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	0019373	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEBROOKE SENIOR LIVING	550 W LIBERTY STREET ADAMS, WI 53910

(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 08/19/2025, Surveyors conducted a complaint investigation and reviewed an open self-report at Rosebrooke Senior Living. As a result of the visit, the complaint was substantiated and two (2) new deficiencies were identified. Census: 41	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not take immediate steps to ensure the safety of all residents or conduct and document a thorough investigation after receiving an allegation of caregiver abuse and neglect of	N 158		

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

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N 158	Continued From page 1 Resident 1 on 07/30/2025. Findings include: The Department received a complaint alleging care concerns. Prior to conducting the onsite visit, Surveyor reviewed the Department's records for the facility. On 08/01/2025 at 10:09 AM, Director A submitted a self-report to the Department. Director A received a call on 07/30/2025 at 9:30 or 10:00 PM from two former caregivers who had just visited Resident 1. They alleged s/he was found full of feces, was not fed supper, had bruises "all over...due to [Caregiver B] hurting [him/her]" and that Caregiver C was "yelling" and "being very disrespectful" to Resident 1. Director A noted s/he planned to "follow up first thing in the morning and would handle it accordingly." The report documented the following actions Director A took on 07/31/2025: --Director A interviewed Resident 1 who said, "No one would feed me," and then clarified Caregiver E attempted to feed him/her, but s/he was distracted and rushed. Resident 1 said it is common for 2nd shift staff to be distracted with conversations among themselves or on their phones and it impacts his/her care. Resident 1 also reported concerns with Caregiver B, stating s/he will "snap at [Resident 1] with attitude" and "talk about [his/her] personal issues." Resident 1 stated on 07/30/2025, Caregiver B said s/he "was not in the mood to deal with [Resident 1]" because of a personal matter s/he was dealing with which was a "bigger issue...to worry about than trying to assist [Resident 1]." Resident 1 went on to say sometime after supper on 07/30/2025, s/he pushed his/her call pendant for	N 158		

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help with toileting. Caregiver B cleared the pendant, said s/he couldn't help and left. Subsequently, "[Caregiver D] was passing medications to [Resident 1] around 7:30 PM and noticed [Resident 1] had urinated on [him/herself] in the recliner" and provided care. Resident 1 also told Director A that Caregiver B "makes [him/her] feel like [expletive]. Uncomfortable." Resident 1 denied s/he had new bruising, only old bruising from an incident two weeks prior involving Caregiver B.
--Director A talked with Caregiver B on 07/31/2025, "Going over working on bedside manners, how to properly approach residents, not talking about personal issues with residents, and making sure that [s/he] is not snapping at [Resident 1] or any other resident's [sic]."
--Director A also wrote, "On 8/1/25 - Director will be calling [Caregiver E] about proper bedside manners, work on asking one question at a time and allowing residents time to respond to questions...work on being professional, not talking with other co-workers while with other residents, needs to be completed [sic] all ADLs on all residents..."

The report did not document:
--review of call logs, meal consumption charting or medication records
--an interview with Caregiver B about the allegations
--an interview with Caregiver E about the allegations
--an interview with Caregiver D as a potential witness
--any other caregiver or resident interviews to determine if others had concerns with Caregiver B and E
--a conclusion whether abuse or neglect occurred

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N 158	Continued From page 3 On 08/19/2025 at 11:30 AM, Surveyor reviewed the provider's policy for abuse and neglect. It included a section titled "Investigation" which instructed immediate investigation of allegations by doing the following; Implement measures to protect the resident from possible further incident/injury; Interview and obtain a statement from any persons allegedly involved including affected resident, the complainant, the accused perpetrator, any witnesses; Arrange replacement for involved caregivers until the investigation is complete; Document all findings about the incident including date/time of interviews and whether conducted via telephone or in person; Signature of the interviewer and interviewee; Take photos of injuries. The section concluded, "Having collected all reasonably ascertainable facts surrounding the allegation, determine whether the incident meets the definition of abuse, neglect...Maintain documentation of the investigation and the outcome." On 08/19/2025 at 11:40 AM, Surveyor reviewed portions of Resident 1's record. S/he had diagnoses to include multiple sclerosis. S/he relied on staff assistance with feeding, toileting and transferring with a sit-to-stand lift. Call light logs from 07/30/2025 showed Resident 1 called for assistance at 5:06 PM and 7:19 PM. The medication administration record documented Caregiver D administered medication at 9:52 PM. Surveyor interviewed Resident 1 at 1:20 PM and observed s/he spoke slowly, quietly and needed to pause for breath in between words. NOTE: "Types of Speech Challenges in MS The 2 main categories of speech problems are dysarthria and dysphonia. Dysarthria is caused by weakness, slowness, changes in muscle tone, or	N 158		

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lack of coordination of the tongue, lips, soft palate, throat, vocal cords and diaphragm. With this symptom, your speech may sound slurred, harsh and uncoordinated and be difficult to understand. Up to 70% of individuals with MS experience some degree of change in speech clarity. With dysphonia, changes with airflow from the lungs or abnormalities with the structures of the throat near the vocal cords may cause you to run out of air when communicating..." SOURCE:https://www.nationalmssociety.org/understanding-ms/what-is-ms/ms-symptoms/speech-problems, retrieval date 08/21/2025.

