STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 02/05/2025, with information gathered through 02/13/2025, Surveyors conducted a standard licensing survey and 3 complaint investigations at Park Ridge, a CBRF in Watertown. Three deficiencies were identified. One deficiency was a repeat deficiency- See statement of deficiency XWTR12, dated 06/26/2024. Two complaints were substantiated. One complaint was unsubstantiated. Census: 39	N 000		
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 observation, interview, and record review, the provider did not ensure Resident 3's	N 389		

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
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 1 Individual Service Plan (ISP) was updated when there was a change in his/her needs and physical condition. This is a repeat deficiency, see Statement of Deficiency (SOD) XWTR12, dated 06/26/2024. Findings include: On 02/05/2025 at 8:45 AM, Surveyor interviewed Resident 3 in Resident 3's room. Surveyor observed different bandages covering Resident 3's bilateral arms. Surveyor asked Resident 3 what happened, and s/he stated s/he had skin cancer and that his/her arms were always like that. Resident 3 stated s/he had a fall sometime since Christmas and s/he easily got scratches/skin tears to his/her arms when they bumped things like the wall or door. Resident 3 also stated a nurse changes the bandages if it needs to be done. On 02/05/2025 at approximately 12:30 PM, Surveyor interviewed LPN Manager B regarding Resident 3's injuries to his/her bilateral arms. LPN Manager B stated some of the bandages covered skin growths, per Resident 3's request to have them covered, and that not all bandages covered injuries. LPN Manager B confirmed Resident 3 had a fall on 01/09/2025, which resulted in one of the skin tears. Since the fall, Resident 3 does see home health, who managers his/her wound care, twice weekly. On 02/05/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 05/10/2023 with diagnosis that included peripheral vascular disease and chronic lymphocytic leukemia. Resident 3's record documented the following:	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 2 -Face sheet: A list of diagnosis, including peripheral vascular disease and chronic lymphocytic leukemia. -Incident report for witnessed fall on 01/09/2025: " ...Skin tear noted to left forearm ..." -Progress note from primary care provider's visit on 12/11/2024: " ...Skin- no masses, no rashes, several non-healing open wounds BUE covered with clear dressings ..." Resident 3's ISP did not include information about skin condition, skin care, or skin needs related to the bandaging and condition of his/her arms. On 02/05/2025 at 4:45 PM, Surveyor interviewed LPN Manager B. LPN Manager B acknowledged the ongoing skin concerns related to Resident 3. LPN Manager B stated Resident 3's arms were being cared for appropriately but was unable to identify information within Resident 3's ISP related to this.	N 389		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 3 advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the health of Resident 1 and Resident 2 was monitored. Resident 1's insulin administration order directed for staff to hold his/her daily mealtime and bedtime insulin if his/her blood sugar values were under 150 and s/he had no oral intake. Between 12/01/2024 - 01/31/2025, there were 43 occasions across 38 days in which staff documented not having administered Resident 1's insulin due to "Vitals Outside of Parameters for Administration" but did not record his/her corresponding blood sugar value. Without the value being recorded, Surveyor was unable to verify on those occasions if staff had correctly held his/her insulin. There were also 110 additional occasions, 90 of which were during meals, in which staff documented holding	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 4	N 431		

Resident 1's insulin due to "No Insulin Required" - all for which Resident 1's blood sugar values were under 150 but there was no documentation to suggest whether Resident 1 had refused his/her corresponding meal in accordance with the second part of his/her hold parameter. Based on staff report, it was unlikely that Resident 1 had been refusing that many meals as s/he was not known to refuse meals. Without any such information, Surveyor was unable to verify on these occasions if staff had correctly held his/her insulin.

