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 _____	R 07/14/2025

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 On 07/09/2025, with information gathered through 07/14/2025, Surveyors conducted a verification visit at Hammersley House. Five (5) deficiencies were identified; 2 were repeat deficiencies. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{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 record review and interview, the licensee did not ensure the CBRF and its operation comply with all laws governing the CBRF. Findings include: On 07/09/2025, Surveyors conducted a verification visit. The facility has a class CNA (non-ambulatory) probationary license, effective 08/01/2024, as a community based residential facility (CBRF) able to serve up to 8 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, emotionally disturbed/mental illness, traumatic brain injury, and advanced age. Surveyors have conducted the following surveys	N 196		

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

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N 196	Continued From page 1 since the change of ownership on 08/01/2024: Statement of deficiency (SOD) FQ7B11, dated 02/04/2025 Probationary/standard survey resulting in the following deficiencies: -83.17(2)(a) Employees Screened for Communicable Disease Screen -83.18(1) Employee Records Maintained and Current -83.28(3) Provide Admission Agreement As Required -83.28(4)(a) Resident Health Screening and Documentation -83.32(3)(h) Rights of Residents: Receive Medications -83.35(3)(c) Implement, Follow The Individual Service Plan -83.35(3)(d) Service Plans Updated Annually or on Changes -83.35(5)(a) Initial Evaluation of Evacuation Limitations -83.37(1)(h) Scheduled Psychotropic Medication -83.37(2)(d) Documentation Of Medication Administration -83.38(1)(g) Health Monitoring -83.38(1)(h) Medication Administration -83.41(2)(c) Nutrition: Menus -83.41(3)(b) Food Safety -83.47(2)(d) Fire Drills -83.47(2)(e) Other Evacuation Drills -83.47(3) Fire Inspection -83.48(3)(a) Fire Detection System Inspected Annually SOD FQ7B12, dated 04/24/2025 Complaint investigation and verification visit resulting in the following deficiencies: -83.12(5)(a) Notification: Incident, Injury,	N 196		

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N 196	Continued From page 2	N 196		

Changes
-83.32(3)(h) Rights of Residents: Receive Medications - repeat
-83.36(1)(a) Adequate Staff To Meet Resident Needs
-83.37(1)(j) Proof-of-Use Record
-83.37(2)(d) Documentation Of Medication Administration - repeat
-83.38(1)(g) Health Monitoring - repeat
-83.41(1)(c) Dishwashing
-83.41(2)(c) Nutrition: Menus - repeat
-83.41(3)(b) Food Safety - repeat
-83.45(3) Toxic Substances
-83.55(3) Bath and Toilet Areas: Hand Drying
The SOD resulted in a Notice and Order Letter with order to Comply With Requirements as well as the following SPECIAL ORDERS:

Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Hammersley House:

PROBATIONARY LICENSE:

1. Based on the results of the Department's investigation, and pursuant to Wis. Stat. §§ 50.03(5g)(b)3. And (b)6., the licensee shall correct all violations identified in Statement of Deficiency (SOD) FQ7B11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License. IF the licensee has not achieved substantial compliance with all laws and administrative rules governing the facility and its operation AND IF the violations identified in SOD FQ7B12 remain substantially uncorrected, the

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N 196	Continued From page 3 PROBATIONARY LICENSE for Hammersley House may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE for Hammersley House, 5222 Hammersley Road, Madison, WI, 53711. This NOTICE is provided in accordance with: - Wis. Stat. § 50.03(4m)(b), whereby, if the applicant for licensure as a community-based residential facility has not been previously licensed under this subchapter or if the community-based residential facility is not in operation at the time application is made, the department shall issue a probationary license. Prior to the expiration of a probationary license, the department shall evaluate the community based residential facility. In evaluating the community based residential facility, the department may conduct an inspection of the community based residential facility. If, after the department evaluates the Community based residential facility, the department finds that the community based residential facility meets the applicable requirements for licensure, the department shall issue a regular license under sub.(4)(a)1.b. If the department finds that the community-based residential facility does not meet the requirements for licensure, the department may not issue a regular license under sub. (4)(a)1.b. - Wis. Admin. Code § DHS 83.08(2), whereby the Department shall deny a probationary license or regular license to any applicant who does not substantially comply with any provision of Wis. Admin. Code ch. DHS 83 or Wis. Stat. ch. 50. CONSULTANT REQUIRED	N 196		

