STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 06/20/2025, with information gathered through 06/26/2025, Surveyor conducted a complaint investigation. Two deficiencies were identified. Complaint was substantiated. Census: 32	N 000		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident received timely assistance with personal cares. Staff did not notice Resident 1 had dried feces on his/her leg, foot and shoe when they provided cares.	N 425		

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

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	0019471	A. BUILDING: _____ B. WING _____	C 06/26/2025

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N 425	Continued From page 1 Findings include: On 06/16/2025, the Department received a concern alleging residents were not receiving adequate care. On 06/20/2025, at approximately 12:35 PM, Surveyor observed Resident 1, his/her Power of Attorney (POA) D, Hospice Social Worker E, and Hospice Nurse F in his/her bedroom. Surveyor was informed Resident 1 had what appeared to be dried feces on his/her left leg, ankle and shoe, which Surveyor observed. POA D stated, "I arrived around 11:15 AM and did not notice the feces on [him/her]. I was explaining to [mom/dad] that hospice would be here and would be asking [him/her] questions. Hospice arrived at 11:30 AM. Around 12:10 PM, hospice observed the feces on Resident 1 and were concerned that it had been there for a while, as it was dry and did not have a strong odor. [S/he] had a scheduled medical appointment at 1:00 PM, which I canceled, because I did not feel staff would have enough time to clean [him/her] up and [s/he] is eating [his/her] lunch." Resident 1 turned around and told 'us' to be quiet, s/he was eating. On 06/20/2025, at approximately 1:15 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) B. Surveyor explained his/her observation of Resident 1. RVPO B stated, "Why didn't [Resident 1] press [his/her] call button, or hospice." Surveyor requested Resident 1's record. On 06/20/2025, Surveyor reviewed Resident 1's record provided by RVPO B. RVPO B stated s/he included a statement s/he had requested from Caregiver G who had provided cares for Resident 1 that morning.	N 425		

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N 425	Continued From page 2 Resident 1 moved into the facility, 08/30/2024, with diagnoses including dementia, anxiety disorder, and Alzheimer's disease. Resident 1's "Care Plan," dated 11/13/2024, documented: "Toileting - Incontinent of bowel and/or bladder and manages toileting needs independently. Staff to alert nursing if this changes." "Orientation/Decision Making - Is alert and oriented to self, and needs occasional prompting or orientation. Has occasional confusion and some difficulty recalling details." Resident 1's "Task Administration Record (TAR)," dated 06/01/2025 to 06/22/2205, documented: "Bathing - Physical Assist w/Shower - 12:00 PM - Tuesdays and Saturdays "Assist with Showers on Tuesday and Friday mornings. Assist with showers on Tuesday and Saturday mornings; laundry and housekeeping to be done w/first shower of the week - 8:00 AM." "Assist with Showers on Tuesday and Friday mornings. Assist with showers on Tuesday and Saturday mornings; laundry and housekeeping to be done w/first shower of the week - As Needed." Caregiver G's written statement, dated 06/20/2025, documented: "7:30 AM - Went to get [Resident 1] up - [s/he] was already awake and sitting on [his/her] couch. Got [him/her] up to the bathroom and to get dressed. [S/he] was dry before I took [him/her] to the bathroom and after." "8:00 AM - [S/he] didn't want to come to the dining room for breakfast - I brought [him/her] breakfast." "10:00 - 10:30 AM - Check on [Resident 1]. [S/he] was dry. [S/he] told me no to the bathroom	N 425		

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N 425	Continued From page 3 after I asked and I told [him/her] lunch will be soon and we should try to get to the dining room for lunch. ... [Resident 1] does a lot of independent movements - [s/he] can take [him/herself] to the bathroom and change [him/herself]." On 06/24/2025 at 1:30 PM, Surveyor interviewed RVPO B and Regional Wellness Director (RWD) C. Surveyor discussed the concern and asked when Resident 1 was scheduled to receive his/her shower. RWD C stated that s/he was scheduled for Tuesday and Saturday, s/he would review the language on the TAR to ensure consistency. Surveyor asked if staff should have noticed the dried-on feces during cares this morning, such as during dressing and/or toileting. RVPO B and RWD C would not provide any feedback. On 06/25/2025 at 6:13 AM, Surveyor emailed RN F and asked for him/her to restate what s/he had observed when observing Resident 1 on 06/20/2025. On 06/25/2025 at 8:13 AM, RN F emailed Surveyor and stated that when s/he arrived, Resident 1 had BM (bowel movement) present which was dried. Staff did not come in to clean up Resident 1 while s/he was in the building.	N 425		
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 4 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 observation, record review and interview, the provider did not ensure 1 of 1 resident reviewed received appropriate health monitoring to meet his/her needs. Resident 1 had a physician order for monitoring of his/her food and fluid intake which was not followed. Resident 1 was hospitalized due to severe dehydration, hypotension (low blood pressure) and sepsis related to a urinary tract infection (UTI) and staff did not document signs and symptoms of his/her change of condition. Findings Include:	N 431		

