STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012891	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MONONA CBRF	111 OWEN RD 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 12/09/2025, Surveyors conducted a complaint investigation at Heritage Monona CBRF, a CBRF located in Monona, WI. As a result of the investigation, 1 violation of Chapter DHS 83 was issued. The complaint was substantiated.	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct an assessment for Resident 1 when his/her condition changed resulting in change of needs. Resident 1 fell, was sent to the hospital and returned with a change of condition. Findings include: On 12/02/2025, the Department received a complaint that a resident fell and eventually	N 381		

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

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N 381	Continued From page 1 passed away due to injuries from the fall. On 12/09/2025 at 9:30 AM, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted 10/24/2025 with diagnoses that include but are not limited to: unsteadiness on feet, abnormal gait, displaced intertrochanteric fracture of right femur, weakness, nontraumatic intracranial hemorrhage, fracture of lower end of left radius, repeated falls, multiple fractures of ribs, osteoporosis, traumatic subdural hemorrhage with loss of consciousness, Atrial fibrillation, congestive heart failure, Unspecified fracture of left femur, dizziness. Resident 1 was identified as a high fall risk. Resident 1's admission comprehensive assessment indicated Resident 1 was able to reposition self in bed with assistance of staff. Assessment indicated that Resident 1 was able to self propel in wheelchair short distances. Resident 1 needed assistance from staff with transfers and mobility of long distances. Progress notes dated 10/24/2025 indicated that Resident 1 had an unwitnessed fall in his/her bathroom. Resident 1 was found on the floor lying on left side and a hematoma was observed on forehead and right leg was swollen. Progress notes dated 10/31/2025 indicated that Resident 1 was using a broda chair. On 12/09/2025 at 10:30 AM, Surveyor interviewed Assistant Director A. Assistant Director A acknowledge that Resident 1 fell, hit his/her head and was sent to the hospital. Assistant Director A acknowledged that Resident 1's needs had changed as s/he needed to use a broda chair instead of a wheelchair due to	N 381		

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N 381	Continued From page 2 mobility/ambulation safety concerns. Surveyor asked Assistant Director A to provide the assessment for Resident 1 upon return from hospital. Assistant Director A stated, "there isn't one because we did not do one."	N 381		