STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 11/01/2023, with information gathered through 11/15/2023, Surveyor conducted two complaint investigations at Stoughton Meadow Assisted Living. Four deficiencies were identified. One of 4 deficiencies was a repeat violation (see Statement of Deficiency (SOD) KFJM11 and SOD KFJM12). One of 2 complaints was substantiated. Census: 37	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by:	N 158		

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
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 158	Continued From page 1 Based on interview and record review, after receiving allegations of neglect, the provider did not take immediate steps to ensure the safety of residents, investigate and document the allegations to make a determination about the alleged caregiver misconduct, and did not report substantiated caregiver misconduct to the Department within 7 days. The provider did not conduct an investigation after Resident 2 suffered a medical emergency and emergency medical services (EMS) observed staff sleeping. Findings include: The provider is licensed for a community based residential facility (CBRF), Class CNA (nonambulatory), to serve up to 45 residents within the client groups advanced aged and irreversible dementia/Alzheimer's. On 11/06/2023, a complaint was filed with the Department alleging that residents were being neglected due to staff sleeping during their shift. On 11/07/2023, Surveyor reviewed Resident 2's EMS report, dated 11/05/2023, which documented: "On arrival, EMS noted an employee/caregiver sleeping on the couch. EMT's (emergency medical technician) were directed to the pt (patient), who was found sitting in a chair in the dining room. PT was not wearing a pendant and needed to walk out of their room to the dining room to find help. Pt was in obvious respiratory distress. ... was taken to the ambulance." On 11/07/2023, at approximately 3:00 PM, Surveyor interviewed Executive Director (ED) A.	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 158	Continued From page 2 Surveyor read the EMS report to ED A who stated s/he was not aware that a staff member was sleeping during their shift. ED A stated, "I have so many questions, how long did the resident wait for assistance, was the call light cord activated in his/her room, which staff member was sleeping." ED A explained that Resident 2 had a call light cord in his/her room, not a personal call pendent unless the resident requests one. ED A stated the call light system does not have the capability to run a report to determine when the lights are activated and when they are deactivated. ED A stated s/he would conduct an internal investigation and forward this information to the Surveyor. On 11/10/2023, at approximately 4:25 PM, Surveyor interviewed Resident 2's Power of Attorney (POA) F. POA F stated s/he had visited Resident 2 the night before his/her emergency transfer and observed Resident 2 struggling to breathe. POA F stated s/he had to go find a caregiver and ask them to administer Resident 2's emergency inhaler. POA F stated, "It is always difficult to find staff when I am there. I will hear call lights going off and nobody is responding. I find the staff sitting in the office and they just tell me the lights will get answered." On 11/15/2023 at 11:51 AM, ED A email Surveyor the following comment: "I haven't received the statements from the 2 staff and reached out again this morning. [Caregiver E] did state that [s/he] did a progress note regarding the incident. I also confirmed that [Caregiver E] is the staff who called EMS." On 11/15/2023, Surveyor reviewed Resident 2's record.	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 158	Continued From page 3 Resident 2's "Progress Notes" documented: "11/03/2023 12:27 PM - Late Entry - Resident sent out for SOB (shortness of breath). Resident was admitted. Care manager notified." Surveyor noted the incident occurred on 11/05/2023. On 11/15/2023, Surveyor reviewed the Department file and determined a written notice had not been submitted regarding the potential case of neglect.	N 158		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit	N 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 310	Continued From page 4	N 310		

may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1's admission agreement outlined all additional services offered, which are not included in the basic services. Resident 1's admission agreement did not outline that the provider used non-emergency EMS (emergency medical services) personnel if resident required assistance in services that staff were unable to provide, with the resident being charged for that service.

Findings include:

On 11/01/2023, at approximately 2:45 PM, Surveyor interviewed Caregiver D. Caregiver D stated that the facility was a "no lift" facility, so when a resident sustains a fall, staff are to call non-emergency 911 for lift assist. Caregiver D stated Resident 1 had sustained several falls since admittance.