On 08/19/2025 at 3:06 PM, Surveyor interviewed Caregiver D. S/he recalled the events of 07/30/2025. Caregiver D said Caregiver E tried to feed Resident 1 "and it didn't go well...[Caregiver E] was too loud and in [Resident 1]'s face...(s/he doesn't) know how to stop and listen to [Resident 1], which is what you need to do. You have to be soft and focus and let [him/her] speak." Caregiver D said in the end, Resident 1 did not eat any dinner that night. Caregiver D said after dinner, between 7:30 and 7:45 PM, two former caregivers who had come to visit Resident 1, "made a big scene" and confronted Caregiver B and Caregiver E for not taking care of Resident 1. Caregiver D confirmed his/her charting of medication administration at 9:52 PM was accurate. Surveyor asked Caregiver D if Resident 1 was incontinent and/or upset when s/he administered medication and Caregiver D replied, "I'm sure we did talk about it to some degree." S/he said it was hard to remember all the details from 3 weeks ago, but there was a "super good chance" s/he provided incontinence care.

Surveyor interviewed Director A at 9:00 AM and 2:25 PM. Director A stated the following:

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N 158	Continued From page 5 --S/he did not immediately report to the facility or arrange for Caregiver B and E to be relieved from the shift, because s/he felt the former caregivers that complained were trying to cause trouble. --Caregiver B finished the shift until 10:00 PM and Caregiver E until 11:00 PM. --The only documentation of the investigation is what was provided on the self-report. --S/he did not interview Caregiver E about whether s/he fed Resident 1 supper and s/he did not review documentation of meal consumption. Caregiver E remained employed until 08/07/2025 when s/he was terminated after different examples of work performance concerns. --S/he did not interview Caregiver B about the allegations s/he did not provide toileting assistance. Caregiver B remained employed as of 08/19/2025. --S/he did not interview Caregiver D about whether s/he found Resident 1 incontinent when s/he administered medications, or anything else s/he may have witnessed. --S/he did not review call logs or medication administration records. S/he agreed with Surveyor's review of the records, indicating it was possible Resident 1 first called for toileting assistance at 5:06 PM, called a second time at 7:19 PM and did not receive assistance until approximately 9:52 PM. --S/he conducted an interview with 1 other staff person that s/he did not document. S/he interviewed Caregiver F, who said s/he has observed Caregiver B talk inappropriately and use a harsh tone with two other residents. Director A said s/he did not further investigate the allegations. --During his/her interview with Resident 1, Director A reviewed notes that Resident 1 keeps on his/her phone to document concerns. Director A did not document his/her review of the notes	N 158		

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N 158	Continued From page 6 and had no recall of what they said. Licensee G was present during the interviews with Director A. Licensee G confirmed the policy was not followed and agreed Director A needed training in conducting investigations. Licensee G said during the onsite visit, s/he scheduled Director A for an upcoming training on conducting misconduct investigations. Licensee G and Director A also stated they would conduct and document thorough investigations into the events in mid-July that caused bruising, the events of 07/30/2025 and the information from Caregiver F. They stated they would also re-submit a misconduct incident report to the Office of Caregiver Quality, based on their findings. Cross Reference: Y3244 Ch 50.09(1)(L) Care	N 158		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

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Y3244	Continued From page 7 This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 1 received adequate care on 07/13/2025. Resident 1 was left on the toilet while still connected to the sit-to-stand lift. The straps left marks on Resident 1's neck and s/he sustained bruising on his/her hands while banging on the wall trying to summon help. Findings include: The Department received a complaint alleging care concerns. The provider is licensed to serve up to 50 residents from the following client groups; advanced aged, physically disabled, emotionally disturbed/mental illness, terminally ill, and irreversible dementia/Alzheimer's. Prior to conducting the onsite visit, Surveyor reviewed the Department's records for the facility. On 08/01/2025 at 10:09 AM, Director A authored and submitted a self-report to the Department which included a 1 page word document titled, "[Resident 1] Investigation 7/14/25": --Resident 1 requested to speak to Director A (date not provided) and reported s/he had bruises on the right side of his/her neck and on both hands near his/her knuckles. Resident 1 said during the overnight hours, Caregiver B assisted him/her to the toilet via a sit-to-stand lift and left him/her there while still hooked up to the lift. S/he said the sling was "too tight and slipped up	Y3244		

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Y3244	Continued From page 8	Y3244		

towards [his/her] face." Director A spoke to Caregiver C who said Resident 1 reported the similar information to him/her, along with other concerns about Caregiver B.
--The report did not document additional investigative steps but concluded, "...discussed with [Caregiver B] that we do not leave residents hooked up to the EZ-stand (aka sit-to-stand) and sling while they are on the toilet. [Caregiver B] seemed to understand and stated that this would not happen again and understood the safety reasoning why we don't leave them like that."