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N 431	Continued From page 5 On 06/16/2025, the Department received an allegation that resident's physician orders were not followed. On 06/20/2025, Surveyor reviewed supporting documentation that was submitted with the concern which reported: "06/13/2025 - [geriatrics office] - 911 called 1402 (2:02 PM) - 911 arrived 1418 (2:18 PM) - Patient referred to [emergency department]. Chief complaint: Hypotension (low blood pressure)/pale/weak. Patient will be arriving by EMS (emergency medical services)/paramedics. Hand off of care completed via report to EMS. ... It was a pleasure seeing your patient, [Resident 1] in the Memory Clinic. [Resident 1] is a pleasant 91 year old with moderate stage late onset dementia, hypertension, hyperlipidemia, coronary artery disease, heart failure with reduced ejection fraction, type 2 diabetes mellitus with chronic kidney disease stage 3a, and anxiety presenting on today for a memory follow-up visit. [Resident 1's] visit had to be discontinued prematurely for transport to the emergency department. ... Diagnosis: 1. Major neurocognitive disorder with behavioral disturbances Stage: moderate stage noted from previous visit 01/2025 2. Severe dehydration in the setting of failure to thrive: unclear when s/he last ate or if s/he's staying hydrated 3. Failure to thrive 4. Generalized weakness and confusion in the setting of failure to thrive 5. Hypotension (low blood pressure) secondary to hypovolemia (condition that occurs when your body loses fluid, like blood or water); unclear if any concerns for infection (family notes dark urine) 6. Concern for delirium 2/2 hypovolemia,	N 431		

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N 431	Continued From page 6	N 431		

hypotension, failure to thrive and physical deconditioning
7. Normocytic anemia; noted to have post-op anemia from 8/1/24 which has resolved
- Anemia likely complicated by a concern for blood loss vs (versus) vitamin deficiencies (marginally normal B12 and folate 08/05/24 but now with a poor appetite of unclear duration) ...
This is my first time meeting [Resident 1] on today. [S/he] was very pale, confused and fell asleep throughout our discussions. Family provided history on today. Family is unclear how much food [s/he's] been eating or if [s/he's] continuing to drink water. Facility documents [his/her] taking a bite of food within the last week. ... [S/he's] been too weak to walk using [his/her] walker ...
Objective: Unable to obtain blood pressure T (temperature) 96.6 F (Fahrenheit) RR (respiratory rate) 12 (BP [blood pressure] of 65/49 obtained by EMT [emergency medical technician]) ...
General: fluctuating cognition, falling asleep during examination but pleasant, -able to respond to some questions and incomprehensible at other times,
-pale appearing with very poor skin turgor, -looks ill and very weak, Mental: sedated and confused at times."

On 06/20/2025, at approximately 12:35 PM, Surveyor observed Resident 1 in his/her bedroom, eating his/her lunch, along with Resident 1's Power of Attorney (POA) D, Hospice Nurse F and Hospice Social Worker E. POA D stated Resident 1 had just returned to the facility after being hospitalized for dehydration and hypotension and was being assessed by hospice to determine if s/he qualified for hospice. Surveyor asked POA D for clarification on why Resident 1 had been hospitalized. POA D stated