On 11/01/2023, at approximately 3:00 PM, Surveyor interviewed Resident 1. Resident 1 stated that s/he had sustained falls while residing at the facility. Surveyor reviewed a stack of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 310	Continued From page 5 paperwork that Resident 1 had handed him/her. Surveyor noted there were several ambulance call receipts. Surveyor asked Resident 1 if s/he understood that s/he was going to be charged every time staff contacted an ambulance service for lift assist. Resident 1 stated, "I was under the impression that my insurance would cover it, but now they tell me that is only when I am being transported to the hospital. I don't know how many of those charges I have now." On 11/01/2023, Surveyor reviewed Resident 1's record. Resident 1 admitted to the facility, 04/20/2023, with diagnoses including weakness, heart failure, major depressive disorder, and malignant neoplasm of prostate. Resident 1's progress notes documented: "04/28/2023 - Caregiver staff observed resident on the floor between [his/her] bed and night stand ... 911 lift assist called ..." "05/08/2023 - Caregiver staff alerted to resident's need for assistance ... 911 lift assistance called ..." "06/23/2023 - Caregiver staff were walking by resident's room and saw [him/her] on the floor. ... lift assist called ..." "07/02/2023 - Caregiver staff found resident on the floor next to [his/her] bed ... non-emergency lift assist called ..." "08/16/2023 - Caregiver staff found resident on the floor in front of [his/her] wheelchair. ... non-emergent lift assist called ..." Resident 1's admission agreement, dated 06/21/2023, did not document fees that associate with 911 lift assistance.	N 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 310	Continued From page 6 On 11/07/2023, at approximately 2:45 PM, Surveyor visited with Resident 1. Resident 1 provided Surveyor with receipts for ambulance calls for non-transport dated: 04/28/2023, 05/08/2023, 05/28/2023, 05/29/2023, 07/02/2023, 07/03/2023, 07/15/2023, 07/22/2023, 07/29/2023 (twice), 08/01/2023, and 08/16/2023. On 11/07/2023, at approximately 3:00 PM, Surveyor interviewed Executive Director A. Executive Director A stated the facility has no lifts and utilize non-emergency EMS (Emergency Medical Services) personnel if assistance is needed when a resident has fallen, and staff cannot assist them. Executive Director A stated the admission agreement did not outline that the facility was a no-lift facility and that non-emergency personnel may be utilized; resulting in a resident being charged for these services, because they are not included in the monthly service fee. Executive Director A stated the admission agreement would be reviewed and updated.	N 310		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 1 of 1	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 352	Continued From page 7	N 352		

resident.

Resident 2 did not receive his PRN (as needed) Albuterol inhaler as prescribed.

This deficiency is being cited for a third time. See Statement of Deficiency (SOD) KFJM11, dated 5/06/2020, and SOD KFJM12, dated 12/16/2020.

Findings Include:

On 11/06/2023, a complaint was filed with the Department alleging that residents did not receive prescribed medications.

On 11/07/2023, Surveyor reviewed Resident 2's emergency medical service (EMS) report, dated 11/05/2023 at 1:18 AM, which documented: "EMT's (emergency medical technician) were directed to the pt (patient), who was found sitting in a chair in the dining room. ... Pt was in obvious respiratory distress. ... Nursing home staff had a bag of the pt's inhalers and reported that they had not used or attempted to use any of them. ... In the ambulance, a set of vitals was taken. Pt had obvious expiratory wheezes, and an elevated respiratory rate. A DuoNeb Nebulizer treatment was administered (1:37 AM)."

On 11/07/2023, at approximately 3:00 PM, Surveyor interviewed Executive Director (ED) A. Surveyor and ED A reviewed the EMS report which documented concerns that [Resident 2] did not receive [his/her] inhaler when [s/he] had experienced respiratory distress. ED A stated staff had not informed him/her that they had not attempted to assist Resident 2. ED A stated staff had received a call from Caregiver G stating that Resident 2 was having shortness of breath and was going to send him/her out. ED A stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 352	Continued From page 8	N 352		

Caregiver E texted him/her at 1:35 AM which stated, "I just sent [Resident 2] out, [s/he] was experiencing extreme shortness of breath and rapid respirations. [S/he] asked to be sent out." Surveyor and ED A reviewed Resident 2's record.

Resident 2 admitted to the facility, 01/31/2023, with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety, depression, and chronic obstructive pulmonary disease.

On 11/07/2023, at approximately 3:15 PM, Surveyor reviewed Resident 2's October and November 2023 Medication Administration Records (MARs) with ED A. Resident 2's MARs documented:
"Albuterol 108MCG/ACT Inhaler - Inhale 2 puffs by mouth 3 times daily as needed for moderate to severe shortness of breath. Order Date: 10/12/2023"
"Advair HFA 230/21 Inhaler - Inhale 2 puffs by mouth twice daily. Order Date: 10/12/2023"
On 11/04/2023, the PRN inhaler (Albuterol) was administered at the same time the scheduled inhaler (Advair) was administered.
On 11/05/2023, the PRN inhaler was documented as administered at 1:42 AM but the EMS report stated that staff informed the EMTs that they had not administered Resident 2's inhalers and Resident 2 received a nebulizer treatment at 1:37 AM in the ambulance.

