STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020250	A. BUILDING: _____ B. WING _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMERSLEY HOUSE	5222 HAMMERSLEY ROAD MADISON, WI 53711

(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 From 01/29/2025 to 02/04/2025, Surveyor conducted a standard survey at Hammersley House, a CBRF in Madison. Seventeen deficiencies were identified. The facility continues to operate with a probationary license that will expire on 08/01/2025. Census: 8	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers reviewed were screened for communicable disease, including tuberculosis, within 90 days before the start of their employment. Caregiver C, who was providing care while Surveyor was present, had not been screened for	N 220		

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

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N 220	Continued From page 1 communicable disease. Findings include: On 01/29/2025 at approximately 10:50 a.m., Surveyor reviewed the provider's employee records, provided by Administrator A. Surveyor noted that the records did not include a record for Caregiver C, who was providing care to residents while Surveyor was present. On 01/29/2025 at approximately 10:55 a.m., Surveyor requested Caregiver C's record from Administrator A. Administrator A stated s/he did not have an employee record for Caregiver C because s/he was hired while consultants were managing the facility. On 01/29/2025 at approximately 11:00 a.m., Surveyor and Administrator A interviewed Caregiver C and asked if s/he had completed a communicable disease screen, including tuberculosis test, at the time of his/her hire. Caregiver C replied, "No."	N 220		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification.	N 223		

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N 223	Continued From page 2	N 223		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a record was maintained for 1 of 3 employees reviewed. The provider did not have a background check on file for Caregiver C. The provider did not have documentation of delegation for injectables for Caregiver B and Caregiver C.

Findings include:

On 01/29/2025 at approximately 10:50 a.m., Surveyor reviewed the provider's employee records, provided by Administrator A. Surveyor noted that the records did not include a record for Caregiver C, who was providing care to residents while Surveyor was present, and records did not include documentation of RN delegation for Caregiver B.

On 01/29/2025 at approximately 10:55 a.m., Surveyor requested Caregiver C's record from Administrator A. Administrator A stated s/he did not have an employee record for Caregiver C because s/he was hired while consultants were managing the facility. Administrator A stated both Caregiver C and Caregiver B had received RN delegation for injectables, but the delegation occurred at the provider's affiliated facility so documentation was at that facility.

On 01/29/2025 at approximately 11:00 a.m., Surveyor and Administrator A interviewed Caregiver C and asked if s/he had completed a background check at the time of hire. Caregiver C replied, "Yes," but stated s/he wouldn't know where the documentation was.

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N 223	Continued From page 3 The provider was given through 01/30/2025 to provide follow up documentation. Documentation of a background check for Caregiver C or RN delegation for Caregiver C and Caregiver B were not received.	N 223		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents reviewed were provided an admission agreement as provided. Resident 1, Resident 2 and Resident 3 had not completed an admission agreement with the provider. Findings include: The provider obtained a probationary license on 08/01/2024 to provide care for up to 8 individuals with diagnoses including advanced age, irreversible dementia/Alzheimer's, traumatic brain injury, emotionally disturbed/mental illness and physically disabled. On 01/29/2025 at approximately 11:15 a.m., Surveyor reviewed resident records and identified the following concerns: - Resident 1 was admitted to the provider's facility on 11/11/2024. Resident 1's record did not include a complete admission agreement.	N 301		

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N 301	Continued From page 4 - Resident 2 was admitted to the provider's facility on 08/09/2021, when the facility was owned and operated by a different provider. Resident 2's record did not include an admission agreement completed with the current provider. - Resident 3 was admitted to the provider's facility on 01/06/2016, when the facility was owned and operated by a different provider. Resident 3's record did not include an admission agreement completed with the current provider. On 01/29/2025 at approximately 1:35 p.m., Surveyor reviewed concern with Administrator A and Caregiver B that the provider did not have a complete admission agreement on file for Resident 1 and that Resident 2 and Resident 3's admission agreements were not updated to reflect the current provider, who had been operating the facility since 08/01/2024. Administrator A made note of Surveyor's concern and explained that s/he had recently taken over the administrative role approximately 1 month prior to Surveyor's visit.	N 301		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.	N 302		