Around midday on 01/12/2025, Resident 2 experienced a change of condition with illness onset. Since onset and throughout 01/12/2025, s/he did not get out of bed (which was not typical for him/her), refused his/her medications, refused his/her evening meal, and experienced 1 episode of vomiting. While Resident 2 typically requested his/her privacy by locking his/her door and not wanting staff to enter until s/he gave them permission, s/he was agreeable that day to leave his/her door unlocked for staff to check in on him/her, as reported by Caregiver F. Caregiver F reported Resident 2's change of condition to Caregiver G, one of the 2 NOC shift staff who worked from 01/12/2025 - 01/13/2025. From approximately 7:00 p.m. on 01/12/2025 - 8:00 a.m. 01/13/2025 (when day shift staff conducted rounds), no staff checked on Resident 2. Resident 2 was discovered by day shift staff deceased on the floor at approximately 8:00 a.m. on 01/13/2025.

Findings include:

Example 1 - Resident 1

On 02/05/2025, Surveyor reviewed Resident 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 5	N 431		

record. Resident 1 was admitted to the provider on 06/07/2024 with diagnoses including type II diabetes mellitus and unspecified dementia. Resident 1's prescriptions included insulin aspart injection solution 100 unit/mL with instructions to, "Inject 8 unit subcutaneously before meals and at bedtime for diabetes hold if [blood glucose] under 150 and [nothing by mouth]." Resident 1's current individual service plan (ISP), last reviewed on 12/06/2024, identified that Resident 1 required staff assistance for medication administration.

Surveyor reviewed Resident 1's medication administration records (MARs) from 12/01/2024 - 01/31/2025, where staff also appeared to document Resident 1's blood sugar values for each potential administration. Surveyor observed the following 43 entries across 38 days in which staff documented not having administered Resident 1's insulin due to "Vitals Outside of Parameters for Administration" but did not record his/her blood sugar value:

- 12/03/2024 (bedtime)
- 12/05/2024 (dinner)
- 12/07/2024 (dinner)
- 12/08/2024 (bedtime)
- 12/09/2024 (dinner)
- 12/12/2024 (bedtime)
- 12/13/2024 (dinner)
- 12/15/2024 (bedtime)
- 12/17/2024 (dinner and bedtime)
- 12/18/2024 (bedtime)
- 12/21/2024 (dinner and bedtime)
- 12/22/2024 (dinner)
- 12/23/2024 (lunch and bedtime)
- 12/27/2024 (bedtime)
- 12/31/2024 (bedtime)
- 01/01/2025 (bedtime)
- 01/02/2025 (dinner)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 6 - 01/03/2025 (bedtime) - 01/04/2025 (bedtime) - 01/05/2025 (dinner) - 01/06/2025 (bedtime) - 01/08/2025 (dinner) - 01/09/2025 (bedtime) - 01/10/2025 (bedtime) - 01/13/2025 (breakfast) - 01/14/2025 (bedtime) - 01/15/2025 (bedtime) - 01/16/2025 (lunch) - 01/17/2025 (dinner and bedtime) - 01/19/2025 (bedtime) - 01/20/2025 (bedtime) - 01/23/2025 (dinner) - 01/24/2025 (bedtime) - 01/25/2025 (bedtime) - 01/28/2025 (dinner and bedtime) - 01/29/2025 (dinner) - 01/30/2025 (lunch) - 01/31/2025 (bedtime) Surveyor reviewed Resident 1's progress notes from 12/01/2024 - 01/31/2025 but did not observe any blood sugar values documented for the above dates/occasions. At approximately 3:45 p.m., Surveyor reviewed the concern that blood sugar recordings seemed to be missing from Resident 1's MARs with Licensed Practical Nurse (LPN) Manager B. LPN Manager B reported that it was possible the values were documented in a separate vitals log, which s/he would provide to Surveyor. In reviewing the "Weights and Vitals Summary" document subsequently provided by LPN Manager B, Surveyor did not observe blood sugar values for the above dates/times.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 7 At approximately 4:45 p.m., Surveyor interviewed Executive Director A, LPN Manager B, and Consultant C. All three acknowledged Surveyor's concern that Resident 1's blood sugar was not consistently being recorded by staff, particularly when they documented not administering it to him/her due to his/her blood sugar value being outside of its administration parameter. Without the value being recorded, Surveyor was unable to verify on the above dates/times if staff had correctly held his/her insulin. On 02/06/2025, Surveyor reviewed Resident 1's MARs again. From 12/01/2024 through 12/31/2024, staff documented holding Resident 1's insulin on 57 additional occasions (besides what was documented above) with corresponding blood sugar values observed to be below 150, 26 of which were during breakfast, 19 of which were during lunch, 1 of which was during dinner, and 11 of which were at bedtime. Surveyor observed that given Resident 1's hold parameter, this would also indicate that Resident 1 had no oral intake during these occasions, which was approximately 84% of the month's breakfasts and 61% of the month's lunches. From 01/01/2025 through 01/31/2025, staff documented holding Resident 1's insulin on 53 additional occasions (besides what was documented above) with corresponding blood sugar values observed to be below 150, 24 of which were during breakfast, 17 of which were during lunch, 3 of which were during dinner, and 9 of which were at bedtime. Surveyor observed that given Resident 1's hold parameter, this would also indicate that Resident 1 had no oral intake during these occasions, which was approximately 77% of the month's breakfasts and 55% of the month's lunches. In reviewing Resident 1's record again, his/her	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 8	N 431		