Surveyor noted the Advair Inhaler was documented as administered on 11/06/2023, the day after Resident 2 was transported to the hospital, and ED A stated Resident 2 was still in the hospital. ED A stated medication administration would be discussed with the staff; s/he could not confirm if the medications had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 352	Continued From page 9 been given as prescribed based on how the medication administration was documented. On 11/10/2023, at approximately 4:25 PM, Surveyor interviewed Resident 2's Power of Attorney (POA) F. POA F stated s/he had visited Resident 2, 11/04/2023, and observed Resident 2 struggling to breathe. POA F stated s/he had to go find a caregiver and ask them to administer Resident 2's emergency inhaler. POA F stated, "[Resident 2] doesn't understand that [s/he] needs to ask staff for [his/her] medications. I would hope that staff understand that when [Resident 2] is having trouble breathing that they should get [his/her] emergency inhaler." POA F stated Resident 2 was still in the hospital and was unsure when s/he would return to the facility.	N 352		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 10	N 389		

provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) was reviewed when s/he experienced a change of condition.

Resident 2's ISP was not updated to include guidelines for staff to recognize signs and symptoms of respiratory distress.
Resident 2's ISP referenced Sertraline medication which was not prescribed.

Findings include:

The provider is licensed for a community based residential facility (CBRF), Class CNA (nonambulatory), to serve up to 45 residents within the client groups advanced aged and irreversible dementia/Alzheimer's.

On 11/06/2023, a complaint was filed with the Department alleging that residents were being neglected when experiencing a medical emergency.

On 11/07/2023, Surveyor reviewed Resident 2's EMS report, dated 11/05/2023, which documented:
"EMT's (emergency medical technician) were directed to the pt (patient), who was found sitting in a chair in the dining room. ... Pt was in obvious respiratory distress. ... Nursing home staff had a bag of the pt's inhalers and reported that they had not used or attempted to use any of them. ... In the ambulance, a set of vitals was taken. Pt had obvious expiratory wheezes, and an elevated respiratory rate. A DuoNeb Nebulizer treatment was administered (1:37 AM)."

On 11/07/2023, at approximately 3:00 PM, Surveyor interviewed Executive Director (ED) A. ED A stated that s/he had concerns that Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 11	N 389		

2 had experienced respiratory distress and that staff did not administer his/her PRN (as needed) inhaler. ED A explained that Resident 2 was prescribed a scheduled inhaler and a PRN inhaler. ED A reviewed Resident 2's ISP and determined that there were not clear guidelines identified for staff regarding signs and symptoms of respiratory distress related to Resident 2 and his/her diagnoses, ED A forwarded Surveyor Resident 2's ISP.

On 11/08/2023, Surveyor reviewed Resident 2's record.

Resident 2 admitted to the facility, 01/31/2023, with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety, depression, and chronic obstructive pulmonary disease.

Resident 2's ISP, dated 08/22/2023, documented:
"Personal Safety: Resident will be kept safe with dignity and respect through next review date. Resident is visually checked on frequently through the day and night to promote safety and to encourage participation in activities."
"Medication/Pharmacy: The resident will receive medications safely and as prescribed through next review date. Staff performs medication administration."
"Wellness/Physical Health: Staff will notify residents medical practitioner timely if any changes in physical health through next review date."
"Behavior Care: Will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Related Meds: Sertraline. Monitor Behavior: Isolation, decrease in meal intake and decrease in activities that were once enjoyed. Observe for and immediately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 12	N 389		

report to the wellness supervisor or executive director any signs or symptoms of resident posing a danger to self and/or others."

Surveyor noted there was no identified guidelines for staff to recognize and react to Resident 2 experiencing respiratory distress.

Resident 2's October and November 2023 Medication Administration Records (MARs) documented:
"Amitriptyline - Give 1 tablet by mouth in the evening for depression."
Surveyor noted Sertraline was not listed on the MARs.

On 11/10/2023, at approximately 4:25 PM, Surveyor interviewed Resident 2's Power of Attorney (POA) F. POA F stated s/he had visited Resident 2, 11/04/2023, and observed Resident 2 struggling to breathe. POA F stated s/he had to go find a caregiver and ask them to administer Resident 2's emergency inhaler. POA F stated, "[Resident 2] doesn't understand that [s/he] needs to ask staff for [his/her] medications. I would hope that staff understand that when [Resident 2] is having trouble breathing that they should get [his/her] emergency inhaler." facility.

Surveyor noted Resident 2's ISP did not identify his/her behaviors regarding PRN medications.