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N 196	Continued From page 4 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. For medical and health monitoring related violations identified in Statement of Deficiency (SOD) FQ7B12, the licensee shall develop and implement corrective measures in consultation with a registered nurse (RN). The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis. Stat. ch. 50) and knowledge of the client groups served by Hammersley House. Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address: Health Monitoring: -Including how the facility will: (a) monitor and document changes in the resident's physical or mental health; (b) notify the resident's legal representative and care manager (if any) when a resident experiences a change of condition, accident, injury, or medical emergency; (c) obtain timely medical care (clinical assessments, medications, prompt medical treatment), and (d) provide or arrange services to address each resident's health care needs. Diabetes Management, Including standards of practice for the assessment, care planning, and provision of services for residents with diabetes. Additional information and resources addressing diabetes can be located on the department website: https://www.dhs.wisconsin.gov/diabetes/index.htm	N 196		

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N 196	Continued From page 5 The licensee will provide the RN with a copy of the Statement of Deficiency (SOD) FQ7B12, along with this Notice and Order letter prior to providing consultation services. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., within 7 days of receipt of this notice, the CBRF will provide each resident's legal representative and case manager (if any), with a copy of Statement of Deficiency (SOD) FQ7B12 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager (if any). The documentation required by Order #2 will be available to department representatives upon request.	N 196		

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N 196	Continued From page 6 SOD FQ7B13, dated 07/14/2025 A verification visit resulting in the following deficiencies: -83.14(2)(a) Licensee Ensures Facility Complies with Laws -83.32(3)(h) Rights of Residents: Receive Medications - repeat -83.36(2) Maintain Current Written Staffing Schedule -83.42(1) Resident Record Maintained -83.55(3) Bath and Toilet Areas: Hand Drying - repeat On 07/11/2025, at 11:10 a.m., Surveyor emailed Consultant H, Administrator G, and Licensee I for clarification, because in reviewing documentation for Hammersley House, there were documentation concerns related to inconsistencies in sliding scale insulin, blood sugars, evacuation assessments, and staff documentation in the medication administration records (MAR) who are not on the schedule. Surveyor addressed that this was a concern for the accuracy of what was being documented in resident's records vs what cares/medications are being provided to them. Surveyor stated it was difficult to determine what occurred when the records and interviews do not align and that the information is not being provided in a timely matter. Surveyor explained that it is the bureau's policy to receive all required information within 24 hours, as Surveyors explained on 07/09/2025 while onsite. Surveyor stated with it being more than 24 hours post survey, and to wrap up both buildings, Surveyor will need the following information or clarification by noon today and I will close the surveys. Surveyor asked for clarification on when Consultant H's firm was working with the licensee to confirm the special order for	N 196		