ISP did not document any behaviors related to frequent meal refusal or oral intake concerns. His/her progress notes or vitals summary document did not document any information regarding his/her oral intake.

On 02/06/2025, at approximately 11:33 a.m., Surveyor interviewed LPN Case Manager B. LPN Case Manager B confirmed that Resident 1 was known to typically eat meals and that it was unlikely s/he was refusing meals this often for staff to have held his/her insulin. LPN Case Manager B reported s/he was going to work with Resident 1's medical provider in attempts to simplify his/her insulin prescription so that it would be easier for staff to interpret and correctly administer.

Example 2 - Resident 2

On 02/05/2025, Surveyor conducted a complaint investigation into concerns of adequate resident supervision for residents who had experienced changes in condition.

On 02/05/2025, at approximately 9:00 a.m., Surveyor interviewed Caregivers D and E. Both reported the provider experienced an infection outbreak a couple weeks prior that affected approximately 10 residents and lasted approximately 2 weeks total. In discussing how resident changes of condition were handled and how that information was relayed to different shifts, both reported that staff conducted verbal handoff of information, would write updates on a whiteboard in the medication room, and also wrote updates in the staff 24-hour log (a log for staff to write any resident updates/changes).

On 02/05/2025, Surveyor reviewed documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 9	N 431		

provided by Executive Director A regarding outbreaks the provider had experienced the previous month, communicated with the local public health agency. The documents indicated report of "[gastrointestinal] issues" that affected 1 resident and 2 staff members on 01/03/2024. An e-mail sent by Executive Director A on 01/15/2025 reported that the provider's CBRF next door (separately licensed) had discovered 2 residents positive for norovirus but that residents at Park Ridge were not tested "as by the time the residents were showing symptoms many of our staff had worked in both buildings and both had same symptoms so we treated it the same in each building."

On 02/05/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 04/01/2024 until his/her passing on 01/13/2025, with diagnoses including unspecified dementia. The ISP for Resident 2 that was active at the time of his/her passing, last reviewed on 09/25/2024, identified that s/he was independent with toileting, transferring, grooming, dressing, and ambulation, but required staff assistance for medication management. Resident 2's ISP, under the "Cognition" section, documented the following intervention as initiated on 11/21/2024: "Resident can effectively use a key/lock and has their own room key ...Staff to always knock and receive permission before entering a residents [sic] room to respect privacy."

