STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110524	A. BUILDING: _____ B. WING _____	R-C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN CROSSINGS OF FITCHBURG	5784 CHAPEL VALLEY RD 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 From 04/19/2024 to 04/26/2024, Surveyor conducted a complaint investigation, verification visit and standard survey at Sylvan Crossing of Fitchburg, a CBRF in Fitchburg. Sixteen deficiencies were identified. Ten deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) LBS211, dated 12/23/2020, DR2111, dated 10/12/2021, 2G1Q11, dated 11/11/2021, SOD 2GIQ12, dated 05/02/2022, 2G1Q13, dated 10/26/2022, KFI312, dated 06/07/2023 and KFI313, dated 10/24/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 15	{N 000}		
N 181	83.13(1)(i) Maintain records of annual fire inspection. The CBRF shall maintain documentation of all of the following: Results of the annual fire inspection as required under s. DHS 83.47(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure annual fire inspection records were maintained. The provider did not have record of the most recent sensitivity test. Findings include: On 04/19/2024 at approximately 8:35 a.m., Surveyor reviewed the provider's environmental records. The records did not include	N 181		

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

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N 181	Continued From page 1 documentation of a sensitivity test completed in the past 5 years. On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M. Surveyor asked VP of Compliance M if the provider had a sensitivity test completed in the past 5 years. VP of Compliance M stated s/he would need to follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to a sensitivity test was not received.	N 181		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the licensee did not ensure the facility complied with all laws governing the facility. This is a repeat deficiency see Statement of Deficiency (SOD) DR2111 dated, 10/12/2021 and KFI313, 10/24/2023. Findings include: From 04/19/2024 to 04/26/2024, Surveyor conducted a complaint investigation, verification visit and standard survey. Sixteen deficiencies, nine of which were repeat deficiencies, were identified (not including Licensee Enures Facility Complies With Laws). The deficiencies included	N 196		

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N 196	Continued From page 2 the following: Environment: - Fire Inspection: The provider did not have documentation of a sensitivity test available to the department for review. - Food Supply: The provider did not have an adequate quantity of their noon meal to meet the needs of all residents. - Clean Environment: The provider's bathroom/shower room and walls/doorways needed repairs. - Heating System: The provider did not have documentation of a furnace inspection available to the department for review. - Sprinkler System: The provider's sprinkler system inspection indicated the system had deficiencies that were not addressed. - Water Temperature: The provider's water temperate exceeded 115 degrees. Employees: - The provider did not have documentation of a complete background check for 1 of 3 caregivers reviewed. - The provider did not have documentation of employee tuberculosis tests available for the department to review. Residents: - The provider did not administer medications as prescribed. Resident 23 was hospitalized for hypoglycemia due to incorrect insulin administration. - Assessments: The provider did not conduct updated assessments when Resident 19 sustained falls and exhibited aggressive	N 196		

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N 196	Continued From page 3	N 196		

behaviors that were affecting other residents.
- Individual Service Plan (ISP): The provider did not ensure Resident 19's Health Care Power of Attorney was in agreement with his/her ISP and signed the ISP to indicate agreement.
- ISP Updates: The provider did not ensure 1 of 3 ISPs reviewed was updated when there was a change in need. Resident 19's ISP was not updated to include his/her need for a pureed diet and supervision.
- Scheduled Psychotropic Reviews: The provider did not ensure 1 of 1 residents reviewed had his/her scheduled psychotropic medications reviewed at least quarterly by a pharmacist, practitioner or nurse. VP of Compliance M, who was not a pharmacist, practitioner or nurse, completed scheduled psychotropic reviews.
- PRN Psychotropic Medications: The provider did not ensure 2 of 2 residents reviewed who received PRN psychotropic medications had the rational for use and detailed description of behaviors that indicated the need for PRN psychotropic administration included in the ISPs.
- Activities: The provider did not offer the 9:00 and 10:00 a.m. activities as posted on their activity calendar.
- Treatment: Caregivers were observed completing tasks for or with residents without explanation of what they were doing. Residents were observed not receiving any response from caregivers when asking a question or making a request.

