STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019987	A. BUILDING: _____ B. WING _____	R-C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC	215 3RD ST MONROE, WI 53566

(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 05/28/2025, the bureau of assisted living southern regional office conducted 2 verification visits at 1st Health LLC a CBRF located in Monroe, WI. As a result of this survey, 7 violations of DHS 83 were issued. Six violations identified were repeat violations from previous statement of deficiencies (SODs) E16T11 dated 12/27/2024, SOD TYPT11 dated 01/24/2025 and SOD E16T12 dated 03/05/2025. Under statutory provisions of Wis. Stat. Chap 50, a $200 revisit fee is being assessed. Census: 14	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the CBRF and its operation complied with all laws governing the CBRF. On 07/18/2024, the Provider was granted a probationary CBRF license for the following 12 months from the bureau of assisted living. As of 05/30/2025, the bureau of assisted living southern regional office had identified 33 violations, 7 repeat violations, substantiated a	N 196		

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

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complaint and placed a no new admit order (NNAO) from 01/16/2025 to 03/05/2025.

This is a repeat violation from statement of deficiency (SOD) E16T11 dated 12/27/2025.

FINDINGS INCLUDE:

On 05/28/2025, Surveyor arrived at facility for two verification visits. The statement of deficiencies(s) (SOD) was SOD E16T12 dated 03/05/2025 and SOD TYPT11 dated 01/24/2025.

COMPLIANCE HISTORY:

On 12/18/2024, the bureau of assisted living southern regional office conducted a complaint investigation. As a result, 16 violations were identified, a complaint was substantiated, and facility was placed on NNAO in SOD E16T11.
1.) 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
2.) 83.12(4)(c) Reporting Incidents With Serious Injury
3.) 83.12(5)(b) Notification: Abuse And Neglect Allegations
4.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws
5.) 83.16(2) Resident Care Staff At least 18 years Old
6.) 83.17(1) Licensee Conduct Caregiver Background Check
7.) 83.17(2)(a) Employees Screened For Communicable Disease
8.) 83.29(2) Admission Agreement Include Services, Charges
9.) 83.32(3)(d) Rights Of Residents: Freedom From Mistreatment
10.) 83.32(3)(i) Rights Of Residents: Adequate Treatment

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N 196	Continued From page 2 11.) 83.32(3)(n) Rights Of Residents: Safe Environment 12.) 83.35(1)(a) Pre-Admission And Ongoing Assessments 13.) 83.35(3)(a) Comprehensive Individualized Service Plan 14.) 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 15.) 83.37(2)(d) Documentation Of Medication Administration 16.) 83.38(1)(c) Leisure Time Activities On 01/22/2025, the bureau of assisted living southern regional office conducted a standard survey. As a result, 7 violations were identified in SOD TYPT11. 1.) 83.15(3)(a) Administrator Shall Supervise Daily Operation 2.) 83.21(1)-(3) All Employee Training 3.) 83.22(1)-(4) Task Specific Training 4.) 83.32(3)(h) Rights of Residents: Receive Medication 5.) 83.37(1)(i) Proof-Of-Use Record 6.) 83.37(3)(c) Medication Storage: Locked Cabinet 7.) 83.55(3) Bath And Toilet Areas: Hand Drying On 03/05/2025, the bureau of assisted living southern regional office conducted a verification visit. As a result, 2 violations were identified and the NNAO was lifted in SOD E16T12. 1.) 83.17(2)(a) Employee Screened For Communicable Disease 2.) 83.35(3)(a) Comprehensive Individualized Service Plan From 05/28/2025 to 05/30/2025, the bureau of assisted living southern regional office conducted 2 verification visits. As a result, 8 violations were identified in SOD E16T13.	N 196		

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N 196	Continued From page 3 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.15(3)(a) Administrator Shall Supervise Daily Operation 3.) 83.32(3)(h) Rights Of Residents: Receive Medication 4.) 83.35(3)(1) Comprehensive Individualized Service Plan (ISP) 5.) 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 6.) 83.46(1)(h) Portable Space Heaters 7.) 83.55(3) Bath And Toilet Areas: Hand Drying REPEAT VIOLATIONS: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.15(3)(a) Administrator Shall Supervise Daily Operation 3.) 83.17(2)(a) Employee Screened For Communicable Disease 4.) 83.32(3)(h) Rights Of Residents: Receive Medication 5.) 83.35(3)(1) Comprehensive Individualized Service Plan 6.) 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 7.) 83.55(3) Bath And Toilet Areas: Hand Drying EXIT INTERVIEW: On 05/30/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator F, Licensee B, and Manager C. Administrator F confirmed Resident 5 reported needing to stomp his/her feet to get Caregiver Q up in the middle of the night. Administrator F reported s/he had told staff they could rest after completing job duties. Administrator F denied following-up on Resident 5's report of needing to wake-up Caregiver Q.	N 196		

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Administrator F stated s/he thought Caregiver Q had just been resting from how Resident 5 described the interaction. Licensee B acknowledged s/he had also received this report from Resident 5; and followed-up with Caregiver Q about staying awake during his/her working hours. Surveyor reported during the on-site portion of the survey, s/he had observed a portable space heater in Resident 5's room. Surveyor reported Caregiver O had acknowledged the portable space heater in Resident 5's room. Administrator F stated s/he was not aware Resident 5 had a portable space heater in his/her room. Surveyor reported during the on-site portion of the survey, s/he observed a roll of paper towel roll stored on the metal grab bar directly above the toilet tank in the staff bathroom, while the wall mounted paper towel dispenser was empty. Surveyor reported Caregiver O had acknowledged the roll of paper towel had been stored above the toilet, while the wall mounted paper towel dispenser was empty. Surveyor reported while reconciling Resident 5's medication administration record (MAR) against the medications physically stored in the medication cart. Surveyor discovered the medication cart did not have a prescription blister pack for his/her paroxetine tablets, and Caregiver O had stated s/he did not have any paroxetine tablets to administer to Resident 5 that morning. Surveyor asked Administrator F why facility staff had been intermittently documenting Resident 5's psychotropic medications as not being available from 04/01/2025 to 05/28/2025. Administrator F asked Surveyor which dates s/he was asking about. Administrator F acknowledged Resident 5's medications were not made available to him/her on 04/01/2025. Administrator F acknowledged Resident 5 had a panic attack which required emergency room admission due

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N 196	Continued From page 5	N 196		

to lack of access to his/her scheduled anxiolytic (anti-anxiety) Clonazepam 0.5 mg tablet. Administrator F, Licensee B, and Manager C verified Surveyor had been given the complete resident record for Resident 5. Administrator H, Licensee B and Manager C acknowledged Resident 5's facility record did not contain a list of his/her medical and psychiatric diagnoses. Surveyor asked about paperwork listing Family Member R as Resident 5's activated power of attorney (APOA). Licensee B stated Resident 5 was his/her own person and Family Member R was not Resident 5's APOA. Licensee B acknowledged Family Member R had signed Resident 5's ISP, and Resident 5 had not signed his/her own ISP. Licensee B acknowledged Resident 5 should have signed the ISP. Administrator F stated s/he had learned after admitting Resident 5 to the facility of his/her history of behaviors related to his/her mental illness. Licensee B and Manager C acknowledged s/he had not been made aware of Resident 5's history of behaviors related to agitation and aggression. Administrator F, Licensee B, and Manager C acknowledged Resident 5's ISP did not have a behavioral plan documented. Administrator F stated on 05/25/2025 Resident 5 became agitated and told Resident 7, "if you keep staring at me I'm going to cut your eyes out," and that local police were called to the facility. Administrator F stated police did not remove Resident 5 from the facility. Regional Director T entered the meeting via zoom. Administrator F denied completing an assessment on Resident 5 after police intervention or updating his/her ISP of the behavior observed. Administrator F stated s/he reported the situation to Family Member R. Administrator F stated s/he was physically at the facility approximately 2-4 hours per day, 4-7 days

