STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015613	A. BUILDING: _____ B. WING _____	C 11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC AT HILLCREST GREENS MEMORY C	2455 SAWGRASS PLACE ALTOONA, WI 54720

(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 11/11/2025, Surveyors conducted a complaint investigation at the Classic at Hillcrest Greens Memory Care. The complaint was substantiated. Two deficiencies were identified. Census: 37	N 000		
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 a practitioner for 1 of 2 residents reviewed. Resident 1 did not receive his/her scheduled Estradiol cream since July 2025. Findings include: On 09/18/2025, the department received a complaint alleging medications were not being administered as ordered. On 11/11/2025, Surveyor reviewed Resident 1's records. Resident 1 was admitted on 04/03/2024 and had an activated power of attorney for	N 352		

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

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N 352	Continued From page 1	N 352		

healthcare.

Resident 1's Individual Service Plan (ISP), last signed on 09/08/2025, indicated staff assisted Resident 1 with scheduled and PRN (as needed) medications.

Resident 1's July 2025 Medication Administration Record (MAR) identified the following:
Estradiol 0.1 Mg/Gm Cream. Insert one gram to urethra 3 times weekly at HS (bedtime) (Mon/Wed/Fri). Effective date: 04/10/2024. No end date identified.
Thirteen entries contained a circle with what appeared to be staff initials. On 07/02/2025, 07/04/2025, 07/07/2025, 07/09/2025, 07/11/2025, 07/14/2025, 07/16/2025, 07/18/2025, 07/21/2025, 07/23/2025, 07/25/2025, 07/28/2025, and 07/30/2025, the medication notes stated, "Med (medication) not received from pharmacy."

Resident 1's August 2025 MAR identified the following:
Thirteen entries contained a circle with what appeared to be staff initials. On 08/01/2025, 08/04/2025, 08/06/2025, 08/08/2025, 08/11/2025, 08/13/2025, 08/15/2025, 08/18/2025, 08/20/2025, 08/22/2025, 08/25/2025,08/27/2025, and 08/29/2025, the medication notes stated, "Med not received from pharmacy."

Resident 1's September 2025 MAR identified the following:
Thirteen entries contained a circle with what appeared to be staff initials. On 09/01/2025 and 09/03/2025, the medication notes read, "Med not available-family supplies." On 09/05/2025, 09/08/2025, 09/10/2025, 09/12/2025, 09/15/2025, 09/17/2025, 09/19/2025, 09/22/2025, 09/24/2025, 09/26/2025, and 09/29/2025, the medication

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N 352	Continued From page 2	N 352		

notes stated, "Med not received from pharmacy."

Resident 1's October 2025 MAR identified the following:
Fourteen entries contained a circle with what appeared to be staff initials. On 10/01/2025, 10/03/2025, 10/06/2025, 10/08/2025, 10/10/2025, 10/13/2025, 10/15/2025, 10/17/2025, 10/20/2025, 10/22/2025, 10/24/2025, 10/27/2025, 10/29/2025, and 10/31/2025, the medication notes stated, "Med not received from pharmacy."

Resident 1's November 2025 MAR identified the following:
Four entries contained a circle with what appeared to be staff initials. On 11/03/2025, 11/05/2025, 11/07/2025, and 11/10/2025, the medication notes stated, "Med not received from pharmacy."

The provider's "Medication List" for Resident 1, printed 08/22/2025, stated Estradiol was ordered to be given 3 times weekly at HS.

A physician's fax, dated 08/26/2025, indicated Resident 1's Estradiol was to be inserted vaginally 3 times a week at night.