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N 302	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed, that had admitted since the provider was issued a probationary license, was screened for communicable disease, including tuberculosis, within 90 days before or 7 days after admission. Resident 1's tuberculosis test was completed greater than 90 days prior to his/her admission. Findings include: On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 11/11/2024. Resident 1's record included a tuberculosis test, dated 07/11/2024, greater than 90 days prior to his/her admission. The record did not include a communicable disease screen/questionnaire. On 01/29/2025 at approximately 1:35 p.m., Surveyor reviewed concern with Administrator A and Caregiver B that Resident 1's record did not indicate s/he had been screened for communicable disease, including a tuberculosis test, within 90 days prior to hire. Administrator A explained that Resident 1 was admitted to the provider's facility when consultants were managing.	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

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In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 residents received their medications as prescribed. Resident 2 did not receive his/her Ademlog Solostar 100 unit/ml as prescribed. Resident 3 did not receive his/her Insulin Aspart 100 unit/ml as prescribed.

Findings include:

Example 1 - Resident 2:

Resident 2 was admitted to the provider's facility on 08/09/2021 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 2's ISP, dated 02/14/2024, indicated the provider's staff was responsible for Resident 2's medication administration. Resident 2's physician orders included:

- Admelog Solostar 100 unit/ml - Inject 9 units in the morning and evening (Hold if blood sugar is <100) plus sliding scale of <151-0 units, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, 401-450=7 units, >450=8 units.

- Admelog Solostar 100 unit/ml - Inject 8 units at noon (Hold if blood sugar is <100) plus sliding

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scale of <151-0 units, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, 401-450=7 units, >450=8 units.

- Admelog Solostar 100 unit/ml - Inject at bedtime based on sliding scale of <251=0 units, 251-300=1 unit, 301-350=2 units, 351-400=3 units, >400=4 units.

Resident 2's MAR, dated 01/01/2025 to 01/29/2025, documented the following occurrences of Resident 2's Admelog Solostar 100 unit/ml's physician order for sliding scale not being followed:

- 01/03/2025 at 12:55 p.m. Blood Sugar 236 - 4 units of insulin administered.
*Per order, 3 units of insulin should have been administered.
- 01/06/2025 at 4:03 p.m. Blood Sugar 350 - 6 units of insulin administered.
*Per order, 5 units of insulin should have been administered.
- 01/07/2025 5:22 p.m. Blood Sugar 347 - 6 units administered.
*Per order, 5 units of insulin should have been administered.
- 01/12/2025 at 5:13 p.m. Blood Sugar 350 - 4 units of insulin administered.
*Per order, 5 units of insulin should have been administered.
- 01/18/2025 at 7:26 p.m. Blood Sugar 431 - 6 units of insulin administered.
*Per order, 4 units of insulin should have been administered.
- 01/22/2025 at 5:45 p.m. Blood Sugar 304 - 6 units of insulin administered.
*Per order, 5 units of insulin should have been administered.

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- 01/28/2025 at 12:57 p.m. Blood Sugar 413 - 6 units of insulin administered.
*Per order, 7 units of insulin should have been administered.
- 01/28/2025 at 6:21 p.m. Blood Sugar 313 - 6 units of insulin administered.
*Per order, 5 units of insulin should have been administered.

On 01/29/2025 at approximately 1:30 p.m., Surveyor interviewed Administrator A and Caregiver B. Surveyor reviewed concerns with sliding scale insulin orders not being followed. Administrator A replied, "That's a lot of insulin," as Surveyor reviewed Resident 2's insulin administration.