Special Orders:

On 02/28/2024, the department issued SOD KFI314 with Special Orders that stated, " ...Within 10 days of receipt of this notice, the CBRF will provide the legal representatives and case managers (if any) of each current resident with a

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N 196	Continued From page 4 copy of [SOD] KFI314 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the Department, to verify compliance with Order #1. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager (if any). The documentation required by Order #1 will be available to department representatives upon request." On 04/19/2024 at 1:30 p.m., Surveyor requested documentation from VP of Compliance M to indicate Special Orders were completed as indicated in the Notice and Order letter. Surveyor requested that all documentation be provided by 04/20/2024 at 1:30 p.m. As of 04/26/2024 at 1:30 p.m., Surveyor had not received documentation to indicate the special orders were followed. On 04/26/2024 at approximately 2:30 p.m., Surveyor reviewed the above concerns with Vice President R and Director EE. Vice President R stated s/he was unaware VP of Compliance M did not provide Surveyor with numerous environmental records requested on 04/19/2024. VP of Compliance M stated s/he was sure Human Resources completed the notifications required in SOD KFI314. VP of Compliance M stated VP of Compliance M was currently at the facility 2-3 days a week to assist with operations, but that Director EE would eventually be taking over administrative duties. Vice President R stated, "We have work to do."	N 196		
N 219	83.17(1) Licensee conduct caregiver background check	N 219		

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N 219	Continued From page 5 Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a background check following the procedures in s. 50.065 and ch. DHS 12 was completed and documented for 1 of 3 caregivers reviewed. The provider did not have documentation of the information maintained by the department of safety and professional service regarding a person's credentials (IBIS). This is a repeat deficiency. See Statement of Deficiency (SOD) DR2111, dated 10/12/2021, KFI311 dated 1/19/2023 and KFI313, dated 10/24/2023. Findings include: The complete background check is to include the background information disclosure form (BID), the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and	N 219		

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N 219	Continued From page 6 professional service regarding a person's credentials (IBIS). On 04/19/2024 at approximately 9:30 a.m., Surveyor reviewed employee records provided by VP of Compliance M. Surveyor reviewed the record of Caregiver DD, hired 11/21/2023. Surveyor noted Caregiver DD's record did not include an IBIS. On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M. Surveyor asked VP of Compliance M if an IBIS was completed for Caregiver DD at the time of hire. VP of Compliance stated an IBIS should have been completed and s/he would follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation of an IBIS for Caregiver DD was not received.	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

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N 220	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the department had access to 2 of 3 caregiver communicable disease screens, including tuberculosis tests. Caregiver BB and Caregiver DD's tuberculosis tests were not on record and available to Surveyor. Findings include: On 04/19/2024 at approximately 9:30 a.m., Surveyor reviewed employee records provided by VP of Compliance M. Surveyor reviewed the records of Caregiver BB, hired 08/08/2023 and Caregiver DD, hired 11/21/2023. Surveyor noted that neither Caregiver BB, nor Caregiver DD's record included evidence of a tuberculosis test. On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M. Surveyor asked VP of Compliance M if Caregiver BB and Caregiver DD had tuberculosis tests completed at the time of hire. VP of Compliance M stated s/he would need to follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to tuberculosis tests for Caregiver BB and Caregiver DD were not received.	N 220		
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	N 352		

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N 352	Continued From page 8	N 352		

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 1 of 3 residents reviewed received his/her medications in the dosage prescribed by his/her physician. Resident 23 received insulin when the insulin should have been held resulting in hypoglycemia and an emergency room visit.

This is a repeat deficiency. See Statement of Deficiency (SOD) KFI312, dated 06/07/2023.

Findings include:

From 04/19/2024 to 04/26/2024, Surveyor conducted a complaint investigation alleging the provider did not administer medications as prescribed.