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N 431	Continued From page 7	N 431		

on 06/13/2025 s/he had picked up Resident 1 for a scheduled medical appointment. POA D stated, "I was in shock when I arrived to pick up [mom/dad], [s/he] was lethargic, looked gray. I asked staff how long [s/he] had been in this condition. They had no idea. They couldn't even tell me the last time they had checked on [him/her] or if [s/he] had eaten. I took [him/her] to [his/her] medical appointment and they couldn't even get a blood pressure of [him/her] so they called 911. Once [s/he] arrived at the hospital [s/he] was hooked up to IV's (intravenous) to get fluids into [him/her] and [s/he] ended up being admitted." POA D explained, "[Resident 1] returned to the facility last night and when I arrived today, [Resident 1's] tray with last night's dinner was sitting here, [s/he] didn't touch the food. They are supposed to give [him/her] an Ensure when [s/he] doesn't eat, but I don't see any containers in the room. [S/he] doesn't like Ensure and probably would not drink it, but it should still be offered. I also found [his/her] water glass in [his/her] refrigerator. [S/he] will not know [s/he] is supposed to go in the refrigerator if [s/he] wants [his/her] water." Hospice Nurse E and Hospice Nurse F confirmed Resident 1 had not eaten his/her evening meal.

POA D provided Surveyor with his/her hospital discharge paperwork which documented:
"06/18/2025 - Internal Medicine Daily Progress Note - Assessment/Plan:
91 y.o. demented [fe/male] from memory care unit, with recent hip fracture and treatment for E. coli UTI (urinary tract infection) 2 months ago who was admitted on 06/13/2025 with weakness, worsening confusion and hypotension requiring pressor support (refers to the use of medications called vasopressors to raise blood pressure in patients experiencing hypotension or shock,

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N 431	Continued From page 8	N 431		

where the body's blood pressure is dangerously low) likely due to possible recurrence of urine tract infection. Started on IV antibiotics and admitted to ICU on pressor support. Sepsis with shock likely due to acute cystitis (E. coli) with microscopic hematuria."

On 06/20/2025, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the facility 08/30/2024 with diagnosis including hypertension (high blood pressure).

Resident 1's physician order, dated 06/03/2025, documented:
"Track patient's daily food/fluid intake and document as best as possible. If eating less than 50% of meal, offer supplemental meal replacement (boost, ensure, etc.) of patient's preference."

Resident 1's June 2025 Medication Administration Record (MAR), dated 06/01/2025 to 06/20/2025, documented:
06/06 8:33 AM - Food Intake: 10%, Fluid Intake (Glasses): 0
06/06 12:26 PM - Food Intake: 10%, Fluid Intake (Glasses): 0
06/06 5:53 PM - Food Intake: 25%, Fluid Intake (Glasses): 4
06/07 9:04 AM - Food Intake: 10%, Fluid Intake (Glasses): 0
06/07 12:06 PM - Food Intake: 25%, Fluid Intake (Glasses): 10
06/07 9:52 PM - Food Intake: 20%, Fluid Intake (Glasses): 2
06/08 9:01 AM - Food Intake: 50%, Fluid Intake (Glasses): 2
06/08 12:11 PM - Food Intake: 50%, Fluid Intake

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N 431	Continued From page 9	N 431		

(Glasses): 1
06/08 7:40 PM - Food Intake: 20%, Fluid Intake (Glasses): 2
06/09 9:17 AM - Food Intake: 0%, Fluid Intake (Glasses): 1
06/09 12:38 PM - Food Intake: 25%, Fluid Intake (Glasses): 1
06/09 6:51 PM - Food Intake: 40%, Fluid Intake (Glasses): 2
06/10 8:33 AM - Food Intake: 20%, Fluid Intake (Glasses): 1
06/10 1:59 PM - Food Intake: 25%, Fluid Intake (Glasses): 1
06/10 5:17 PM - Food Intake: 75%, Fluid Intake (Glasses): 1
06/11 8:55 AM - Food Intake: 50%, Fluid Intake (Glasses): 2, Did you give Ensure: Yes
06/11 11:01 AM - Ensure - Not yet available will be calling nurse
06/11 12:33 PM - Food Intake: 0%, Fluid Intake (Glasses): 0
06/11 4:32 PM - Ensure - Refused by patient
06/11 5:09 PM - Food Intake: 50%, Fluid Intake (Glasses): 2
06/12 9:04 AM - Food Intake: 50%, Fluid Intake (Glasses): 1, Did you give Ensure: No
06/12 12:23 PM - Food Intake: 10%, Fluid Intake (Glasses): 1, Did you give Ensure: Yes
06/12 5:44 PM - Ensure - Refused by patient - wanted to just eat [his/her] dinner
06/12 6:22 PM - Food Intake: 100%, Fluid Intake (Glasses): 1
06/13 8:50 AM - Food Intake: 25%, Fluid Intake (Glasses): 0, Did you give Ensure: Yes
06/13 11:51 AM - Food Intake: 25%, Fluid Intake (Glasses): 1. Did you give Ensure: No
06/13 6:00 PM - Out of Building
06/19 9:36 PM - Food Intake: 50%, Fluid Intake (Glasses): 2
06/19 9:36 PM - Ensure - Refused by patient -