Resident 2's progress notes, reviewed from 12/01/2024 - 01/13/2025 (the date s/he passed) documented the following entries made by Caregiver F:

- 01/12/2025 (3:02 p.m.): "has not been well today. has been vomiting."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 10 - 01/12/2025 (7:20 p.m.): "has not been feeling well today." Surveyor observed that these entries were made the afternoon and evening before Resident 2 had passed away. At approximately 1:40 p.m., Surveyor interviewed Caregiver F. Caregiver F reported that Resident 2 was known to typically have his/her room locked and didn't like staff entering it without his/her permission. Caregiver F reported that Resident 2 had a sign outside of his/her door indicating staff were not to enter without his/her permission. Caregiver F confirmed that Resident 2 was independent with cares but had required occasional verbal cuing/reminders to participate in self-cares. Caregiver F reported that Resident 2 had ambulated with a cane or walker sometimes, but mostly utilized a power scooter, which s/he independently navigated and transferred on/off of. Caregiver F reported that Resident 2 was typically up and out of his/her room during the days and was known to go out into the community independently, and so staff working daytime and evening hours typically saw him/her. Caregiver F reported that s/he thought Resident 2 received 2-hour checks by overnight (NOC) shift staff but knew that some staff weren't doing that because Resident 2 would yell at staff for entering his/her room. As part of the same interview, Caregiver F confirmed s/he worked during the daytime and evening on 01/12/2025 (the evening prior to Resident 2's passing), which was from approximately 9:00 a.m. until 8:00 p.m. Caregiver F reported that in conducting the noon medication pass, of which Resident 2 had scheduled medications, s/he found Resident 2 still in bed.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 11	N 431		

Resident 2 refused his/her noon medications and reported to him/her that s/he didn't feel good. Caregiver F reported that these behaviors were new for him/her. Caregiver F reported s/he discussed with Resident 2 leaving his/her door unlocked so that staff could check in on him/her, to which s/he was agreeable.

As part of the same interview, Caregiver F reported that Resident 2 also had medications that were to be passed during the early afternoon. Caregiver F reported that when s/he entered Resident 2's room for that medication pass, which was around 3:00 p.m., Resident 2 was still laying in bed, again reported s/he wasn't feeling well, and refused his/her early afternoon medications. Caregiver F reported s/he could see vomit all over the floor of Resident 2's room, which s/he cleaned up. Caregiver F reported s/he offered water to Resident 2, which s/he accepted. Caregiver F reported that Resident 2 declined to put an order in for dinner, which was not typical for him/her. Caregiver F reported s/he had checked on Resident 2 again at some point during the late afternoon or evening and that s/he continued to be in bed with reporting not feeling well.

As part of the interview, Caregiver F reported that his/her last check on Resident 2 was at approximately 7:00 p.m. when s/he conducted the evening medication pass. Caregiver F reported that Resident 2 was still in bed, again reported s/he wasn't feeling well, and refused his/her evening medications. Caregiver F reported that Resident 2 didn't appear to be any better or worse than s/he was that morning since his/her illness onset. Caregiver F confirmed that it was not typical for Resident 2 to have been in bed all day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 12 As part of the interview, Caregiver F reported that prior to his/her shift ending, and upon NOC shift staff starting, s/he reported to Caregiver G that Resident 2 was not feeling well, had thrown up, had not eaten, and that his/her door had been left unlocked for staff to check on him/her during the night. Caregiver F replied that Caregiver G acknowledged understanding of his/her report. Caregiver F reported s/he had also written about Resident 2 not feeling well in addition to his/her medication and meal refusals in the staff 24-hour log (as also referenced by Caregivers D and E above), which was where staff were known to document any daily changes with residents. As part of the interview, Caregiver F reported that s/he did not work the next day but had heard that Resident 2 had passed away and that there had been concerns that NOC shift staff didn't check on him/her during the NOC shift. Caregiver F reported that s/he had filled out a paper statement about the incident. On 02/05/2025, Surveyor reviewed the January staff schedule, which identified Caregivers G and I as the NOC shift staff who worked from 10:00 p.m. on 01/12/2025 until 6:00 a.m. on 01/13/2025. On 02/05/2025, Surveyor reviewed records related to Resident 2's passing, provided by Consultant C, which consisted of a printout of a photograph of Resident 2's door sign, Resident 2's ISP, 5 witness statements by caregiving staff, and a statement by Executive Director A. Two of the staff statements, from Caregivers E and H who worked on the morning of 01/13/2024 (the day of Resident 2's passing), documented having discovered Resident 2 on the floor at	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 13	N 431		

approximately 8:00 a.m., not breathing and unresponsive, with his/her skin cold to the touch.