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N 196	Continued From page 6 per week. Administrator F and Licensee B reminded Administrator F was not aware of many issues discussed during the interview. Licensee B stated s/he felt Administrator F was doing an adequate job of managing the daily operations of the facility. Licensee B stated Caregiver P usually was Resident 5's biggest advocate and s/he was disappointed to learn of the manner Caregiver P spoke to Resident 5 in front of Surveyor. Administrator F and Licensee B acknowledged Caregiver P was requesting help managing Resident 5's behaviors when Caregiver P asked Surveyor to leave Resident 7's room. Licensee B acknowledged Resident 5's lack of psychotropic medications and behavioral plan were contributing factors to the incident.	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review, and interview, the administrator did not supervise the daily operation of the CBRF including but not limited to resident care and services, personnel	N 214		

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N 214	Continued From page 7	N 214		

and physical plant or provide the supervision necessary to ensure that the residents received proper care and treatment and that their health and safety were protected and promoted and that their rights were respected.

This was a repeat violation from statement of deficiency (SOD) TYPT11 dated 01/24/2025.

FINDINGS INCLUDE:

On 05/28/2025 at approximately 9:30 AM, Surveyor arrived at facility for 2 verification visits. Surveyor asked Caregiver O who the current administrator for the facility was. Caregiver O stated Administrator F was the facilities' current administrator.

On 05/28/2025 at 9:31 AM, Surveyor called Administrator F. Administrator F stated s/he was 2 hours away and would not be present for the survey. Administrator F instructed Surveyor to contact Licensee B to have documentation emailed to them. Administrator F acknowledged Licensee B still lived outside of the state. Administrator F stated s/he would expect staff to contact him/her or Licensee B over the phone if there was an emergency.

On 05/28/2025 at 9:40 AM, Surveyor called Licensee B. Licensee B verified s/he was not physically in the state of Wisconsin. Licensee B stated s/he could email any documentation Surveyor needed to complete the survey.

On 05/28/2025 at 2:16 PM, Surveyor interviewed Caregiver P. Caregiver P stated Resident 5 gets upset when s/he is forced to wake up staff at night. Caregiver P stated s/he did not agree with the policy, but Administrator F had told night shift

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staff they could sleep after they were done with their "chores." Caregiver P stated there was an incident when night a staff had fallen asleep, and Resident 5 stomped loudly behind them to wake them up. Caregiver P reported s/he worked PM shift and did not administer medication to Resident 5. Caregiver P stated s/he called the police on Resident 5 because s/he became agitated with Resident 7 and said s/he was going to cut his/her eyes out. Caregiver P reported Resident 5 was not following verbal re-directions.

On 05/28/2025 at 2:40 PM, Surveyor interviewed Resident 5. Resident 5 reported there was a staff member who worked night shift, and s/he was in a deep sleep. Resident 5 reported s/he could not wake him/her up with normal volume talking. Resident 5 stated s/he had clapped his/her hands loudly and banged on the floor to wake up the staff member. Resident 5 reported this staff member called Administrator F and Administrator F told Resident 5 s/he wasn't allowed outside of his/her room after 10:00 PM. Resident 5 stated the Caregiver O helped him/her call Licensee B the next morning. Licensee B told Resident 5 the facility was his/her home and s/he was never to be secluded to his/her room by force. Licensee B assured Resident 5 s/he would follow up with the staff member. Resident 5 identified Caregiver Q as the staff member who s/he needed to wake up that night.

On 05/28/2025 at 2:44PM, Surveyor asked Caregiver O if Administrator F had told Resident 5 not to leave his/her room after 10:00 PM. Caregiver O told Surveyor Caregiver Q had reported Resident 5 wasn't to leave his/her room at night, but Resident 5 was upset the next morning. Caregiver O stated s/he connected Resident 5 with Licensee B and s/he was in a

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much better mood afterwards.

On 05/28/2025 at approximately 2:46 PM, Caregiver P knocked on Resident 7's door and interrupted Surveyor's interview with Resident 7. Caregiver P appeared distressed and said s/he needed Surveyor. Surveyor excused himself/herself from Resident 7 and followed Caregiver P out of the room. Caregiver P told Surveyor, "[Resident 5] is a liar, and [s/he] was gonna just leave." Surveyor explained s/he was here to observe the resident's care, and it was not his/her place to intervene. Caregiver P started to walk down the hallway towards Resident 5 and told Surveyor to, "observe this." Caregiver P approached Resident 5 in the facility living room, and said to Resident 5, "I'm not always on my phone ...", then Resident 5 loudly interrupted Caregiver P, "you're the liar!" and then Caregiver P said loudly, "no, you're lying!". Surveyor verbally intervened by telling Caregiver P s/he could not speak to resident's in that manner. Caregiver P stated, "[Expletive] this!" turned around towards the facility front entrance and exited the facility. Caregiver O immediately ran after Caregiver P and exited the facility as well.

On 05/28/2025 at 2:49 PM, Surveyor called Licensee B and reported both Caregiver O and Caregiver P had exited the building leaving Surveyor alone. Licensee B apologized and disconnected with Surveyor to contact Caregiver P.

On 05/28/2025 at approximately 2:52 PM, Surveyor observed Caregiver P and Caregiver O re-enter the facility. Caregiver P apologized to Surveyor. Caregiver P explained s/he feared Resident 5.

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N 214	Continued From page 10 From 05/28/2025 to 05/30/2025, Surveyor identified the following violations of DHS Chapter 83: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.15(3)(a) Administrator Shall Supervise Daily Operation. 3.) 83.32(3)(h) Rights Of Residents: Receive Medication. 4.) 83.35(3)(a) Comprehensive Individualized Service Plan (ISP). 5.) 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 6.) 83.46(1)(h) Portable Space Heaters 7.) 83.55(3) Bath And Toilet Areas: Hand Drying. EXIT INTERVIEW: On 05/30/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator F, Licensee B, and Manager C. Administrator F confirmed Resident 5 reported needing to stomp his/her feet to get Caregiver Q up in the middle of the night. Administrator F reported s/he had told staff they could rest after completing job duties. Administrator F denied following-up on Resident 5's report of needing to wake-up Caregiver Q. Administrator F stated s/he thought Caregiver Q had just been resting from how Resident 5 described the interaction. Licensee B acknowledged s/he had also received this report from Resident 5; and followed-up with Caregiver Q about staying awake during his/her working hours. Surveyor reported during the on-site portion of the survey, s/he had observed a portable space heater in Resident 5's room. Surveyor reported Caregiver O had acknowledged the portable space heater in Resident 5's room. Administrator F stated s/he was not aware Resident 5 had a portable space	N 214		

