STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011240	A. BUILDING: _____ B. WING _____	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT	531 PHEASANT DRIVE NEW LONDON, WI 54961

(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
M 000	INITIAL COMMENTS An abbreviated survey was conducted on 05/28/2024 at Pheasant Adult Family Home. As a result of this survey 1 deficient practice was identified. Census: 4	M 000		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation, staff interview, and record review the provider did not ensure placement of a smoke detector in 1 out of 4 resident bedrooms. Resident 1's ceiling had a covering over the area where a smoke detector would have been but there was no smoke detector in the room. Findings include: This facility serves residents who are advanced	M 334		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 334	Continued From page 1 aged, developmentally disabled, physically disabled, and who have irreversible dementia/Alzheimer's, emotional disturbance or mental illness, or traumatic brain injury. On 05/28/2024 at approximately 11:00 a.m. while touring the facility Surveyor noted there was no smoke detector on the ceiling of Resident 1's bedroom. A covering the approximate size of a smoke detector was in place of the smoke detector. Facility records from smoke detector inspections dated 06/17/2020 and 05/20/2021 showed a smoke detector was present and tested in that room. There was no further documentation of a smoke detector in Resident 1's room following the 2021 report. During an interview with Surveyor on 05/28/2024 at approximately 12:00 p.m., CMD (Care Management Director) - A and PM (Program Manager) - B verified there was no smoke detector in Resident 1's bedroom and had no knowledge of when or why it had been removed.	M 334		