Resident 2's MAR, dated 01/01/2025 to 01/29/2025, documented the following occurrences of Resident 2's base unit of Admelog Solostar 100 unit/ml being completely held due to resident not eating:

- 01/04/2025 at 11:40 a.m. Blood Sugar 95
- 01/05/2025 at 8:13 a.m. Blood Sugar 134
- 01/11/2025 at 8:23 a.m. Blood Sugar 116
- 01/12/2025 at 8:56 a.m. Blood Sugar 349
- 01/12/2025 at 11:32 a.m. Blood Sugar 275
- 01/24/2025 at 8:53 a.m. Blood Sugar 43

On 02/04/2025 at approximately 1:40 p.m., Surveyor interviewed Caregiver B. Surveyor shared observation that Resident 2's base unit of insulin was completely held at times. Surveyor requested the physician order instructing staff to hold Resident 2's base unit if s/he did not eat. Caregiver B reviewed Resident 2's record and replied, "Oh, maybe that was an old order." Caregiver B went on to explain that Resident 2 previously had an order to hold the base unit

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based on intake, but that the order must have gotten updated and caregivers were still following the old order.

Resident 2's MAR, dated 01/01/2025 to 01/29/2025, documented the following occurrences of Resident 2 receiving 5 units of base Admelog Solostar 100 unit/ml, rather than 9 units as prescribed, due to Resident 2 eating only half his/her meal:

- 01/10/2025 at 9:02 p.m. Blood Sugar 72
- 01/18/2025 at 5:26 p.m. Blood Sugar 399
- 01/19/2025 at 8:31 a.m. Blood Sugar 332
- 01/26/2025 at 9:10 a.m. Blood Sugar 314

On 02/04/2025 at approximately 1:40 p.m., Surveyor interviewed Caregiver B. Surveyor shared observation that Resident 2's base unit was reduced to 5 units when Resident 2 only ate half his/her meal. Surveyor requested the physician order instructing staff to decrease Resident 2's base unit based on intake. Caregiver B reviewed Resident 2's record and replied, "Oh, maybe that was an old order." Caregiver B went on to explain that Resident 2 previously had an order to reduce the base unit based on intake, but that the order must have gotten updated and caregivers were still following the old order.

Example 2 - Resident 3:

Resident 3 was admitted to the provider's facility on 01/06/2016 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 3's ISP, dated 01/02/2025, indicated the provider's staff was responsible for Resident 3's medication administration. Resident 3's physician orders

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N 352	Continued From page 10 included: Insulin Aspart 100 unit/ml (Start Date: 11/01/2022) - Inject in the morning, at noon and in the evening based on sliding scale of <151=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, >450=14 units & Call MD. Max dose 48 units/day. Resident 3's MAR, dated 01/01/2025 to 01/29/2025, documented the following occurrences of Resident 3's Insulin Aspart 100 unit/ml's physician order not being followed: - 01/02/2025 1:22 p.m. Blood Sugar 290 - 0 units of insulin administered. *Per order, 6 units of insulin should have been administered. - 01/02/2025 4:30 p.m. Blood Sugar 126 - 2 units of insulin administered. *Per order, 0 units of insulin should have been administered. On 01/29/2025 at approximately 1:30 p.m., Surveyor interviewed Administrator A and Caregiver B. Surveyor reviewed concerns with sliding scale insulin orders not being followed. Administrator A replied, "That's a lot of insulin," as Surveyor reviewed Resident 3's insulin administration.	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by:	N 388		

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N 388	Continued From page 11 Based on record review and interview, the provider did not ensure 1 of 3 individual service plans (ISP) reviewed were followed. The provider did not monitor Resident 2's bowel movements as indicated on his/her ISP. Findings include: On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 08/09/2021when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 2's diagnoses included celiac disease. Resident 2's ISP, dated 02/14/2024, documented that staff should monitor and document Resident 2's bowel movements. Resident 2's record did not include monitoring or documentation of bowel movements. On 01/29/2025 at approximately 11:50 a.m., Surveyor interviewed Caregiver B and asked if the provider monitored Resident 2's bowel movements. Caregiver B replied, "No. We don't do that."	N 388		
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	N 389		

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resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 individual service plans (ISP) reviewed were updated when there was a change in the resident's needs, abilities or physical or mental condition and that the ISP included the signature of all individuals involved with the ISP. Resident 2's ISP was not updated to include his/her hallucinations. Resident 1's ISP did not include their signature.