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N 196	Continued From page 7 consultation on the survey FQ7B12 was met. At 11:56 a.m., Consultant H responded, "Thank you for working with us to gather this information. As you are aware, there have been several leadership transitions over the past seven months, which have naturally led to some challenges along the way. We understand that this may have resulted in inconsistencies or perceived inaccuracies in certain documentation. It has truly taken a collaborative team effort to stabilize operations and bring the buildings back on track following these transitions. I want to assure you that the changes implemented under [Administrator G's] consistent oversight since mid-June have made a significant and positive impact. ...[Current consulting firm] did not have oversight of this building from January through May 14. If this is in regards to the requirement of hiring a consultant as part of the last SOD-- The enforcement letter typically states 'a consultant not previously associated with the facility' if that is a requirement. The enforcement letter did not contain that verbiage." Since being issued a probationary license on 08/01/2024, the facility has had 3 surveys, a complaint investigation, 34 deficiencies, 7 repeat deficiencies, and an order for consultation. The licensee has not ensured the CBRF and its operation comply with all laws governing this CBRF. On 07/14/2025 at 4:13 p.m., Surveyor reviewed the above concerns regarding non-compliance with Licensee I. Licensee I acknowledged the concerns and stated s/he was aware of them. Licensee I stated s/he thought s/he had people in place previously that were completing required	N 196		

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N 196	Continued From page 8 tasks and has seen improvements with Administrator G.	N 196		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by their practitioner. Resident 3 did not receive the correct dose(s) of sliding scale insulin appropriate to the parameters prescribed by their practitioner 5 times from 07/01/2025 to 07/08/2025. Repeat deficiency from statement of deficiency (SOD) FQ7B11, dated 02/04/2025, and SOD FQ7B12, dated 04/24/2025. Findings include: On 07/09/2025, at approximately 12:30 p.m., Surveyor requested to review the record of Resident 3, including his/her July 2025 medication administration record (MAR). Resident 3 was admitted to the provider on 01/06/2016 with diagnoses including diabetes. Surveyor reviewed physician orders, dated	{N 352}		

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{N 352}	Continued From page 9 06/30/2025, for: -Insulin aspart 100 unit/ml pen to inject subcutaneously: 1UN with breakfast plus sliding scale: <150=0UN; 150-200= 1UN; 201-250=2UN; 251-300=4UN; >301=6UN CALL MD. MAX DOSE OF 35UN PER DAY. -Insulin aspart 100 unit/ml pen to inject subcutaneously: 1UN with lunch plus sliding scale: <150=0UN; 150-200= 1UN; 201-250=2UN; 251-300=4UN; >301=6UN CALL MD. MAX DOSE OF 35UN PER DAY. -Insulin aspart 100 unit/ml pen to inject subcutaneously: 1UN with dinner plus sliding scale: <201=0UN; 201-250=2UN; 251-300=4UN; >300=6UN CALL MD. MAX DOSE OF 35UN PER DAY. Surveyor reviewed Resident 3's July 2025 medication administration record (MAR), which documented the following occurrences when Resident 3's sliding scale insulin was not administered as ordered: -07/01/2025 at 5:19 p.m. "How Many Units Were Given (including Sliding Scale): 4 units (200-250) What Is Residents Blood Sugar?: 246" *Per order, 1 unit dose + 2 sliding scale dose = 3 units of insulin should have been administered. -07/03/2025 at 5:08 p.m. "How Many Units Were Given (including Sliding Scale): 2 units (151-200) What Is Residents Blood Sugar?: 231" *Per order, 1 unit dose + 2 sliding scale dose = 3 units of insulin should have been administered. -07/04/2025 at 7:47 a.m.	{N 352}		

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{N 352}	Continued From page 10 "Total Number of Units Given: 4 UNITS (201-250) What Is Residents Blood Sugar?: 247" *Per order, 1 unit dose + 2 sliding scale dose = 3 units of insulin should have been administered. -07/04/2025 at 12:33 p.m. "Total Units Given: 4 UNITS (201-250) What Is Residents Blood Sugar?: 249" *Per order, 1 unit dose + 2 sliding scale dose = 3 units of insulin should have been administered. -07/08/2025 at 5:15 p.m. "How Many Units Were Given (including Sliding Scale): 4 units (201-250) What Is Residents Blood Sugar?: 220" *Per order, 1 unit dose + 2 sliding scale dose = 3 units of insulin should have been administered. On 07/09/2025 at 4:15 p.m., Surveyor reviewed the MAR and explained the above concerns with Administrator G. Administrator G stated s/he understood the concern. On 07/10/2025, at 12:00 p.m., Administrator G emailed Surveyor stating, "I have spoken with [Resident 3's] Endo MD (medical doctor) this morning to clarify sliding scale insulin. The doctor was unaware of any order changes for sliding scale and insulin. The doctor stated we are administering the current order from them, as they have no changes. I am waiting on the doctor's documentation to send proof to you that we are giving the correct sliding scale and insulin. At 3:46 p.m., Administrator G confirmed, "I am still waiting to receive the documentation from [Resident 3's] Endo. Apparently, they are having issues with their fax machine today."	{N 352}		