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heater in his/her room. Surveyor reported during the on-site portion of the survey, s/he observed a roll of paper towel stored on top of the metal grab bar directly above the toilet tank in the staff bathroom, while the wall mounted paper towel dispenser was empty. Surveyor reported Caregiver O had acknowledged the roll of paper towel had been stored above the toilet, while the wall mounted paper towel dispenser was empty. Surveyor reported while reconciling Resident 5's medication administration record (MAR) against the medications physically stored in the medication cart. Surveyor discovered the medication cart did not have a prescription blister pack for his/her Paroxetine tablets, and Caregiver O had stated s/he did not have any Lithium Paroxetine tablets to administer to Resident 5 that morning. Surveyor asked Administrator F why facility staff had been intermittently documenting Resident 5's psychotropic medications as not being available from 04/01/2025 to 05/28/2025. Administrator F asked Surveyor which dates s/he was asking about. Administrator F acknowledged Resident 5's medications were not made available to him/her on 04/01/2025. Administrator F acknowledged Resident 5 had a panic attack which required emergency room admission due to lack of access to his/her scheduled anxiolytic (anti-anxiety) Clonazepam 0.5 mg tablet. Administrator F, Licensee B, and Manager C verified Surveyor had been given the complete resident record for Resident 5. Administrator H, Licensee B and Manager C acknowledged Resident 5's facility record did not contain a list of his/her medical and/or psychiatric diagnoses. Surveyor asked about paperwork listing Family Member R as Resident 5's activated power of attorney (APOA). Licensee B stated Resident 5 was his/her own person and Family Member R was not Resident

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N 214	Continued From page 12 5's APOA. Licensee B acknowledged Family Member R had signed Resident 5's ISP, and Resident 5 had not signed his/her own ISP. Licensee B acknowledged Resident 5 should have signed the ISP. Licensee B and Manager C acknowledged s/he had not been made aware of Resident 5's history of behaviors related to agitation and aggression. Administrator F, Licensee B, and Manager C acknowledged Resident 5's ISP did not have a behavioral plan documented. Administrator F stated on 05/25/2025 Resident 5 became agitated and told Resident 7, "if you keep staring at me I'm going to cut your eyes out," and that local police were called to the facility. Administrator F stated police did not remove Resident 5 from the facility. Regional Director T entered the meeting via zoom. Administrator F denied completing an assessment on Resident 5 after police intervention or updating his/her ISP of the behavior observed. Administrator F stated s/he reported the situation to Family Member R. Administrator F stated s/he was physically at the facility approximately 2-4 hours per day, 4-7 days per week. Administrator F and Licensee B acknowledged Resident 5 currently lived at the facility. Licensee B stated s/he felt Administrator F was doing an adequate job of managing the daily operations of the facility. Licensee B stated Caregiver P usually was Resident 5's biggest advocate and s/he was disappointed to learn of the manner Caregiver P spoke to Resident 5 in front of Surveyor. Administrator F and Licensee B acknowledged Caregiver P was requesting help managing Resident 5's behaviors when Caregiver P asked Surveyor to leave Resident 7's room. Licensee B acknowledged Resident 5's lack of psychotropic medications and behavioral plan were contributing factors to the incident.	N 214		

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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 observation, record review and interview, the provider did not ensure Resident 5 received all prescribed medications in the dosage and at intervals prescribed by their practitioner. On 04/01/2025, the provider admitted Resident 5. The provider did not have Resident 5's medications available from him/her upon arrival. Resident 5 was taking the medication scheduled Clonazepam (Klonopin) for anxiety prior to admission and experienced a panic attack when the medication was not made available to him/her. From 04/10/2025 to 05/29/2025, Resident 5 did not receive 52 medications as prescribed. This is a repeat of statement of deficiency (SOD) TYPT11 dated 01/24/2025. FINDINGS INCLUDE: On 05/28/2025, Surveyor arrived at facility for two verification visits. OBSERVATION:	N 352		

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N 352	Continued From page 14 On 05/28/2025 at 9:52 AM, Surveyor observed the facility medication cart with Caregiver O. Surveyor observed an empty blister pack of Resident 5's lamotrigine 100 mg tablet ordered to be administered two times daily (Picture 1) on top of the medication cart. Surveyor asked Caregiver O to pull up Resident 5's current medication administration record (MAR) on the computer located on top of the medication cart. Caregiver O was able to pull up a May 2025 summary of MAR documentation for Resident 5 and allowed Surveyor to scroll through the month. Surveyor reviewed at 7:03 AM, Caregiver P documented Resident 5's morning dose of Paroxetine Hcl 40 mg tablet as, "No Pass Reason: Other Problems ...needs to see a doctor." Surveyor asked Caregiver O about the Paroxetine tablets. Caregiver O responded that Resident 5's doctors had been making it difficult to get all of Resident 5's medications. Caregiver O stated Resident 5's Paroxetine Hcl 40 mg other medications had not been available to Resident 5 on the day of his/her admission to the facility. Caregiver O explained that after admission Resident 5 refused many of his/her medications but then became more compliant with his/her medications. Caregiver O reported the week before Resident 5 had not been able to sleep during the night. Caregiver O described Resident 5 as verbally abusive towards staff during that period. Caregiver O stated s/he felt like Resident 5 could have been experiencing a "manic phase." Caregiver O stated that Resident 5 was diagnosed with bipolar disorder and schizophrenia. Caregiver O reported that Resident 5 refused his/her medication s/he documented that s/he refused the medication on the MAR. Caregiver O stated when the medication is not available s/he would document that it needs to be ordered from the pharmacy. Caregiver O stated when a medication runs out	N 352		

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N 352	Continued From page 15 s/he will press the re-order button on the electronic health record (EHR). Caregiver O stated s/he did not know what happened after s/he hit the re-order button but that [name of local pharmacy] used [name of local delivery service] to deliver medications to the facility. Caregiver O had reported that compounded with the doctors not maintaining medication orders the pharmacy had also not delivered medications consistently. RECORD REVIEW: On 05/28/2025, Surveyor reviewed Resident 5's facility face sheet. Resident 5 was admitted to the facility on 04/01/2025. On 05/28/2025, Surveyor reviewed Resident 5's most recent assessment and current individualized Service plan ISP. The ISP was dated 04/25/2025. The ISP was not signed by Resident 5. The ISP stated staff were to administer all of Resident 5's medications. On 05/28/2025, Surveyor reviewed Resident 5's clinical after visit summary. The clinical after visit summary was dated 04/01/2025 Resident 5 was treated at the emergency room for an episode of anxiety. On 05/28/2025, Surveyor reviewed Resident 5's April 2025 MAR. The following was documented: - Lamotrigine 100mg tablet, "Take 1 Tablet 2 Times Daily for Mood" 1.) 04/02/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 2.) 04/26/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 3.) 04/27/2025, "No Pass Reason: Not Yet Filled By Pharmacy"	N 352		

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N 352	Continued From page 16 - Lithium ER 450mg tablet, "Take 1 Tablet by Mouth Daily for Bipolar" 1.) 04/01/2025, "No Pass Reason: Other Problems ...didn't arrive until 1p" 2.) 04/27/2025, "No Pass Reason: Not Yet Filled By Pharmacy" - Lurasidone HCL 20mg tablet, "TAKE 1 TABLET BY MOUTH DAILY FOR SCHIZOPHRENIA" 1.) 04/01/2025, "No Pass Reason: Other Problems ...didn't arrive until 1p" 2.) 04/27/2025, "No Pass Reason: Not Yet Filled By Pharmacy" - Paroxetine Hcl 40mg Tablet, "Take 1 Tablet by Mouth at Bedtime for Depression" 1.) 04/01/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 2.) 04/03/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 3.) 04/29/2025, "No Pass Reason: Not Yet Filled By Pharmacy" -Gabapentin 100mg capsule ,"Take 1 Tablet By Mouth At Bedtime For Pain" 1.) 04/01/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 2.) 04/03/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 3.) 04/04/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 4.) 04/05/2025, "No Pass Reason: Out of (inform office)" 5.) 04/06/2025, "No Pass Reason: Refused By Resident ...on order ...none found present in med cart." 6.) 04/07/2025, "No Pass Reason: Not Yet Filled By Pharmacy" On 05/28/2025, Surveyor reviewed Resident 5's	N 352		