On 08/19/2025 at 9:00 AM, Surveyor interviewed Director A. S/he recalled the incident in mid-July but initially was confused about the date. Director A looked through timesheet records and eventually determined it occurred during the early morning hours of 07/13/2025. Director A said, "I probably should have done a self-report on that (sooner)...It was like a small thing, and it ended up not being anything to me compared to what I was informed of at first." Director A did not have additional documentation related to the incident or his/her investigation, other than what was submitted to the Department on 08/01/2025.

Director A confirmed Resident 1 complained that Caregiver B left him/her on the toilet with the straps on his/her body and still hooked to the sit-to-stand lift. Director A said Resident 1 has multiple sclerosis and does not have good control of his/her torso, so his/her body will "fold" forward if left in a sitting position on the toilet. Resident 1 said while s/he was on the toilet, the sling was digging into his/her neck so s/he tried to get out of the sling, causing marks on his/her neck, and s/he was banging on the wall with his/her hands causing bruises on the back of his/her hands near the knuckles. Resident 1 also said when

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Y3244	Continued From page 9 Caregiver B finally came and disconnected the sling, one of the straps hit him/her. Director A said while talking with Resident 1, s/he observed "a mark on one side of [his/her] neck". Manager A could not remember which side of the neck, but estimated it was approximately 1 inch x 1/4 inch. Director A also observed bruising on the top of his/her right hand near the knuckles and lighter bruising on the left hand. Director A said s/he did not document or photograph the bruising/marks or further assess Resident 1 to determine if s/he sustained bruising or injury anywhere else. Director A also said s/he did not review call light logs. Surveyor requested call light logs during the timeframe of the incident and Director A said the system only allows them to look back 30 days, so the records were no longer available. Director A explained sometimes Resident 1 needs and prefers to be on the toilet for a long time to have a bowel movement, but s/he did not further investigate to determine the time of the incident, how long Resident 1 wanted to be on the toilet or how long s/he was trying to get staff's attention to get off the toilet. Director A said regardless, it was concerning because Resident 1 was still hooked up to the lift presenting a risk s/he could fall into it or the stand could tip, and s/he had no way to call for help. Director A recalled, "I did talk with [Caregiver B]. I said, 'Don't leave them [sic] in the (sit-to-stand). [S/he] has no way for calling for help, the pedant is in the walker in front [him/her].'... I also talked to [Caregiver B] about properly removing (the straps), make sure...they don't swing back on the resident."	Y3244		

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Y3244	Continued From page 10 On 08/19/2025 at 3:06 PM, Surveyor interviewed Caregiver D. S/he said staff are supposed to make sure Resident 1 has access to his/her call light when s/he is on toilet, but there have been 3 times when staff did not do that and s/he was "forgotten." Caregiver D said when that happened, Resident 1 banged on the walls for help. On 08/19/2025 at 9:20 AM, Surveyor interviewed Caregiver C. (Surveyor reviewed the schedule and noted his/her shift started at 3:00 AM on 07/13/2025.) Caregiver C explained Resident 1 tends to be overly particular about his/her cares and who provides them. That was the case on 07/13/2025 and Resident 1 was unhappy with Caregiver B. Caregiver B came out of Resident 1's room, "...frustrated and crying so [s/he] was going to take a minute...[S/he] went back in and tried to finish...trying to get [Resident 1] off the toilet..." Caregiver C confirmed Caregiver B kept [Resident 1] connected to the lift while s/he was on the toilet and commented, "The only thing I would have done different is I would have taken [Resident 1] off the EZ stand." On 08/19/2025 at 1:20 PM, Surveyor interviewed Resident 1. Surveyor observed s/he had poor neck and upper body control. Resident 1 recalled an incident that occurred in mid-July when Caregiver B assisted him/her to the toilet and Resident 1 subsequently used his/her call pendant 3 times for help. (Surveyor note: this is contrary to Director A's impression Resident 1 did not have access to the call pendant.) Resident 1 said the first time s/he pressed the pendant Caregiver B cleared the call, left and didn't return for 45 minutes. This prompted Resident 1 to call again. S/he said Caregiver B "came back yelling ...in an irritated state ...[s/he] got me up and was being very rough with the lift and jerky." Resident	Y3244		

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Y3244	Continued From page 11 1 described an argument between the two about whether Caregiver B had connected him/her to the correct hook on the lift. Resident 1 said eventually, Caregiver B left Resident 1 in the sling, on the toilet and still connected to the lift. Resident 1 stated, "I pushed the button right away because I was stuck in that position ...the lift was turning on me ... because the one side was not locked." Resident 1 said s/he tried to free him/herself from the sling, but it ended up near his/her neck. Resident 1 said s/he was in pain and his/her arms were stuck in the sling. Resident 1 recalled s/he was left for "over an hour" and started to feel "disoriented." Resident 1 said s/he sustained injuries and volunteered photos to Surveyor. Surveyor observed photos of a scratch on Resident 1's neck and bruises on the back of his/her hand. Cross Reference N0158 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	Y3244		