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{N 352}	Continued From page 11 On 07/11/2025 at 12:00 p.m., Administrator G emailed Surveyor a copy of a fax that's content was dark and unable to read, stating, "This just came through my fax. It's a bit difficult to read but if you need any clarification you can call the clinic." On 07/14/2025 at 12:21 p.m., Surveyor called UW Health's Endocrinology Diabetes phone number provided on the fax Administrator G emailed. Surveyor spoke with Diabetic Nurse K and reviewed Resident 3's physician orders. Diabetic Nurse K stated that Resident 3's sliding scale insulin order was placed on 06/24/2025, but it was the same order as before, so it must have been missing an insurance code or something. Diabetic Nurse K stated that a new order was signed 07/11/2025 that was just sent to the pharmacy today. Diabetic Nurse K stated s/he was aware there were concerns with Resident 3's sliding scale insulin because the provider had called to verify the order and reached out to request a fixed dose rather than sliding scale. At 2:35 p.m., Surveyor reviewed the above concerns with Administrator G. Administrator G stated that s/he was confused because that was not the information s/he was provided and that the clinic had told him/her there was no change in the order and the order the provider has is correct. On 07/14/2025 at 4:13 p.m., Surveyor reviewed the above concerns with Administrator G and Licensee I. Surveyor reviewed the physician order and the documentation of the sliding scale insulin that was documented as administered and explained that the concern was not in the physician order or sliding scale parameters, the error is in the amount of insulin staff are	{N 352}		

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{N 352}	Continued From page 12 documenting and administering. Administrator G stated that made sense and that s/he understands. CROSS REFERENCE 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 352}		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a current written schedule for staffing the CBRF including each employee's full name and time worked. Findings include: On 07/09/2025, Surveyors conducted a verification visit. At approximately 12:30 p.m., Surveyors asked Administrator G for a staff schedule to verify who was working for April, May and July 2025. Administrator G provided Surveyors with a July schedule that listed employee's first names and times they were scheduled to work. At approximately 3:20 p.m., Surveyors asked Administrator G if the staff schedule that was provided was accurate, explaining that if any caregivers called into work and picked up shifts,	N 399		

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N 399	Continued From page 13	N 399		

that should be documented. S/he stated s/he believes so.

At approximately 3:35 p.m., Surveyors reviewed Resident 6's medication administration record (MAR) and had some questions regarding staff documenting blood sugars and insulin. Surveyor noted that Caregiver J had documented Resident 6's blood sugars from 07/01/2025 to 07/09/2025. Surveyors reviewed the staff schedule which documented that Caregiver J did not work on 07/05/2025 and 07/06/2025, and asked Administrator G how Caregiver J checked Resident 6's blood sugars 2 times on 07/05/2025 and 2 times on 07/06/2025 if s/he was not working. Administrator G stated that Caregiver J was on call that weekend and must have came in to assist. Surveyors asked to review Caregiver J's time keeping to verify s/he was in the building and in pay status that weekend. Administrator G and Consultant H, who was on the phone, stated that Caregiver J was a salaried employee and does not punch in and out. Surveyor asked why the schedule was not updated to reflect that Caregiver J was working on 07/05/2025 and 07/06/2025. Administrator F stated it was a busy weekend, noting that one of Licensee I's other buildings was left without staff that weekend.