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N 352	Continued From page 17 May 2025 MAR. The following was documented: - Lamotrigine 100mg tablet, "Take 1 Tablet 2 Times Daily for Mood" 1.) 05/03/2025, "No Pass Reason: Other Problems ...none in stock" 2.) 05/04/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 3.) 05/07/2025, "No Pass Reason: Not Yet Filled By Pharmacy ...don't have" 4.) 05/08/2025, "No Pass Reason: Not Yet Filled By Pharmacy ...none" 5.) 05/10/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 6.) 05/11/2025 at 8:53 AM, "No Pass Reason: Not Yet Filled By Pharmacy" 7.) 05/11/2025 at 7:38 PM, "No Pass Reason: Out Of (inform office)" 8.) 05/21/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 9.) 05/22/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 10." 05/23/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 11.) 05/24/2025, "No Pass Reason: Out Of (inform office)" 12.) 05/28/2025, "No Pass Reason: Other Problems ... needs to see a doctor" 13.) 05/29/2025, "No Pass Reason: Out Of (inform office)" -Lithium ER 450mg tablet, "Take 1 Tablet by Mouth Daily for Bipolar" 1.) 05/03/2025, "No Pass Reason: Other Problems ...none in stock" 2.) 05/04/2025, "No Pass Reason: Other Problems ...none in stock" 3.) 05/10/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 4.) 05/11/2025, "No Pass Reason: Not Yet Filled By Pharmacy"	N 352		

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N 352	Continued From page 18 5.) 05/24/2025, "No Pass Reason: Not Yet Filled By Pharmacy ...[Resident 5] needs to see a doctor first" 6.) 05/25/2025, ""No Pass Reason: Not Yet Filled By Pharmacy" - Paroxetine Hcl 40mg Tablet, "Take 1 Tablet by Mouth at Bedtime for Depression" 1.) 05/08/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 2.) 05/10/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 3.) 05/11/2025, "No Pass Reason: Out of (inform office)" 4.) 05/12/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 5.) 05/13/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 6.) 05/14/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 7.) 05/15/2025, "No Pass Reason: Out of (inform office)" 8.) 05/20/2025, "No Pass Reason: Out of Building ...staff questioned the medication: either- needs filled or discontinued ...be corrected." 9.) 05/21/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 10.) 05/22/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 11.) 05/23/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 12.) 05/24/2025, "No Pass Reason: Out of (inform office)" 13.) 05/25/2025, "No Pass Reason: Not Needed" 14.) 05/27/2025, "No Pass Reason: Not Yet Filled By Pharmacy" 15.) 05/28/2025, "No Pass Reason: Other Problems ...needs to see a doctor" 16.) 05/29/2025, "No Pass Reason: Out of (inform office)"	N 352		

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N 352	Continued From page 19 -Clonazepam 0.5mg tablet, "Take 3 Tablets (1.5 mg) by Mouth 2 Times Daily": 1.) 05/03/2025, "No Pass Reason: Not Yet Filled By Pharmacy" On 05/30/2025, Surveyor reviewed Resident 5's observation notes from 04/01/2025 to 05/28/2025: 1.) On 04/01/2025 at 11:00 AM, Administrator F documented the following, "[Resident 5] went to the Emergency Room because [s/he] had not had [his/her] controlled medication and was having anxiety. The emergency room doctor gave [him/her] the medication and will send a prescription to [Name Of Pharmacy]. 2.) On 05/03/2025 at 7:45 AM, Caregiver BB documented, "lamotrigine and lithium not in stock" 3.) On 05/03/2025 at 1:30 PM, Caregiver BB documented the following, "having bad anxiety without [his/her] clonazepam]" On 06/19/2025, Surveyor reviewed an e-mail sent from managed care organization (MCO) Manager FF on 6/13/2025 at 11:19 AM. Manager FF wrote MCO had recently meet with facility to discuss Resident 5's care and possible relocation. Manager FF wrote MCO had coordinated Resident 5's medication to be available from admission until his/her medical appointment on 5/13/2025. Manager FF wrote Resident 5's medication orders(s) were to be renewed during the 5/13/2025 appointment. Manager FF wrote Resident 5 had refused to attend the 5/13/2025 appointment; and MCO case manager hadn't been notified of his/her refusal. Manager FF wrote about concerns related to Resident 5's overall treatment by staff. Manager FF described observations of facility staff which demonstrated	N 352		

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N 352	Continued From page 20 lack of knowledge in behavior management. According to of Pearson Nurse's Drug Guide 2015 (pages 365 to 367) , "CLONAZEPAM...Classifications: ANTICONVULSANT, ANTIANXIETY...Controlled Substance: Schedule IV...Route & Dosage...Panic Disorders Adult: PO (by mouth) 1-2 mg/day in divided doses (max: 4 mg/day)...NURSING IMPLICATIONS Assessment & Drug Effects...Both psychological and physical dependence may occur in patient on long-term high dose therapy...Do no abruptly discontinue this drug. Abrupt withdrawl symptoms include convulsion, tremor, abdominal pain and muscle cramps...(page 1685) APPENDIX B U.S. SCHEDULES OF CONTROLLED SUBSTANCES...Schedule IV Lower potential for abuse than Schedule III drugs. Examples: certain psychotropics..." (Pearson Nurse Drug Guide 2015, 2015, p.365, 366, 367, 1685) On 06/11/2025 at 11:57 AM, Surveyor received Resident 5's 05/29/2025 clinical after visit summary from [Name Of Clinic]. Doctor X documented the following, "PRESENTING PROBLEM: [S/He] returns for follow up. [S/He] presented irritable and agitated. [S/He] has been through multiple changes in [his/her] life. [S/He] has moved from the [Name Of Previous Facility] and has moved several times since then. Has been at [his/her] current place for less than one month. Has shown increasing mood swings and agitation at [his/her] facility. Making paranoid comments about people taking things from [him/her]. Better appetite. Sleep initially [s/he] stated was poor later stated was good. Spending more time isolated in [his/her] room. More tense and edgy overall Significant confusion as to [his/her] medications, wether (sic.) [s/he] has	N 352		

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been getting them or exactly what [s/he] is taking. We have medications lists from different places with different amounts. [S/He] [himself/herself] is not sure what [s/he] is on, only that [s/he] wants to be on buspar, klonopin and paxil ...Records Reviewed: Medications, problem list, medical, surgical, family & social histories are current as of 5/29/2025 ...PERTINENT HISTORY ...Mental Health Problems: schizophrenia, ptsd ...MENTAL STATUS ...Anger/Mood: more irritable in general, aggressive verbally and physically at times. Stated [s/he] hoped someone would get a gun and shoot me ...PLAN ...Provided brief education on the psychophysiological affects of stress ...Recommend that [Doctor W] review the above with the patient as needed ...Quite honestly we are not sure what medications [s/he] is prescribed or has been getting. We have different lists of medications from different facilities and providers. We also have mention of [him/her] not getting [his/her] medications. We will try to further sort through what [s/he] has been taking as [s/he] has not been in this clinic for about 10 months. I have not prescribed medications in months for [him/her] but will renew [his/her] klonopin (Clonazepam) for now. Unclear if [s/he] is still on an antipsychotic or [his/her] lithium, [s/he] denies that [s/he] takes these They are working on setting up care closer to [him/her]. [S/He] stated [s/he] has no desire to return here for ongoing follow up ... We discussed [his/her] chronic schizophrenia, treatment of this and stress management skills ..."