A statement from Caregiver G, 1 of the 2 NOC shift staff who worked that evening, documented the following: "I, unfortunately had no contact with [Resident 2] on Sunday, Jan 12th, 2025. I was working on the other wing with residents and medications."

A statement from Caregiver I, the second of 2 NOC shift staff who worked that evening, documented the following: "I had no interaction with [Resident 2] at all that night or ever. I never did that side before, that was my first time on that side. If I knew [s/he] was sick I definitely would have been on it like I should have. It was just a busy night with a lot of sick residents and its hard to keep up with all of them with only 2 people on the shift. Sometimes I feel bad and do blame myself for not checking on [him/her] that night. I didn't know we had to check on everyone, even the independent ones. No one told me that during training. They just told me they like to be left alone and don't like people coming in their rooms, but now I know I have to check on everybody. I will do that from now on."

The statement from Executive Director A documented the following: "On 1/13/2025 around 8am staff went in to give resident breakfast knocked and got no response and cracked door open as resident has sign on door saying 'Stop! Knock, I will let you in don't just walk in" and did not see resident in the room. [S/he] went to the med passer who was on his/her way to give [him/her] [his/her] morning medications. Med passer knocked and did not get response cracked [his/her] door and saw [his/her] legs on the floor on the other side of bed and called for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 431	Continued From page 14	N 431		

help. Resident did not appear to be breathing and was cold to the touch. Called 911.

"Interviewed the night shift who had not checked on resident as resident calls when [s/he] needs assistance and does not like to be bothered. Interviewed PM shift who did report that [s/he] had started with [gastrointestinal] symptoms during the shift and refused [his/her] medications and meal. Resident was resting and instructed to call for help if needed ...

"Staff followed the residents [sic] wishes by not entering [his/her] room without permission until day shift opened the door. Resident was feeling ill but was calling for help when needed. Coroner reported [s/he] felt the death was due to natural causes."

At approximately 4:45 p.m., Surveyor interviewed Executive Director A, LPN Manager B, and Consultant C. Executive Director A reported that in his/her investigation s/he did not find that the NOC shift staff from 01/12/2024 - 01/13/2024 intentionally neglected Resident 2 and that they were busy answering call lights and caring for other sick residents, since this was during the facility's outbreak. Executive Director A and LPN Manager B confirmed they had no reason to doubt Caregiver F's report of handing off information regarding Resident 2's change of condition to NOC shift staff. LPN Manager B reported that s/he thought Caregiver F had also made a note on the staff whiteboard (located in the medication room) regarding Resident 2's change of condition. All 3 acknowledged Surveyor's concern that the NOC shift staff did not monitor Resident 2's health or conduct any checks on him/her after onset of his/her change of condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110538	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE	1148 BAYBERRY DR WATERTOWN, WI 53098

(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 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 of 4 dryer vents were of rigid material. Two of 4 dryer vents were flexible material. Findings include: On 02/05/2025 at 9:23 AM, Surveyor toured the laundry room during a physical inspection of the facility. Two of 4 dryers in the laundry room used flexible venting, and two used rigid venting. On 02/05/2025 at 4:45 PM, Surveyor interviewed Executive Director A and LPN Manager B. Executive Director A stated s/he knew the regulation for rigid dryer vents and even thought the provider was previously cited for this. LPN Manager B stated s/he recalled at least 1 of the dryers had been replaced in recent months and thought it was at that time the wrong venting could have been put on.	N 488		