At approximately 4:30 p.m., Surveyor asked Administrator G for staff schedules for April and May. Administrator G stated s/he did not have access to staff schedules, so s/he would have to provide Surveyor with that information later. Surveyor told Administrator G that s/he would accept additional information until noon on 07/10/2025.

On 07/10/2025 at 3:45 p.m., Administrator G emailed Surveyor stating, "We are waiting to

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N 399	Continued From page 14 receive the hours worked report from Heartland. Hopefully we'll have both by tomorrow." On 07/11/2025 at 2:10 p.m., Consultant H attached a staff schedule from 03/30/2025 to 05/31/2025 stating, "I have attached the schedules that I just received from the previously involved consultant. I cannot confirm if they were updated to reflect call ins/staffing changes." On 07/14/2025 at 2:25 p.m., Surveyor reviewed the above concerns with Administrator G. Administrator G stated s/he aware there were concerns with the schedule, noting there was not a schedule previously and that the provider was aware of that. On 07/14/2025 at 4:13 p.m., Surveyor reviewed the above information with Administrator G and Licensee I. Licensee I stated that s/he was aware that a staff schedule was not being completed before and now there is a system in place. CROSS REFERENCE 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 399		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health	N 454		

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N 454	Continued From page 15 screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including	N 454		

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N 454	Continued From page 16	N 454		

rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 3's record accurately described a change in condition, resulting in Resident 3 being a point of rescue for evacuation, or included documentation of significant incidents, such as an emergency room visit on 06/16/2025, and the outcome of that visit.

Findings include:

On 07/09/2025, Surveyors conducted a verification visit.

At approximately 3:00 p.m., Surveyor reviewed the record of Resident 3. Resident 3 was admitted to the facility on 01/06/2016 with diagnoses including spina bifida, obesity, seizures and diabetes with neuropathy and nephropathy.

Example 1
Surveyor reviewed Resident 3's progress notes which documented that on 06/16/2025, "Went to ER (emergency room) for not feeling like [him/herself], did have lower abdominal pain."

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N 454	Continued From page 17 At approximately 3:30 p.m., Surveyor requested documentation of the after visit summary from the ER visit on 06/16/2025. Administrator G stated s/he would have to find that information and would send it to the Surveyor. Surveyor requested that the information be provided by 4:00 p.m. on 07/10/2025. On 07/11/2025 at 11:10 a.m., Surveyor emailed Administrator G, Consultant H, and Licensee I, stating that s/he has not yet received Resident 3's ER discharge summary. At 11:56 a.m., Consultant H responded, "requested from provider-- waiting for it to be faxed" On 07/14/2025 at 2:35 p.m., Surveyor reported to Administrator G that s/he has not received Resident 3's ER discharge summary. Administrator G confirmed s/he was not able to provide that. At 04:13 p.m., Surveyor reviewed the above concerns with Administrator G and Licensee I. Administrator G confirmed again that s/he did not have a discharge summary for Resident 3 stating that Resident 3 usually keeps one but s/he does not have one. Example 2 Surveyor reviewed Resident 3's evacuation assessment on 04/24/2025 which documented that Resident 3 has an evacuation time of over 4 minutes and needs limited assistance from two staff to evacuate. Resident 3's individual service plan (ISP) at that time identified that Resident 3 required a sit to stand to transfer; it did not identify the amount of staff or level of assistance	N 454		