INTERVIEW:

On 05/28/2025 at 10:50 AM, Surveyor interviewed Resident 5 in his/her room. Resident 5 stated that s/he preferred to sleep during nighttime hours. Resident 5 stated s/he had been

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diagnosed with manic-depression and lately s/he had not felt well. Resident 5 described feeling increased agitation and depression within the last 2 weeks. Resident 5 described sleeping all day as isolating, and that staff get mad at him/her for making too much noise at night. Resident 5 stated s/he had had a panic attack the first day s/he was at the facility because his/her Clonazepam had gone missing. Resident 5 stated s/he had been refusing his/her lithium but was now interested in restarting the medication. Resident 5 stated s/he did not realize that his/her paroxetine had not been administered to him/her that morning. Resident 5 stated s/he is seeing the doctor tomorrow and hopes to figure how to feel better.

On 05/28/2025 at 12:10 PM, Surveyor spoke with Licensee B over the phone. Licensee B stated Administrator F had made him/her aware Resident 5 had not been sleeping last week. Licensee B reported that staff called 911 on Resident 5 the week prior due to him/her threatening another resident. License B stated police did not remove Resident 5 from the residence. Licensee B reported Administrator F reported to them that Resident 5 psychotropics couldn't be dispensed or given until his/her appointment on May 29th. Licensee B could not explain to Surveyor why Resident 5's MAR showed psychotropic medication orders as still active.

On 05/28/2025 at 12:25 PM, Surveyor spoke with License B over the phone. License B reported the primary care physician (PCP) facility had set up for Resident 5 had not agreed to write an order for his/her psychotropic medications. Licensee B stated Resident 5 psychotropic medications needed to be prescribed by a psychiatrist.

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Licensee B stated Resident 5 was to be seen by psychiatry at [Name Of Clinic]. License B agreed to send Surveyor Resident 5's PCP and pharmacy contact information.

On 05/28/25 at 3:25 PM, Surveyor discussed Resident 5 with Nurse U over the phone. Nurse U reported s/he worked for [Name Of Clinic]. Nurse U verified s/he had access to Resident 5's EHR. Nurse U reported Doctor V had ordered Paroxetine, Lamictal, and Lithium for Resident 5 it had been the plan Resident 5 would be seen on May 14th and the appointment had been documented as cancelled. Nurse U stated facility had called the clinic on 05/22/2025 requesting an order for Clonazepam. Nurse U stated it was explained to facility normally the new primary care physician (PCP) orders psychotropic medications for the patient. Nurse U stated the May 29th appointment was then scheduled because their clinic did not feel comfortable continuing to order medication on a patient they had not personally observed. Nurse U repeated that their clinic had been under the understanding when Resident 5 transferred facilities his/her new PCP would be the one ordering the psychotropic regimen.

On 05/29/2025 at 8:20 AM, Surveyors spoke with Pharmacist S over the phone. Pharmacist S stated s/he had been working with Doctor V to bridge Resident 5's psychotropic medications from 04/01/2025 until s/he established a new doctor, but that Resident 5 had recently missed an appointment with Doctor V. Pharmacist S stated Doctor V refused facilities most recent request to refill Resident 5's psychotropic medications. Pharmacist S stated Resident 5's psychotropic medication had been ordered thru the end of May. Pharmacist S stated Resident 5's psychotropic medications were dispensed with

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the facilities cycle fill at the beginning of the month. Pharmacist S did not know why Resident 5's psychotropic medications hadn't been made available to him/her consistently.

On 05/30/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator F, Licensee B and Manager C. Surveyor reported while reconciling Resident 5's medication administration record (MAR) against the medications physically stored in the medication cart. Surveyor discovered the medication cart did not have a prescription blister pack for his/her Paroxetine tablets, and Caregiver O had stated s/he did not have any Paroxetine tablets to administer to Resident 5 that morning. Surveyor asked Administrator F why facility staff had been intermittently documenting Resident 5's psychotropic medications as not being available from 04/01/2025 to 05/28/2025. Administrator F asked Surveyor which dates s/he was asking about. Administrator F acknowledged Resident 5's medications were not made available to him/her on 04/01/2025. Administrator F acknowledged Resident 5 had a panic attack which required emergency room admission due to lack of access to his/her scheduled anxiolytic (anti-anxiety) Clonazepam 0.5 mg tablet. Administrator F reported Resident 5 had been taken to see Doctor X on 05/29/2025. Administrator F stated Doctor X had explained that consistent medication compliance was very important to Resident 5's overall wellbeing. Licensee B and Manager C verified that facility staff were trained on how to document a resident refusing medication versus the medication not being available in the medication cart.

CROSS REFERENCE: N0386 DHS Chapter 83.35(3)(a) Comprehensive Individualized

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N 352	Continued From page 25 Service Plan (ISP)	N 352		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure a comprehensive individualized service plan (ISP) had been developed for Resident 5. On 04/01/2025, Resident 5 was admitted to provider. Resident 5 was diagnosed with but not limited to schizophrenia. Resident 5's individualized service plan (ISP) did not include signs, symptoms or interventions related to his/her diagnosis of schizophrenia. Following his/her admission Resident 5 experienced the following: falls, anxiety, insomnia and increased depression.	{N 386}		

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{N 386}	Continued From page 26 Since admission the provider had observed Resident 5 engage in the following behaviors verbal aggression towards staff, threatening other residents, and not-following staff's verbal re-directions. On 05/25/2025, Resident 5's symptoms resulted in him/her verbally threatening to rip out Resident 7's eyes followed by refusal to comply with Caregiver P's verbal re-directions. Administrator F called the local police to the facility for a wellness check. This is a repeat violation of statement of deficiency (SOD) E16T11 dated 12/27/2024 and SOD E16T12 03/05/2025. FINDINGS INCLUDE: On 05/28/2025, Surveyor arrived at facility for two verification visits. RECORD REVIEW: On 05/28/2025, Surveyor reviewed Resident 5's facility face sheet. Resident 5 was admitted to the facility on 04/01/2025. On 05/28/2025, Surveyor reviewed Resident 5's most recent assessment and current individualized service plan ISP. The ISP was dated 04/25/2025. The ISP was not signed by Resident 5. The ISP had been signed by Administrator F and Family Member R. The ISP documented Resident 5 had a mental illness but did not specify his/her diagnosis. The ISP did not document Resident 5's observed symptoms of anxiety, insomnia, depression and agitation. The ISP did not document a behavioral plan for Resident 5's observed behaviors of verbal	{N 386}		

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aggression towards staff, threatening other residents, and refusal to follow staff's verbal re-direction. ISP did not have documentation of fall or fall prevention interventions. ISP did describe how to administer Resident 5's oxygen therapy.

On 05/28/2025, Surveyor reviewed Resident 5's clinical after visit summary. The clinical after visit summary was dated 04/01/2025 Resident 5 was treated at the emergency room for an episode of anxiety.

On 05/25/2025, Surveyor reviewed [Name Of Local Police Department] report, IR #M25-03384: 1.) On 05/25/2025 at 8:28 AM, Officer AA documented the following, "Welfare check on [Resident 5] at name of facility. Administrator F requesting a welfare check on the subject because of the way [s/he's] acting towards staff, the strange things [s/he's] saying to staff and [his/her] history of violence they attempted contact with after hours (sic.) mental yesterday but [s/he] lied to them and said everything is all right."