On 04/19/2024 at approximately 8:00 a.m., Surveyor reviewed hospice records, obtained by Surveyor. Hospice records indicated Resident 23 was admitted to the provider with a physician order for Novolog 100 unit/ml (Start Date: 02/09/2024) - Inject 3 times daily at mealtimes 300-350=4 units, 351-400=6 units, 401-450=8 units. The record included a note, dated 02/18/2024, that stated Resident 23 was hospitalized due to hypoglycemia caused by incorrect amounts of insulin given, which caused Resident 23 to be unresponsive.

On 04/19/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 23's record, provided by VP of Compliance M. Resident 23 was

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N 352	Continued From page 9 admitted to the provider's facility on 02/09/2024 with diagnosis of diabetes. Resident 23's Medication Administration Record (MAR), dated 02/09/2024 to 02/29/2024, identified the following insulin administration errors: - 02/12/2024 9:22 a.m. BS 116 - 4 units administered *Per order, 0 units should have been administered. - 02/12/2024 12:12 p.m. BS 116 - 4 units administered *Per order, 0 units should have been administered. - 02/12/2024 6:13 p.m. BS 93 - 4 units administered *Per order, 0 units should have been administered. - 02/13/2024 7:22 a.m. BS 121 - 4 units administered *Per order, 0 units should have been administered. - 02/13/2024 12:11 p.m. BS 108 - 4 units administered *Per order, 0 units should have been administered. - 02/14/2024 7:29 p.m. BS 105 - 4 units administered *Per order, 0 units should have been administered. - 02/15/2024 4:34 p.m. BS 165 - 4 units administered *Per order, 0 units should have been administered. - 02/16/20247:54 a.m. BS 144 - 4 units administered *Per order, 0 units should have been administered. - 02/29/2024 8:05 a.m. BS 308 - 0 units administered. *Per order, 4 units should have been administered. - 02/29/2024 12:51 p.m. BS 373 - 4 units administered. *Per order, 6 units should have been administered. Resident 23's record included a progress note, dated 02/15/2024, that stated Resident 23 was sent to the ER due to a low blood sugar.	N 352		

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N 352	Continued From page 10 On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M. VP of Compliance M stated Resident 23's admission orders were unclear to the provider's staff and several attempts were made to obtain clarification from Resident 23's providers. VP of Compliance M stated the facility acknowledged a medication error occurred and completed a self-report regarding the error.	N 352		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were safeguarded from environmental hazards. The facility's water temperature reached 121.6° F. Findings include: On 04/19/2024 at approximately 8:35 a.m., Surveyor toured the provider's facility. The provider is licensed to serve up to 19 residents with diagnoses including advanced age and irreversible dementia/Alzheimer's. Surveyor took the temperature of water in the provider's shower	N 358		

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N 358	Continued From page 11 room and noted the temperature reached 121.6° F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (Source: Publication DHS P-01942 - 08/2017). On 04/19/2024 at approximately 1:30 p.m., Surveyor reviewed concern with VP of Compliance M that the facility's water temperature exceeded 115° F. VP of Compliance M confirmed the shower room was used by residents and stated the director and maintenance staff were responsible for testing water temperatures routinely. Surveyor then reviewed the provider's environmental book in the presence of VP of Compliance M, which included blank water temperature logs.	N 358		
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	N 381		

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N 381	Continued From page 12 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 observation, record review and interview, the provider did not assess each resident's needs and physical condition when there was a change in condition. Resident 19's needs were not assessed when s/he sustained falls and exhibited behaviors of aggression. This is a repeat deficiency. See Statement of Deficiency (SOD) LBS211, dated 12/23/2020. Findings include: On 04/19/2024, Surveyor reviewed Resident 19's record and made observations. Resident 19 was admitted to the provider's facility on 02/22/2024. The following concerns were identified: Example 1 - Falls: On 04/19/2024 at approximately 11:48 a.m., Surveyor and Caregiver BB entered Resident 19's room. Surveyor observed Resident 19 on the floor and unable to get up on his/her own. Surveyor observed Caregiver BB walk over to Resident 19, grab Resident 19's hands and pull Resident 19 up by his/her upper extremities. Caregiver BB did not visually assess Resident 19 for injuries, Caregiver BB did not perform range of motion or verbally ask Resident 19 any questions. After Caregiver BB had assisted Resident 19 to stand, Caregiver BB walked	N 381		