Findings include:

On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 2:

On 01/29/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 2's needs with Caregiver B. Caregiver B stated Resident 2 hallucinated nearly every day. Caregiver B stated Resident 2 appeared fearful when hallucinating, would talk to individuals that were not there and would require redirection from staff to calm him/her. Surveyor reviewed Resident 2's ISP, dated 02/14/2024, and noted the ISP did not include Resident 2's hallucinations.

Example 2 - Resident 1:

Resident 1 was admitted to the provider's facility

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N 389	Continued From page 13 on 11/11/2024. Resident 1's record indicated s/he was his/her own decision maker. Resident 1's ISP, dated 11/12/2024, was not signed by him/herself. On 01/29/2025 at approximately 1:35 p.m., Surveyor reviewed concern with Administrator A and Caregiver B that 2 of 3 ISPs reviewed were either not updated or not signed by involved parties. Administrator A explained that s/he had recently taken over the administrative role approximately 1 month prior to Surveyor's visit and that s/he was still working on getting caught up with documentation.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed had their mental and physical capability to respond to a fire alarm evaluated. Resident 3 and Resident 2's record did not include an evacuation	N 393		

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N 393	Continued From page 14	N 393		

evaluation.

Findings include:

The provider obtained a probationary license on 08/01/2024 to provide care for up to 8 individuals with diagnoses including advanced age, irreversible dementia/Alzheimer's, traumatic brain injury, emotionally disturbed/mental illness and physically disabled.

On 01/29/2025 at approximately 11:15 a.m., Surveyor reviewed resident records, which indicated the following:

- Resident 3 was admitted to the provider's facility on 01/06/2016 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 3's record did not include an evacuation assessment.
- Resident 2 was admitted to the provider's facility on 08/09/2021 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 2's record did not include an evacuation assessment.

On 01/29/2025 at approximately 1:35 p.m., Surveyor reviewed concern with Administrator A and Caregiver B that Resident 3 and Resident 2's record did not include an evacuation assessment. Administrator A explained that s/he had recently taken over the administrative role approximately 1 month prior to Surveyor's visit and that s/he would need to follow up with prior management regarding evacuation assessments.

The provider was given through 01/30/2025 to provide follow up documentation. Documentation

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N 393	Continued From page 15 of evacuation assessments was received.	N 393		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed, who received a scheduled psychotropic medication, was reassessed by a pharmacist, practitioner or registered nurse at least quarterly for the desired responses and possible side effects of the medication. Findings include: On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed resident records provided by Administrator A. Resident 2 was admitted to the provider's facility on 08/09/2021 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 2's physician orders included Escitalopram 20 mg (Start Date: 08/09/2021) daily for depression. Resident 2's	N 407		

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N 407	Continued From page 16 record did not include a scheduled psychotropic review. On 01/29/2025 at approximately 11:00 a.m., Surveyor asked Administrator A if Resident 2 had quarterly scheduled psychotropic reviews completed. Administrator A stated s/he would need to check records further because s/he had recently taken over the administrative role approximately 1 month prior to Surveyor's visit. The provider was given through 01/30/2025 to provide follow up documentation. Documentation of scheduled psychotropic reviews was not received.	N 407		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 1 of 3 residents reviewed had accurate documentation of his/her medication administration. Resident 1's	N 415		

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N 415	Continued From page 17 Medication Administration Record (MAR), dated 01/01/2025 to 01/29/2025, documented 8 administrations of Vitamin B-1 100 mg when the medication was unavailable for administration. Findings include: On 01/29/2025 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record and the provider's medication storage with Caregiver B. Resident 1 admitted to the provider's facility on 11/11/2024. Resident 1's physician orders included an order for Vitamin B-1 100 mg (Start Date: 11/13/2024) - Take 1 tablet twice daily. Resident 1's MAR, dated 01/01/2025 to 01/29/2025, indicated s/he had the Vitamin B-1 100 mg administered 8 times (01/03/2025, 01/13/2025, 01/14/2025, 01/18/2025, 01/19/2025, 01/23/2025, 01/24/2025 and 01/27/2025); however, the medication was documented as unavailable 19 times. Surveyor observed the provider did not have Vitamin B-1 100 mg available in the medication cart for administration and that the "Physician Order Sheet" indicated the medication was pending authorization. Surveyor shared observation with Caregiver B that Vitamin B-1 100 mg was unavailable, and Caregiver B confirmed the medication was unavailable throughout the month pending authorization.	N 415		
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	N 431		

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N 431	Continued From page 18	N 431		

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 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 3 of 3 residents reviewed had their health monitored and documented. Resident 2, Resident 1 and Resident 3 did not have their blood sugars monitored as ordered.