2.) On 05/25/2025 at 9:57 AM, Officer Z documented the following, "Officers were dispatched to [Address Of Facility] for a welfare check on [Resident 5]. The RO (responding officer) spoke to [Administrator F] and [Caregiver P]. Both stated [Resident 5] has been staying here for approximately 1 month and noticed [his/her] mental health has been declining. [Caregiver P] stated [Resident 5] is schizophrenic and needs mental [his/her] medications adjusted. Staff advised [Resident 5] has an appointment coming up this week. [Caregiver P] stated [Resident 5] has been making concerning comments to other residents and getting in their

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{N 386}	Continued From page 28 faces. No history of assaultive behavior. Officer spoke to [Resident 5] who advised [s/he] is upset with staff at night because [s/he] does not sleep well and wakes the staff up. [Resident 5] does not think they should be getting paid to sleep it's their job to help [him/her]. [Resident 5] stated [s/he] has made comments about stories while [s/he] was in prison but does not want to harm anyone. The RO explained to [Resident 5] that if [s/he] wants to move facilities, [s/he] needs to contact [his/her] family. [Resident 5] stated [s/he] agreed and said there won't be any issues. Officers explained to staff there's no criteria for mental health assessment at this time." On 05/30/2025, Surveyor reviewed Resident 5's observation notes from 04/01/2025 to 05/28/2025: 1.) On 04/01/2025 at 11:00 AM, Administrator F documented, "[Resident 5] went to the Emergency Room because [s/he] had not had [his/her] controlled medication and was having anxiety. The emergency room doctor gave [him/her] the medication and will send a prescription to [Name Of Pharmacy]. 2.) On 05/03/2025 at 7:45 AM, Caregiver BB documented, "lamotrigine and lithium not in stock" 3.) On 05/03/2025 at 1:30 PM, Caregiver BB documented, "having bad anxiety without [his/her] clonazepam]" 4.) On 05/06/2025 at 5:30 AM, Caregiver CC documented, "Up all night because [s/he] sleeps almost all day. [S/He] came out 10xs throughout my 8 hour shift. It is getting ridiculous. Need a glass of ice 6xs period [s/he] is waking up a couple of the residents down by [him/her]	{N 386}		

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because [s/he] opens and shuts [his/her] door very loudly. [S/He] is getting to be extremely inconsiderate and [his/her] room is absolutely going to keep the bug problem going. [S/He] has sugary drinks spilled all over on the floor and furniture in [his/her] room."

5.) On 05/06/2025 at 1:45 PM, Caregiver O documented has big ugly bruise on left side and back, I think from (sic.) when [s/he] fell."

6.) On 05/08/2025 at 1:45 PM, Caregiver O documented, "has [his/her] days and nights mixed up"

7.) On 5/14/2025 at 5:30 AM, Caregiver CC documented, "[s/he] did stay in [his/her] room ALL NIGHT LONG. [S/He] only came out 2xs to go to the bathroom. Now hopefully, [s/he] will get on a normal sleep schedule."

8.) On 05/17/2025 at 12:45, Caregiver BB documented, "up and anxious all day, drink way to (sic.) many fluids it, it was constant"

9.) On 05/18 2025 at 5:45 AM, Caregiver CC documented. "[s/he] has been showing aggressive behavior tonight. I've reported it to [Manager C] and [Licensee B]."

10.) On 05/18/2025 at 12:30 PM, Caregiver BB documented, "pacing in and out of [his/her] room, up and down the hallways"

11.) On 05/21/2025 at 5:30 AM, Caregiver CC documented, "[s/he] has been up all night walking the halls"

12.) On 05/21/2025 at 7:45 PM, Caregiver DD documented," o2 was 94 and [s/he] was

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{N 386}	Continued From page 30 breathing fine" 13.) 05/23/2025 at 1:15 PM, Caregiver O documented, "[Resident 5] has exploded today, and has been yelling at everyone today." 14.) 05/23/2025 at 11:00 PM, Caregiver BB documented, "Incident Report for [Resident 5] event notes: [Caregiver BB] observed [Resident 5] on the floor of [his/her] bedroom with [his/her] head out in the doorway. [Caregiver BB] told [him/her] to stay there while [Caregiver BB] call for help but [s/he] got up anyways. [Resident 5] stumbled on [his/her] feet and sat in [his/her] chair." 15.) On 05/25/2025 at 4:45 AM Caregiver EE documented, "Awake all night, telling staff this is [his/her] home and that [s/he] could do whatever [s/he] wanted here, facing up and down hallways, slamming doors, saying [s/he] wants list of numbers or looking for someone to call, [s/he] changes [his/her] moods apparently shortly after evening shift staff leaves ... going into all the bathrooms all hours of the night, messing with TV remotes and staff puts them up when [s/he] get upset about it (sic.) , [s/he] walks into kitchen knows how to unlock the door to see whatever [s/he] can do, staff also caught him trying to fix something in bathroom door way messing with the screw with some gadget [s/he] had in [his/her] room as [s/he] went left staff see what it was as [s/he] noticed [s/he] were being observed. * NOTE: these been (sic.) issues noted past 2-night shifts... wanting TV and radio both on night, staff tells [him/her] that should keep the noise down [s/he] gets upset about it and retaliates telling staff [s/he] can do whatever [s/he] wants here."	{N 386}		

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{N 386}	Continued From page 31 On 06/11/2025 at 11:57 AM, Surveyor received Resident 5's 05/29/2025 clinical after visit summary from [Name Of Clinic]. Doctor X documented the following, "PRESENTING PROBLEM: [S/He] returns for follow up. [S/He] presented irritable and agitated. [S/He] has been through multiple changes in [his/her] life. [S/He] has moved from the [Name Of Previous Facility] and has moved several times since then. Has been at [his/her] current place for less than one month. Has shown increasing mood swings and agitation at [his/her] facility. Making paranoid comments about people taking things from [him/her]. Better appetite. Sleep initially [s/he] stated was poor later stated was good. Spending more time isolated in [his/her] room. More tense and edgy overall Significant confusion as to [his/her] medications, wether (sic.) [s/he] has been getting them or exactly what [s/he] is taking. We have medications lists from different places with different amounts. [S/He] [himself/herself] is not sure what [s/he] is on, only that [s/he] wants to be on buspar, klonopin and paxil ...Records Reviewed: Medications, problem list, medical, surgical, family & social histories are current as of 5/29/2025 ...PERTINENT HISTORY ...Mental Health Problems: schizophrenia, ptsd ...MENTAL STATUS ...Anger/Mood: more irritable in general, aggressive verbally and physically at times. Stated [s/he] hoped someone would get a gun and shoot me ...PLAN ...Provided brief education on the psychophysiological affects of stress ...Recommend that [Doctor W] review the above with the patient as needed ...Quite honestly we are not sure what medications [s/he] is prescribed or has been getting. We have different lists of medications from different facilities and providers. We also have mention of [him/her] not getting [his/her] medications. We will try to further sort through what [s/he] has been taking as [s/he] has	{N 386}		