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N 381	Continued From page 13 Resident 19 to his/her bed and stated s/he needed to get his/her coworkers. On 04/19/2024 at approximately 12:00 p.m., Surveyor reviewed incident reports and noted the following falls did not include assessments to identify change in need/intervention: - 03/23/2024: Fall - S/he was walking towards his/her closet and fell face first into the closet, hitting his/her elbows and head on a closet door. - 03/27/2024: Fall - S/he was laying on the floor. Noticed shelving behind the door was removed and s/he had a red area on his/her head and right chest. - 03/29/2024: Fall - S/he was walking normally, bent down a little and his/her body went backwards. Resident 19's most recent assessment was dated 02/21/2024 and indicated s/he was a high fall risk, but did not identify any methods of fall prevention. On 04/19/2024 at approximately 1:00 p.m., Surveyor interviewed VP of Compliance M. Surveyor asked what the protocol was when a resident falls. VP of Compliance M stated staff should complete an assessment, which included range of motion, vitals and a skin assessment and that staff should have at least 2 caregivers assist a resident up from the ground. Surveyor shared his/her 11:48 a.m. observation of Resident 19 and Caregiver BB and requested documentation of the assessment that was completed post fall. Surveyor asked what interventions had been put into place due to Resident 19's falls. VP of Compliance M stated s/he would have to follow up with records. VP of Compliance M was given until 04/20/2024 at 1:30	N 381		

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p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to Resident 19's falls was received.

Example 2 - Resident 19's Behaviors:

Resident 19's progress notes and incident reports, dated 02/22/2024 to 04/19/2024, included the following:

- 02/23/2024: Presents with very anxious behavior which causes risk of falls. Wanted to tear off the hose from his/her urinary system.
- 02/26/2024: Fights, hits and keeps standing up. Staff spending a lot of time with resident. S/he needs one on one care.
- 03/06/2024: Going into other's room.
- 03/08/2024: Getting very agitated. Became very grabby and angry.
- 03/11/2024: Picked up another resident from dining room chair trying to get him/her into the wheelchair. Staff stopped Resident 19, but s/he became combative and angry. Urinated all over his/her bathroom floor. Tried to get into other resident rooms.
- 03/12/2024: Very restless. Urinated in the corner of his/her room more than once during shift.
- 03/27/2024: Grabbed liquid hand soap and tried taking a drink of it.
- 04/01/2024: Showing aggression toward staff.
- 04/09/2024: Hit another resident. Tried moving another resident in his/her wheelchair. You must be checking him/her every 15 minutes so that s/he doesn't hit another resident.
- 04/15/2024: Slapped another resident twice. Punched another resident.
- 04/17/2024: Entered another resident's room and moved things around.

Resident 19's most recent assessment was dated

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N 381	Continued From page 15 02/21/2024 and indicated Resident 19 had no wandering behaviors and no signs of destructive or abusive behaviors. On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M. Surveyor reviewed documentation of behaviors Resident 19 had exhibited since admission. Surveyor asked if the provider had completed an updated behavior assessment and put interventions into place. VP of Compliance M stated s/he would need to follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to Resident 19's behaviors was not received.	N 381		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.	N 387		

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N 387	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 individual service plans (ISP) reviewed involved the resident's Health Care Power of Attorney (HCPOA) in the development of the ISP and that the ISP was signed by the HCPOA acknowledging their involvement in, understanding of and agreement with the plan. Resident 19's ISP was not signed by his/her HCPOA. This is a repeat deficiency. See Statement of Deficiency (SOD) 2G1Q11, dated 11/11/2021 and SOD 2GIQ12, dated 05/02/2022. Findings include: On 04/19/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 19's record. Resident 19 was admitted to the provider's facility on 02/22/2024 with diagnosis of dementia. Resident 19 had an activated HCPOA. Resident 19's ISP, dated 02/26/2024, was signed by Resident 19. The ISP did not include the signature of his/her HCPOA. On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M. Surveyor asked VP of Compliance M why Resident 19's ISP was signed by Resident 19 and not his/her HCPOA. VP of Compliance M was unable to locate an ISP signed by Resident 19's HCPOA and stated s/he would need to follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to Resident 19's ISP was not received.	N 387		