Findings include:

On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed resident records and identified

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N 431	Continued From page 19 the following concerns: Example 1 - Resident 2: Resident 2 was admitted to the provider's facility on 08/09/2021 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 2's physician orders included an order to check blood sugars 4 times daily at 8:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. to determine need for sliding scale insulin. (Start Date: 09/24/2024). Resident 2's Medication Administration Record (MAR), dated 01/01/2025 to 01/29/2025, did not document blood sugar monitoring on the following dates and times: 01/03/2025 8:00 a.m., 01/06/2025 8:00 a.m., 01/06/2025 12:00 p.m., 01/07/2025 8:00 a.m., 01/10/2025 5:00 p.m., 01/13/2025 5:00 p.m., 01/18/2025 12:00 p.m., 01/20/2025 5:00 p.m., 01/22/2025 8:00 a.m., 01/23/2025 5:00 p.m., 01/24/2025 12:00 p.m., 01/24/2025 5:00 p.m. and 01/28/2025 8:00 a.m. Example 2 - Resident 1: Resident 1 was admitted to the provider's facility on 11/11/2024. Resident 1's physician orders included an order to test blood sugars 3 times daily at 8:00 a.m., 12:00 p.m. and 5:00 p.m. (Start Date: 11/13/2024). Resident 1's MAR, dated 01/01/2025 to 01/29/2025, did not document blood sugar monitoring on the following dates and times: 01/07/2025 at 8:00 a.m., 01/13/2025 at 5:00 p.m., 01/14/2025 at 12:00 p.m., 01/18/2025 at 12:00 p.m., 01/19/2025 at 5:00 p.m., 01/22/2025 at 8:00 a.m. and 5:00 p.m., 01/23/2025 at 5:00 p.m., 01/24/2025 at 12:00 p.m. and 5:00 p.m. and 01/27/2025 at 8:00 a.m.	N 431		

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N 431	Continued From page 20 Example 3 - Resident 3: Resident 3 was admitted to the provider's facility on 01/06/2016 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 3's physician orders included an order to test blood sugars 4 times daily at 8:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. (Start Date: 08/13/2022). Resident 3's MAR, dated 01/01/2025 to 01/29/2025, did not document blood sugar monitoring on the following dates and times: 01/07/2025 8:00 a.m., 01/09/2025 12:00 p.m., 01/15/2025 8:00 a.m., 01/15/2025 12:00 p.m., 01/16/2025 8:00 p.m., 01/18/2025 12:00 p.m., 01/18/2025 5:00 p.m., 01/22/2025 8:00 a.m., 01/23/2025 5:00 p.m., 01/24/2025 12:00 p.m., 01/24/2025 5:00 p.m., 01/25/2025 8:00 p.m., 01/26/2025 8:00 a.m., 01/26/2025 12:00 p.m. and 01/26/2025 5:00 p.m. On 01/29/2025 at approximately 1:30 p.m., Surveyor reviewed concerns with blood sugar monitoring with Administrator A and Caregiver B. Caregiver B checked records further to see if the provider had additional documentation of blood sugar monitoring but was unable to locate documentation of further monitoring. Administrator A acknowledged Surveyor's concerns with monitoring and stated, "That's a lot of insulin," when reviewing the needs of Resident 2, Resident 1 and Resident 3.	N 431		
N 432	83.38(1)(h) Medication administration. 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	N 432		

