Director A would have a copy of it. On 07/06/2023 at approximately 2:30 PM, Surveyor requested to review a weekly menu. Director A stated s/he would have to get that information from his/her Head Chef at the main building. Surveyor asked if they give the residents a copy of the weekly menu ahead of it being served and/or post it in the building. Director A stated yes. Surveyor requested to review the weekly menu for that week at the building. Director A stated there was not one for the week located in the building currently.	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.	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 12	N 481		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not provide a living environment that was safe, clean, comfortable and homelike.

Findings include:

On 07/06/2023 at approximately 12:30 PM, as part of the survey process, Surveyor toured the facility. During the tour Surveyor observed the following:

-food and dirt on the floor by chair in the sunroom by med cart/patio
-room #16 had crumbs and debris all over the floor
-room #15 had very stained carpets
-room #14 had dark spots and stains all over carpet and had a strong urine odor
-chuck pads on recliners in both common areas
-black scuff marks all over the wall down the hallway by the kitchen
-wood trim coming off of wall by room #9
-wood transition strip coming off by kitchen where it transitions to wood flooring to carpet
-chip off of the wall on the corner by the kitchen door
-cobb webs in corner of front office door by entry
-carpet in entryway with dirt, paper, debris and hair
-room #3 stained carpet, debris and garbage on the floor, chips out of the wall, splattered brown spots all over the wall by outlet
-Resident 4's room had french doors and there were windows on his/her door. There were some privacy films put on the windows to try and make it more private but Surveyor could see through the privacy film. Surveyor interviewed Resident 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 13 about door since his/her was the only one like that. Resident 4 stated that s/he would like doors like the other resident rooms so that it is more private and so people can't look into his/her room. On 07/06/2023 at approximately 2:30 PM, Surveyor went over above information with Director A and Assistant Director B. Director A and Assistant Director B acknowledged the information.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. Findings include: The provider is licensed to serve up to 22 residents with diagnoses of advanced age and irreversible dementia/Alzheimer's. On 07/06/2023 at approximately 12:30 PM, as part of the survey process, Surveyor toured the facility. During the tour, Surveyor observed the laundry room. Surveyor observed a box of powder laundry detergent, a bottle of Febreze, a bottle of bleach, and two bottles of cleaning disinfectant in the laundry room. The items were unsecured and accessible to anyone entering the	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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 499	Continued From page 14 laundry room. On 07/06/2023 at approximately 2:30 PM, Surveyor shared the above concerns with Director A and Assistant Director B. Both acknowledged that chemicals were not stored in a secure area with the laundry room accessible to everyone.	N 499		
{Y3244}	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure every resident received adequate and appropriate care within the capacity of the facility. This is a repeat deficiency from Statement of Deficiency (SOD) #9S8811 dated 05/05/2022. Findings include:	{Y3244}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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
{Y3244}	Continued From page 15 On 04/28/2023, the department received a complaint that alleged residents were experiencing frequent falls and not receiving the care they needed. EXAMPLE 1 On 07/06/2023, Surveyor requested to review Resident 2's record. Resident 2's hospice physician's orders stated on 02/24/2023 the following: "-Left great toe lateral aspect: cleanse with wound wash, pat dry with gauze. Care to be completed twice daily and as needed. -Lotion to feet/ankles for skin protection twice daily and as needed." Resident 2's Medication Administration Record (MAR) for February 2023 did not indicate any treatment for his/her left great toe for wound care. On 07/06/2023 at approximately 2:30 PM, Surveyor shared the above information with Director A and Assistant Director B. Assistant Director B looked at the February 2023 MAR and pointed to a treatment that staff was supposed to change the bandage on Resident 2's left wrist for wound care, but acknowledged there was nothing indicated for Resident 2's toe. Assistant Director B then stated, "That order must have not gotten on there because it was over the weekend." Surveyor asked Assistant Director B if there was any documentation in the resident's progress notes or anywhere else that would verify the wound care was completed as ordered. Assistant Director B stated no. EXAMPLE 2 On 07/06/2023, Surveyor reviewed Resident 6's	{Y3244}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010105	A. BUILDING: _____ B. WING _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP OF PEPPER	630 PEPPER AVE WISCONSIN RAPIDS, WI 54494

(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
{Y3244}	Continued From page 16	{Y3244}		

record. Surveyor reviewed an incident report dated 04/10/2023 at 3:00 PM. The incident report stated the following:
"-[Resident 6] was found on the floor by [his/her] bedroom. [Resident 6] said [Resident 1] pushed [him/her] and [s/he] fell. Staff helped [Resident 6] up. Staff performed [range of motion], checked for bruises. [Resident 6] said his/her shoulder hurt but was able to move it.
-Action taken by staff/treatment given: Tylenol, continue to monitor."

Resident 6's progress notes stated the following on 04/10/2023:
"-Up and down, complaining of shoulder pain"

Surveyor reviewed progress notes after 04/11/2023 and 04/12/2023 and did not see any follow up on Resident 6's shoulder pain.

On 07/06/2023 at approximately 2:30 PM, Surveyor reviewed the above information with Director A. Surveyor asked if there was any follow up on Resident 6's shoulder pain and what they did to monitor. Director A reviewed Resident 6's progress notes and stated s/he could not tell if there was any follow up.