At approximately 3:15 PM, Surveyors interviewed Nurse A. When asked about the status of Resident 1's Estradiol cream, Nurse A stated s/he would have to check with the pharmacy. Surveyors expressed concerns that the medication appeared to be scheduled and not given for several months. Nurse A stated the caregivers were usually good about telling him/her when orders need to be refilled. Nurse A stated the provider should notify the resident's physician within a week if a medication was not given. Nurse A stated s/he would need to call the

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N 352	Continued From page 3 physician as s/he did not think the Estradiol was discontinued. When asked about how often the medication cart was audited, Nurse A stated staff should report if a medication was low at the end of each shift. Nurse A stated s/he did not recall receiving an alert about the Estradiol being low.	N 352		
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 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:	N 431		

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N 431	Continued From page 4 Based on interview and record review, the provider did not ensure 1 of 2 residents reviewed (Resident 1) received health monitoring services. Resident 1's medical providers were not notified when Residents 1's blood glucose levels were outside of parameters per provider protocol. Findings include: On 09/18/2025, the department received a complaint regarding resident care and treatment. On 11/11/2025, Surveyors conducted an onsite visit and requested Resident 1's records including protocols for diabetic management and any documentation pertaining to provider follow up when glucose levels were out of parameters. At approximately 10:30 AM, Surveyor interviewed Nurse A. Nurse A stated the Resident Assistants (RA) would report any medication changes in the Medication Administration Record (MAR) and to a nurse. Resident 1 was admitted on 04/03/2024 and had multiple diagnoses including diabetes mellitus with hyperglycemia. Resident 1 had an activated power of attorney for healthcare. Resident 1's September 2025 MAR stated, if blood sugar was greater than 399, call on-call nurse for further direction. If blood sugar was less than 70, juice, high carb (Carbohydrate) food, or glucose tabs were to be given. On 09/08/2025, at 4:00 PM, Resident 1's Insulin Aspart FlexPen 100 unit/ML Sliding scale insulin was held due to a request by Resident 1's family member. Dexcom (Glucose Monitoring) sensor read 91 and finger poke read 142.	N 431		

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N 431	Continued From page 5 On 09/09/2025, at 4:00 PM, Resident 1's Insulin Aspart FlexPen 100 unit/ML Sliding scale insulin was held due to other: low blood sugar. On 09/11/2025, at 8:00 AM, Resident 1's Insulin Lantus SoloStar 100 unit/ML and Insulin Aspart FlexPen 100 unit/ML Sliding scale insulin was "held per M.D." Surveyor noted blood sugars were inconsistently recorded on Resident 1's MAR. On 11/11/2025, at approximately 1:00 PM, Surveyor was provided Resident 1's blood sugar readings logged separately which did not indicate parameters and were as follows: Resident 1's "Blood Sugar" or glucose reading on 09/08/2025 at 12:45 PM was 162, and at 8:11 PM, 160. On 09/09/2025 at 3:39 PM it was recorded as 52, and at 8:15 PM, 330. Resident 1's Individualized Service Plan (ISP) signed and dated 09/08/2025 read, Resident 1 "has Diabetes Mellitus and has a Dexcom 7 which monitors [his/her] blood sugars. Finger stick blood sugar tests may be utilized if the Dexcom device fails. Or if the Dexcom readings seem higher or lower than normal." Resident 1 "receives both Novolog and Lantus insulins. Nurse is to notify MD if blood sugar readings are out of parameters." On 11/11/2025, at approximately 2:45 PM, Surveyor interviewed 4 medication passing RAs. All RAs stated they would follow the directions in the MAR for blood sugar readings that were out of the parameters and call the nurse in charge if insulin was held. Out of parameters were defined	N 431		

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N 431	Continued From page 6 by RA's as less than 70 or over 399. At approximately 3:10 PM, Surveyor requested any documentation of Resident 1's follow up when insulin was held or when blood sugar readings were considered out of parameters. Surveyor was provided Resident 1's Nursing Progress Notes for September 2025 and found no documentation of Resident 1's blood sugar readings, diabetic management, or insulin being held. There was no documentation of the primary medical provider updated per facility's standing orders of a reading below 60. There was no documentation provided of the medical provider ordered insulin to be held on 09/11/2025. At approximately 3:15 PM, Surveyor interviewed Nurse A. Nurse A reported the expectation would be that Resident 1's diabetic follow up, including reason for insulin being held and blood sugars out of parameters, would be reported to the nurse in charge, and notification to the nurse and/or medical provider would be documented.	N 431		