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N 432	Continued From page 21 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 2 of 3 residents reviewed had all medications available to meet their needs. Findings include: On 01/29/2025 at approximately 12:00 p.m., Surveyor reviewed resident physician orders and the provider's medication storage with Caregiver B. Surveyor identified the following concerns: Example 1 - Resident 3: Resident 3 was admitted to the provider's facility on 01/06/2016 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 3's physician orders included the following medications, which were unavailable for administration: - Albuterol 90 mcg inhaler (Start Date 02/21/2019) - Inhale 2 puffs every 6 hours PRN for shortness of breath and wheezing: The inhaler in the medication cart expired 01/17/2024. - Diclofenac Sodium 1% gel (Start Date: 09/01/2023) - Apply 4 grams to right thumb and right lateral epicondyle up to 4 times daily PRN	N 432		

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for pain: The container available expired 08/25/2024.
- Glutose 15 gel (Start Date: 02/21/2019) - Take 1 tube orally PRN if blood sugar is <60 or <40 and patient is unable to swallow: Caregiver B confirmed they were "out" of this medication.
- Oxybutin Cl ER 15 mg (Start Date: 07/18/2022) - Take 1 tablet once daily PRN for bladder spasms: Surveyor and Caregiver B were unable to locate this medication.
- Polyethylene Glycol 3350 Powder (Start Date: 06/06/2024) - Mix 17 grams in 8 ounces of water or juice once daily PRN for constipation: Caregiver B stated this medication was "on order."
- Reguloid Powder (Start Date: 09/27/2024) - Mix 1 Tbsp in 8 ounces of water once daily for constipation: Caregiver B stated this medication was "on order." Resident 3's Medication Administration Record (MAR), dated 01/01/2025 to 01/29/2025, documented this medication as unavailable for administration 9 times.
- Vitamin A&D Ointment (Start Date: 11/08/2024) - Apply to affected area of groin 2-3 times daily PRN: Caregiver B stated, "Doesn't have."

Example 2 - Resident 2:

Resident 2 was admitted to the provider's facility on 08/09/2021 when the facility was owned and operated by a different provider and had remained a resident since the change of ownership on 08/01/2024. Resident 2's physician orders included the following medications, which were unavailable for administration:

- Glutose 15 gel (Start Date: 05/06/2022) - Give 1 tube PRN for blood sugar <70. Caregiver B stated, "Don't have."
- Gvoke Hypopen (Start Date: 08/09/2021) - Inject

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N 432	Continued From page 23 1 ML intramuscularly PRN for hypoglycemia. Give only if unable to swallow or unable to take oral medication and if blood sugar is <70. Caregiver B stated, "Don't have." On 01/31/2025 at approximately 1:35 p.m., Surveyor reviewed concern with Administrator A and Caregiver B that 2 of 3 residents reviewed had numerous medications that were unavailable for administration. Administrator A explained that s/he had recently taken on the administrative role approximately 1 month prior to Surveyor's present and was still working on getting things in line. Administrator A stated s/he planned to switch pharmacies and review all physician orders and medications at the end of the week.	N 432		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure a weekly menu was available to residents and that deviations from the planned menu were documented. Findings include: On 01/29/2025 at approximately 10:35 a.m.,	N 450		

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N 450	Continued From page 24 Surveyor toured the provider's facility and was unable to locate documentation of a menu. Surveyor observed a white board located near the kitchen that was entirely blank. On 01/29/2025 at approximately 10:38 a.m., Surveyor interviewed Caregiver C and asked if staff followed a menu for meals. Caregiver C replied, "Yes," and showed Surveyor a binder located on top of the refrigerator. Caregiver C showed Surveyor a menu that listed "Beef Stew with the works, beets, dinner roll and dessert" for that day's noon meal. Caregiver C stated s/he was serving chicken instead of the meal listed because that was what the overnight shift had prepared. Caregiver C was unsure why chicken was prepared and said nothing was documented on the facility's white board to inform residents of the meal because staff hadn't updated it yet. On 01/29/2025 at approximately 11:00 a.m., Surveyor interviewed Resident 3 and asked how s/he knew what would be served for each meal. Resident 3 stated s/he usually referenced the white board posted near the kitchen, which was currently blank.	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen	N 452		