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	0019471	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 10	N 431		

Said [s/he] had enough to eat
06/20 9:51 AM - Food Intake: 75%, Fluid Intake (Glasses): 1, Did you give Ensure: Yes
06/20 12:34 PM - Food Intake: 50%, Fluid Intake (Glasses): 1, Did you give Ensure: Yes

Based on 06/20/2025 interview with POA D, Hospice Nurse E, and Hospice Nurse F, Resident 1 had not eaten his/her evening meal on 06/19/2025.

Resident 1's June 2025 "Observations," dated 06/01/2025 to 06/20/2025, documented:
06/08 4:30 PM - Resident was asked to come out of [his/her] room for dinner and [s/he] refused to leave [his/her] room, so room tray was sent down with a drink.
06/20 8:30 AM - Late entry for 06/19/2025 at 1630 (4:30 PM) - [Hospice] nurse here to admit resident to hospice services.
The observations did not document any concerns regarding Resident 1 displaying signs and symptoms of distress which would require medical attention on 06/13/2025.

Resident 1's "Care Plan," dated 11/13/2024, documented:
"Capacity for Self-Care - Needs some assistance."
"Capacity for Self-Direction - Needs assistance."
"[Resident 1] is independent with dining. Staff to alert nursing if this changes."

Resident 1's Medication Administration Record, dated 06/01/2025 to 06/20/2025, documented:
"Freestyle Lite Test - Check Blood Sugar Daily. Scheduled at 8:00 AM."
"Document Intake and Fluids."
The MAR documented the blood sugar had been checked on 06/13/2025 by Med Passer I.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 11	N 431		

The MAR documented s/he had eaten 25% of his/her morning meal, did not drink any fluids and was offered an Ensure. Resident 1 was documented as eating 25% of his/her noon meal and was not offered an Ensure.

On 06/24/2025 at 10:43 AM, Surveyor interviewed Licensee A. Surveyor discussed concerns that are being investigated at the facility and the lack of documentation by caregivers to determine if proper health monitoring is being completed. Licensee A stated s/he would discuss their processes with management.

On 06/24/2025 at 1:30 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) B and Regional Wellness Director (RWD) C. Surveyor discussed the concerns regarding staff recognizing Resident 1 was not baseline prior to the family's arrival on 06/13/2025. Surveyor discussed the concern that staff were documenting that they provided Ensure to resident but there was no documentation that s/he consumed it. Surveyor discussed that the food monitoring entries did not align with what was observed. RVPO B and RWD C did not provide any feedback.

Summary: Caregiver G and Med Passer I interacted with Resident 1 prior to his/her family arrival on 06/13/2025, and neither staff member documented that Resident 1 had experienced a 'change in condition.' Resident 1 had been observed by Med Passer I twice during meals and during morning and noon med pass. Caregiver G documented s/he had provided cares for Resident 1.

On 06/26/2025, at approximately 5:30 PM, Surveyor interviewed Med Technician H.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 431	Continued From page 12 Surveyor asked for clarification on how staff documented a change in condition of a resident. Med Technician H stated staff were to update the nurse and/or enter a note into the resident's record. The nurse would update the resident's progress notes. Surveyor asked for clarification on how Resident 1's food and fluid were monitored. Med Technician H stated Resident 1 had to be cued to eat or drink fluids. Med Technician H stated, "You can't walk into [his/her] room and say, do you want breakfast, and if [s/he] said no, then just leave. You had to cue [him/her], encourage [him/her] to eat. If [s/he] didn't eat at least 50% of [his/her] food, then you were to offer [him/her] an Ensure. We did not have to document if [s/he] consumed the Ensure." Surveyor asked what the protocol would be if a staff member walked into Resident 1's room, and s/he was lethargic and not responding to cueing. Med Technician H stated, "[Resident 1] is considered independent, so staff may not think too much of it."	N 431		