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{N 386}	Continued From page 32 not been in this clinic for about 10 months. I have not prescribed medications in months for [him/her] but will renew [his/her] klonopin (Clonazepam) for now. Unclear if [s/he] is still on an antipsychotic or [his/her] lithium, [s/he] denies that [s/he] takes these They are working on setting up care closer to [him/her]. [S/He] stated [s/he] has no desire to return here for ongoing follow up ... We discussed [his/her] chronic schizophrenia, treatment of this and stress management skills ..." On 06/19/2025, Surveyor reviewed an e-mail sent from managed care organization (MCO) Manager FF on 6/13/2025 at 11:19 AM. Manager FF wrote MCO had recently meet with facility to discuss Resident 5's care and possible relocation. Manager FF wrote MCO had coordinated Resident 5's medication to be available from admission until his/her medical appointment on 5/13/2025. Manager FF wrote Resident 5's medication order(s) were to be renewed during the 5/13/2025 appointment. Manager FF wrote Resident 5 had refused to attend the 5/13/2025 appointment; and MCO case manager hadn't been notified of his/her refusal. Manager FF wrote about concerns related to Resident 5's overall treatment by staff. Manager FF described observations of facility staff which demonstrated lack of knowledge in behavior management. The Mayo Clinic Website defines schizophrenia as, "Schizophrenia is a serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior. Hallucinations involve seeing things or hearing voices that aren't observed by others. Delusions involve firm beliefs about things that are not true. People with schizophrenia can seem	{N 386}		

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to lose touch with reality, which can make daily living very hard...People with schizophrenia need lifelong treatment. This includes medicine, talk therapy and help in learning how to manage daily life activities...Because many people with schizophrenia don't know they have a mental health condition and may not believe they need treatment, many research studies have examined the results of untreated psychosis. People who have psychosis that is not treated often have more-severe symptoms, more stays in a hospital, poorer thinking and processing skills and social outcomes, injuries, and even death. On the other hand, early treatment often helps control symptoms before serious complications arise, making the long-term outlook better ..." (Source: The Mayo Clinic Website, Schizophrenia, October 16, 2024, https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443 (retrieval date - June 6, 2025).)

INTERVIEW:

On 05/28/2025 at 9:52 AM, Surveyor observed the facility medication cart with Caregiver O. Caregiver O responded that Resident 5's doctors had been making it difficult to get all Resident 5's medications. Caregiver O stated Resident 5's Paroxetine Hcl 40 mg tablets had not been made available to Resident 5 on the day of his/her admission to the facility. Caregiver O explained that after admission Resident 5 refused many of his/her medications but then became more compliant with his/her medications. Caregiver O reported the week before Resident 5 had not been able to sleep during the night. Caregiver O described Resident 5 as verbally abusive towards staff during that period. Caregiver O stated s/he felt like Resident 5 could have been experiencing

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a "manic phase." Caregiver O stated that Resident 5 was diagnosed with bipolar disorder and schizophrenia.

On 05/28/2025 at 10:50 AM, Surveyor interviewed Resident 5 in his/her room. Resident 5 stated that s/he preferred to sleep during nighttime hours. Resident 5 stated s/he had been diagnosed with manic-depression and lately s/he had not felt well. Resident 5 described feeling increased agitation and depression within the last 2 weeks. Resident 5 described sleeping all day as isolating, and that staff get mad at him/her for making too much noise at night. Resident 5 stated s/he had had a panic attack the first day s/he was at the facility because his/her Clonazepam had gone missing. Resident 5 stated s/he had been refusing his/her lithium but was now interested in restarting the medication. Resident 5 stated s/he did not realize that his/her paroxetine had not been administered to him/her that morning. Resident 5 stated s/he is seeing the doctor tomorrow and hopes to figure how to feel better.

On 05/30/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator F, Licensee B and Manager C. Administrator F, Licensee B, and Manager C verified Surveyor had been given the complete resident record for Resident 5. Administrator H, Licensee B and Manager C acknowledged Resident 5's facility record did not contain a list of his/her medical and/or psychiatric diagnoses. Surveyor asked about paperwork listing Family Member R as Resident 5's activated power of attorney (APOA). Licensee B stated Resident 5 was his/her own person and Family Member R was not Resident 5's APOA. Licensee B acknowledged Family Member R had signed Resident 5's ISP, and

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{N 386}	Continued From page 35 Resident 5 had not signed his/her own ISP. Licensee B acknowledged Resident 5 should have signed the ISP and not Family Member R. Administrator F stated s/he had learned after admitting Resident 5 to the facility of his/her history of behaviors related to his/her mental illness. Licensee B and Manager C reported they had not been made aware of Resident 5's history of behaviors related to his/her mental illness prior to admission. Administrator F, Licensee B, and Manager C acknowledged Resident 5's ISP did not have a behavioral plan documented. Administrator F stated on 05/25/2025 Resident 5 became agitated and told Resident 7, "if you keep staring at me I'm going to cut your eyes out," and that local police were called to the facility. Administrator F stated police did not remove Resident 5 from the facility. Regional Director T entered the meeting via zoom. Administrator F denied completing an assessment on Resident 5 after police intervention or hospitalization. Administrator F denied updating Resident 5's ISP needs/behaviors observed. CROSS REFERENCE: N0352 DHS Chapter 83.32(3)(h) Right Of Residents: Receive Medication	{N 386}		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified	N 397		

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resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure at least one qualified resident care staff was on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring.

During night time hours Resident 5 had found Caregiver Q sleeping in the main living room of the facility. Caregiver Q was the only staff member on duty at the time.

On 05/28/2025, following a loud verbal exchange between Caregiver P and Resident 5. Caregiver P exited the facility and Caregiver O followed him/her out of the building. Surveyor was alone in

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1ST HEALTH LLC	215 3RD ST MONROE, WI 53566

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N 397	Continued From page 37 the building for approximately 2 minutes. This is a repeat of statement of deficiency (SOD) E16T11 dated 12/23/2024. FINDINGS INCLUDE: Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's. On 05/28/2025, Surveyor arrived at facility for 2 verification visits. RECORD REVIEW: On 05/25/2025, Surveyor reviewed [Name Of Local Police Department] report, IR #M25-03384: On 05/25/2025 at 9:57 AM, Officer Z documented the following, "Officers were dispatched to [Address Of Facility] for a welfare check on [Resident 5]. The RO (responding officer) spoke to [Administrator F] and [Caregiver P]. Both stated [Resident 5] has been staying here for approximately 1 month and noticed [his/her] mental health has been declining. [Caregiver P] stated [Resident 5] is schizophrenic and needs mental [his/her] medications adjusted. Staff advised [Resident 5] has an appointment coming up this week. [Caregiver P] stated [Resident 5] has been making concerning comments to other residents and getting in their faces. No history of assaultive behavior. Officer spoke to [Resident 5] who advised [s/he] is upset with staff at night because [s/he] does not sleep well and wakes the	N 397		

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staff up. [Resident 5] does not think they should be getting paid to sleep it's their job to help [him/her]. [Resident 5] stated [s/he] has made comments about stories while [s/he] was in prison but does not want to harm anyone. The RO explained to [Resident 5] that if [s/he] wants to move facilities, [s/he] needs to contact [his/her] family. [Resident 5] stated [s/he] agreed and said there won't be any issues. Officers explained to staff there's no criteria for mental health assessment at this time."

On 05/28/2025, Surveyor reviewed the facility staff schedule from 05/04/2025 to 05/28/2025. Caregiver Q was documented as working alone from 10:00 PM to 6:00 AM on the following nights: 05/06/2025, 05/08/2025, 05/13/2025, 05/15/2025, 05/20/2025, 05/22/2025 and 05/27/2025.

On 05/29/2025, Surveyor reviewed Caregiver Q disciplinary report dated 05/28/2025. Administrator F documented the following, "Date: 05-28-2025 ... Incident Description: It has been reported by residents and corroborated by staff that during multiple night shifts, [Caregiver Q] was found to be sleeping so deeply that residents in need of assistance were unable to wake [him/her]. According to residents, this has occurred on several instances particularly during your shifts this month of May, and in at least one instance, a resident reported a delay in receiving needed help that night. This behavior presents a serious risk to resident health and safety, violates the expectations of CBRF caregiver responsibilities, and is a breach of regulations pertaining to supervision, resident rights, and staff conduct ..."