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N 452	Continued From page 25 foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under conditions that prevented food borne illnesses. Findings include: On 01/29/2025 at approximately 10:35 a.m., Surveyor toured the provider's kitchen. Surveyor observed the following concerns in the provider's refrigerator: - A block of cheese that had mold on it. The cheese was not dated. - An open container of black forest ham that did not have a date of opening on it. - An open container of turkey breast that did not have a date of opening on it. - An open container of bologna that did not have a date of opening on it. - Sliced cheese that did not have a date of opening on it. - A pitcher of juice that was not labeled or dated. - One of 2 vegetable drawers had a brown substance hardened on the surface. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under	N 452		

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N 452	Continued From page 26 refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) On 01/29/2025 at approximately 1:35 p.m., Surveyor reviewed concern of moldy food and food not labeled/dated in the refrigerator with Administrator A and Caregiver B. Administrator A nodded his/her head in understanding.	N 452		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire evacuation drills were	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020250	A. BUILDING: _____ B. WING _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMERSLEY HOUSE	5222 HAMMERSLEY ROAD MADISON, WI 53711

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N 525	Continued From page 27 conducted at least quarterly. The provider had not conducted any fire drills since obtaining a probationary license on 08/01/2024. Findings include: The provider obtained a probationary license on 08/01/2024 to serve up to 8 residents with primary diagnoses including advanced age, irreversible dementia/Alzheimer's, traumatic brain injury, emotionally disturbed/mental illness and physically disabled. On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed the provider's environmental binder. The record did not include documentation indicating fire drills had occurred at the facility since the provider obtained a probationary license on 08/01/2024. On 01/29/2025 at approximately 1:30 p.m., Surveyor interviewed Administrator A and reviewed concern that the provider's environmental records did not include documentation of fire drills. Administrator A stated s/he had just taken over his/her role with the facility approximately 1 month prior to Surveyor's visit. Administrator A was given through 01/30/2025 to provide follow up documentation. Documentation of fire drills was not provided.	N 525		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years.	N 530		

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	0020250	A. BUILDING: _____ B. WING _____	02/04/2025

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N 530	Continued From page 28	N 530		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the facility was inspected annually by the local fire authority or certified fire inspector. The facility had not had a fire inspection completed since 12/26/2023.

Findings include:

The provider obtained a probationary license on 08/01/2024 to serve up to 8 residents with primary diagnoses including advanced age, irreversible dementia/Alzheimer's, traumatic brain injury, emotionally disturbed/mental illness and physically disabled.

On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed the provider's environmental binder. The record included documentation of a fire inspection, dated 10/17/2022.

On 01/29/2025 at approximately 1:30 p.m., Surveyor interviewed Administrator A and reviewed concern that the provider's environmental records did not include a fire inspection completed within the past year. Administrator A stated s/he had just taken over his/her role with the facility approximately 1 month prior to Surveyor's visit.

On 01/29/2025 at approximately 4:00 p.m., Surveyor reviewed a fire inspection, dated 12/26/2023, in the department's records for the facility. Records did not include a fire inspection completed within the past year.

Administrator A was given through 01/30/2025 to

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	0020250	A. BUILDING: _____ B. WING _____	02/04/2025

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N 530	Continued From page 29 provide follow up documentation. Documentation of a fire inspection was not provided.	N 530		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's fire detection system was inspected, cleaned and tested annually. The provider's fire detection system had not been inspected in greater than 1 year. Findings include: The provider obtained a probationary license on 08/01/2024 to serve up to 8 residents with primary diagnoses including advanced age, irreversible dementia/Alzheimer's, traumatic brain injury, emotionally disturbed/mental illness and physically disabled. On 01/29/2025 at approximately 10:35 a.m., Surveyor reviewed the provider's environmental binder. The record included documentation of a fire detection system inspection, dated 12/07/2023. On 01/29/2025 at approximately 1:30 p.m., Surveyor interviewed Administrator A and Caregiver B. Surveyor reviewed concern that the provider's environmental records did not include	N 538		

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	0020250	A. BUILDING: _____ B. WING _____	02/04/2025

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N 538	Continued From page 30 an inspection of the fire detection system completed in the past year. Caregiver B replied, "I thought [an inspector] was just here." Administrator A was given through 01/30/2025 to provide follow up documentation. Documentation of a fire detection system inspection was not provided.	N 538		