STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014709	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHVIEW HEIGHTS	199 CTY DF JUNEAU, WI 53039

(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 05/21/2025, Surveyor conducted an abbreviated survey and complaint investigation at Northview Heights, a CBRF located in Juneau, WI. As a result of the survey, 3 violations of Chapter DHS 83 were issued. The complaint was unsubstantiated. Census: 19	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 3 of 3 residents had pre-admission or ongoing assessments. Resident 1, Resident 2 and Resident 3 did not have any documented assessments in their medical record. Findings include:	N 381		

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

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N 381	Continued From page 1 On 05/21/2025 at 9:00 AM, Surveyor reviewed Resident 1's file. Resident 1 was admitted 07/21/2024 with diagnoses that included but are not limited to: schizoaffective disorder bipolar type, AODA, Diabetes Type II, Bipolar disorder, anxiety, borderline personality disorder, mild cognitive impairment, GERD, chronic gout, depression. There were no documented assessments in Resident 1's file. On 05/21/2025 at 9:00 AM, Surveyor reviewed Resident 2's file. Resident 2 was admitted 06/29/2022 with diagnoses that include but are not limited to: bipolar disorder, osteoarthritis, spinal stenosis, chronic kidney disease stage 3, major depressive disorder, PTSD, emphysema, GERD, acute and chronic respiratory failure. There were no documented assessments in Resident 2's file. On 05/21/2025 at 9:00 AM, Surveyor reviewed Resident 3's file. Resident 3 was admitted 05/03/2022 with diagnoses that include but are not limited to: cerebral infarction due to embolism of bilateral posterior cerebral arteries, chronic kidney disease stage 3, Diabetes Type II, major depressive disorder, anxiety, peripheral vascular disease, GERD, cognitive communication deficit. There were no documented assessments in Resident 3's file. On 05/21/2025 at 10:00 AM, Surveyor interviewed Administrator A. Administrator A stated, "I never knew that I needed to do assessments, I just completed the Individual Service Plan (ISP) based on diagnoses and abilities. Nobody ever told me I had to do these." Surveyor advised Administrator A on Chapter DHS 83 requirements for assessments.	N 381		

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N 381	Continued From page 2 Administrator A acknowledged that Chapter DHS 83 requires the facility to conduct assessments to assess abilities and needs of residents. Surveyor asked if all resident records were checked, would there be assessments in their respective files. Administrator A stated, "No, because I didn't know I had to do them,"	N 381		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's Individual Service Plan (ISP) included a rationale for use. There was no rationale for use of prn lorazepam in Resident 1's ISP.	N 408		

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N 408	Continued From page 3 Findings include: On 05/21/2025 at 9:00 AM, Surveyor reviewed Resident 1's file. Resident 1 was admitted 07/21/2024 with diagnoses that included but are not limited to: schizoaffective disorder bipolar type, AODA, Diabetes Type II, Bipolar disorder, anxiety, borderline personality disorder, mild cognitive impairment, GERD, chronic gout, depression. According to Resident 1's active medication orders, Resident 1 is prescribed .5 milligram (mg) tablet Lorazepam as needed (prn) for anxiety. Surveyor reviewed Resident 1's ISP dated 03/26/2025. There was no rationale in Resident 1's ISP for prn Lorazepam. On 05/21/2025 at 10:15 AM, Surveyor interviewed Administrator A. Administrator A stated that Resident 1's behaviors are outlined in his/her ISP and non-medical interventions as well. Administrator A acknowledged that the rationale for prn Lorazepam should be included in Resident 1's ISP. Surveyor asked if other residents on prn psychotropic medications had rationale in their ISP? Administrator A stated, "No, I they would not, I would be the one that put that in their ISP."	N 408		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by	N 535		

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N 535	Continued From page 4 CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not test facility smoke detectors bimonthly as required. There were no documented internal smoke/heat detector tests in facility records. Findings include: On 05/21/2025 at 10:15 AM, Surveyor reviewed the facility records. There were no documented internal tests for smoke/heat detectors for calendar year 2023 or 2024. On 05/21/2025 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated, "the county does not allow us to touch the smoke/heat detectors. They say they test them annually. Surveyor advised Administrator A that Chapter DHS 83 requires the facility to conduct internal testing bimonthly. Administrator A stated s/he did not know that was a requirement. On 05/23/2025 at 08:53 AM, Surveyor received an email from Facilities Director B. Email states: "I would like to explain Dodge County's position on testing the smoke detectors in our CBRF every other month. We have been going by the following statute in the testing section: DHS 83.48 (3) (a) After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in	N 535		

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N 535	Continued From page 5 accordance with the specifications in NFPA 72 and the manufacturer's specifications and procedures. As we view this, we believe we are in compliance with the regulations, and this is what we have been operating under ever since the facility opened back 2013 if I remember the date correctly. We have never been asked to check them every two months."	N 535		