OBSERVATION AND INTERVIEW:

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N 397	Continued From page 39 On 05/28/2025 at 2:16 PM, Surveyor interviewed Caregiver P. Caregiver P stated Resident 5 gets upset when s/he is forced to wake up staff at night. Caregiver P stated s/he did not agree with the policy, but Administrator F had told night shift staff they could sleep after they were done with their "chores." Caregiver P showed Surveyor a list of night shift duties to be completed before staff could go to sleep (Picture 3). Caregiver P reported an incident of night shift staff member sleeping, and Resident 5 stomped loudly behind them to wake them up. Caregiver P reported s/he worked PM shift and did not administer medication to Resident 5. Caregiver P stated s/he called the police on Resident 5 because s/he became agitated with Resident 7 and said s/he was going to cut his/her eyes out. Caregiver P reported Resident 5 was not following verbal re-directions. On 05/28/2025 at 2:40 PM, Surveyor interviewed Resident 5. Resident 5 reported there was a staff member who worked night shift, and s/he was in a deep sleep. Resident 5 reported s/he could not wake him/her up with normal volume talking. Resident 5 stated s/he had clapped his/her hands loudly and banged on the floor to wake up the staff member. Resident 5 reported this staff member called Administrator F and Administrator F told Resident 5 s/he wasn't allowed outside of his/her room after 10:00 PM. Resident 5 stated the Caregiver O helped him/her call Licensee B the next morning. Licensee B told Resident 5 the facility was his/her home and s/he was never to be secluded to his/her room by force. Licensee B assured Resident 5 s/he would follow up with the staff member. Resident 5 identified Caregiver Q as the staff member who s/he needed to wake up that night.	N 397		

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N 397	Continued From page 40 On 05/28/2025 at 2:44PM, Surveyor asked Caregiver O if Administrator F had told Resident 5 not to leave his/her room after 10:00 PM. Caregiver O told Surveyor Caregiver Q had reported Resident 5 wasn't to leave his/her room at night, but Resident 5 was upset the next morning. Caregiver O stated s/he connected Resident 5 with Licensee B and s/he was in a much better mood afterwards. On 05/28/2025 at approximately 2:46 PM, Caregiver P knocked on Resident 7's door and interrupted Surveyor's interview with Resident 7. Caregiver P appeared distressed and said s/he needed Surveyor. Surveyor excused himself/herself from Resident 7 and followed Caregiver P out of the room. Caregiver P told Surveyor, "[Resident 5] is a liar, and [s/he] was gonna just leave." Surveyor explained s/he was here to observe the resident's care, and it was not his/her place to intervene. Caregiver P started to walk down the hallway towards Resident 5 and told Surveyor to, "observe this." Caregiver P approached Resident 5 in the facility living room, and said to Resident 5, "I'm not always on my phone ...", then Resident 5 loudly interrupted Caregiver P, "you're the liar!" and then Caregiver P said loudly, "no, you're lying!". Caregiver P stated, "[Expletive] this!" turned around towards the facility front entrance and exited the facility. Caregiver O immediately ran after Caregiver P and exited the facility as well. On 05/28/2025 at 2:49 PM, Surveyor called Licensee B and reported both Caregiver O and Caregiver P had exited the building leaving Surveyor alone. Licensee B apologized and disconnected with Surveyor to contact Caregiver P.	N 397		

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N 397	Continued From page 41 On 05/28/2025 at approximately 2:52 PM, Surveyor observed Caregiver P and Caregiver O re-enter the facility. Caregiver P apologized to Surveyor. Caregiver P explained s/he feared Resident 5. On 05/30/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator F, Licensee B and Manager C. Administrator F confirmed Resident 5 reported needing to stomp his/her feet to get Caregiver Q up in the middle of the night. Administrator F reported s/he had told staff they could rest after completing job duties. Administrator F denied following-up on Resident 5's report of needing to wake-up Caregiver Q. Administrator F stated s/he thought Caregiver Q had just been resting from how Resident 5 described the interaction. Licensee B acknowledged s/he had also received this report from Resident 5; and followed-up with Caregiver Q about staying awake during his/her working hours. Licensee B apologized to Surveyor for Caregiver P and Caregiver O leaving him/her alone in the facility for approximately 2 minutes. Licensee B stated Caregiver P usually was Resident 5's biggest advocate and s/he was disappointed to learn of the manner Caregiver P spoke to Resident 5 in front of Surveyor. Administrator F and Licensee B acknowledged Caregiver P was requesting help managing Resident 5's behaviors when Caregiver P asked Surveyor to leave Resident 7's room.	N 397		
N 503	83.46(1)(b) Portable space heaters prohibited. The use of portable space heaters is prohibited except for Underwriters Laboratories listed electric heating equipment that is listed for	N 503		

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permanent attachment to the wall. Portable space heaters shall have an automatic thermostatic control and shall be physically attached to a wall.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure the use of space heaters that were not physically attached to the wall were prohibited.

On 05/28/2025, Surveyor and Caregiver O observed a portable space heater plugged into the wall outlet of Resident 5's room. The portable space heater was on.

FINDINGS INCLUDE:

On 05/25/2025, Surveyor arrived at facility for two verification visits.

On 05/25/2025 at 10:50 AM, Surveyor interviewed Resident 5 in his/her room. Surveyor observed a small portable space heater under Resident 5's table. The portable space heater was plugged into a wall outlet. The portable space heater was on and pushing out hot air.

On 05/25/2025 at 11:00 AM, Caregiver O acknowledged the portable space heater in Resident 5's room. Caregiver O responded, "yes" when asked if Administrator F was aware of Resident 5's portable space heater.

On 05/30/2025 at 1:00 PM, Surveyor discussed the above concern with Administrator F, Licensee B and Manager C. Surveyor reported during the on-site portion of the survey, s/he had observed a portable space heater plugged into a wall outlet of Resident 5's room. Surveyor reported Caregiver

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N 503	Continued From page 43 O had acknowledged the portable space heater in Resident 5's room. Administrator F stated s/he was not aware Resident 5 had a portable space heater in his/her room.	N 503		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the enclosed toweled dispenser had single use paper towels. The paper towel dispenser was empty. This is a repeat of statement of deficiency (SOD): SOD TYPT11 dated 01/24/2025. FINDINGS INCLUDE: On 05/28/25, Surveyor arrived at facility for two verification visits. On 05/28/2025 at 10:15 AM, Surveyor observed the bathroom connected to the resident living room/dining area. A roll of paper towel was stored on the grab bar directly above the toilet tank. The paper towel dispenser mounted to the wall was empty (Picture 1). On 05/28/2025 at 10:20 AM, Surveyor asked Caregiver O to observe the bathroom Caregiver O acknowledged the paper towel dispenser	N 612		

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N 612	Continued From page 44 mounted on the wall was empty, while a roll of paper towel was set on top of the grab bar directly above the toilet tank. Caregiver O stated it was a night shift staff responsibility to refill the paper towel dispenser. On 05/30/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator F, Licensee B and Manager C. Surveyor reported during the on-site portion of the survey, s/he observed a roll of paper towel roll stored on the metal grab bar directly above the toilet tank in the staff bathroom, while the wall mounted paper towel dispenser was empty. Surveyor reported Caregiver O had acknowledged the roll of paper towel had been stored above the toilet, while the wall mounted paper towel dispenser was empty.	N 612		