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N 454	Continued From page 18 s/he needs to evacuate in an emergency. On 07/09/2025 at approximately 3:15 p.m., Administrator G provided Surveyor with a Resident Evacuation Assessment for Resident 3, dated 06/25/2025, that documented Resident 3 needs limited assistance from only one staff, meaning there was no specific evidence that the resident needs help from two or more persons in a fire emergency. Resident 3's ISP, signed and dated 06/02/2025, identified that s/he is not able to walk, and that a lift is used for all transfers and uses a wheelchair when out of bed. Under Compliance Requirement it stated, "Resident needs more than 2 minutes to evacuate the CBRF." At approximately 3:30 p.m., Surveyor requested supporting documentation from when Resident 3 was downgraded from a 2 person assist to evacuate to 1. Administrator G stated that Resident 3 had successfully completed physical therapy (PT) and now can evacuate with the assist of 1 staff. Surveyor asked to review PT documentation. Administrator G stated s/he would have to find that information and would send it to the Surveyor. Surveyor requested that the information be provided by 4:00 p.m. on 07/10/2025. On 07/10/2025 at 12:59 p.m., Administrator G emailed Surveyor stating, "Attached is the updated and current Evac Assessment for [Resident 3] at Hammersley. A list of residents with evacuation info has been sent to the Madison fire Department." The Resident Evacuation Assessment was dated 07/09/2025, and documented that if Resident 3 is in his/her wheelchair s/he is a 1 person assist, if resident is in bed s/he is still a 1 person assist but will take	N 454		

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N 454	Continued From page 19 over allotted time so will be a POR (point of rescue). At 1:09 p.m., Surveyor responded, "...I requested the documentation for the change in [his/her] condition or whatever was going on with [him/her]. You stated [s/he] had improved with PT, so I would need that or any other documentation you had. This is the 3rd evac assessment that I have received for [Resident 3] since 4/24, all documenting different evac needs. I didn't see changes in the ISP or progress notes, so I'm trying to piece together what is going on with [him/her]; please send the documentation of the changes in [him/her] rather than changes in documentation." At 1:36 p.m., Administrator G stated, "I thought [s/he] had PT, I was mistaken. We have done a change of condition on [his/her] care plan to reflect [s/he] is a 1 person assist wither in or out of bed. However, [s/he] is a POR due to evacuation time when in bed and not when [s/he's] up in her wheelchair. I will email you this shortly." At 3:10 p.m., Administrator G emailed surveyor an update to Resident 3's ISP, signed 07/10/2025, documenting a change in condition and that Resident 3 needs less than 2 minutes to evacuate in an emergency if s/he is already in his/her wheelchair and more than 2 minutes if s/he is in bed. at 5:36 p.m., Surveyor responded, "This documents that this assessment was completed and signed today. Do you have documentation of this change before the plan of correction date?" At 6:13 p.m., Administrator G responded, "No, we	N 454		

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N 454	Continued From page 20 did [his/her] change of condition today once we saw there wasn't one done already."	N 454		
{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 4 of 4 public bathrooms had enclosed paper towels, cloth towel dispensing units or electric hand dryers. This is a repeat deficiency. See Statement of Deficiency (SOD) FQ7B12, dated 04/24/2025. Findings include: On 07/09/2025 at 12:30 p.m., Surveyor conducted a verification visit and observed the following: -Surveyor observed 4 public bathrooms that did not have enclosed paper towels, cloth towel dispensing units, or electric hand dryers. Surveyor observed individual paper towel rolls placed inside the bathrooms. The paper towel rolls were placed next to the sinks (x2), on a grab bar, and the 4th bathroom did not have any paper towel available. At 3:07 p.m., the same above conditions were observed. On 07/09/2025 at 3:30 p.m., Surveyor interviewed	{N 612}		

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{N 612}	Continued From page 21 Resident 4. Resident 4 reported s/he used their shirt to dry their hands because its hard to rip a paper towel off the roll. On 07/09/2025 at 4:15 p.m., Surveyor interviewed Administrator G. Administrator G acknowledged the provider did not have enclosed dispensers or electric hand dryers. Administrator G reported that with the low census the provider could not fix everything at once, but s/he had the enclosed paper towel dispensers onsite and was waiting for maintenance to install them. Throughout the duration of the survey, Surveyor observed residents independently using the bathrooms.	{N 612}		