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N 387	Continued From page 17 On 04/22/2024 at approximately 9:00 a.m., VP of Compliance M emailed Surveyor an ISP signed by Resident 19's HCPOA on 04/19/2024 at 3:24 p.m., after Surveyor had identified the HCPOA had not signed Resident 19's ISP.	N 387		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) of 1 of 3 residents reviewed was updated when there was a change in need. Resident 19's ISP was not updated to include his/her need for a pureed diet and supervision. This is a repeat deficiency. See Statement of Deficiency (SOD) NKN511 dated, 12/14/2020; SOD 2G1Q12, dated 05/02/2022; SOD KF1311, dated 01/19/2023; SOD KFI312, dated 06/07/2023, SOD KFI313, dated 10/24/2023 and	{N 389}		

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{N 389}	Continued From page 18 SOD KFI314, dated 01/22/2024. Findings include: On 04/19/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 19's record. Resident 19 was admitted to the provider's facility on 02/22/2024. Resident 19's ISP, dated 02/26/2024, stated s/he would be escorted to/from all meals by staff and served finger food. On 04/19/2024 at approximately 12:30 p.m., Surveyor observed Resident 19 was not in the dining room while lunch was being served. Caregiver BB stated Resident 19 would eat in his/her room after lunch was served in the dining room and be provided assistance by staff. Surveyor observed the meal that would be served to Resident 19 was soup and a baked potato. Director EE stated Resident 19 required a pureed diet and s/he wasn't able to puree the fish served to the rest of the residents so Resident 19 was going to be served soup. On 04/19/2024 at approximately 1:00 p.m., Surveyor reviewed a progress note, dated 03/24/2024, that stated "Resident is allowed to eat in [his/her] room per hospice but a staff member must stay in [his/her] room with [him/her] while [s/he] eats as [s/he] is a choke hazard." On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M regarding Resident 19's diet. VP of Compliance M confirmed Resident 19 required a pureed diet and was served lunch in his/her room, which was not identified on the ISP.	{N 389}		

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N 407	Continued From page 19	N 407		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed that required scheduled psychotropic reviews had his/her scheduled psychotropic medications reviewed by a pharmacist, practitioner or registered nurse at least quarterly. Resident 9's scheduled psychotropic medications were not reviewed quarterly by a pharmacist, practitioner or registered nurse. Findings include: On 04/19/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider's facility on 07/14/2022. Resident 9's physician orders included the following: - Quetiapine 12.5 mg twice daily for delusions, hallucinations and dangerous agitation (Start Date: 02/16/2023) - Lorazepam .5 mg twice daily for anxiety, nausea	N 407		

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N 407	Continued From page 20	N 407		

and restlessness (Start Date: 10/10/2022)
- Sertraline 100 mg once daily for mood (Start Date: 02/16/2023)

Resident 9's record included scheduled psychotropic reviews that were completed monthly by VP of Compliance M.

On 04/19/2024 at approximately 1:30 p.m., Surveyor asked VP of Compliance M if s/he was a practitioner, pharmacist or registered nurse. VP of Compliance M replied, "No." Surveyor asked if the provider had scheduled psychotropic reviews completed by a practitioner, pharmacist or registered nurse. VP of Compliance M stated s/he was sure pharmacy took care of that, but would need to follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to psychotropic reviews was not received.

On 04/22/2024 at approximately 9:00 a.m., VP of Compliance M emailed Surveyor monthly psychotropic reviews with Nurse Practitioner FF's signature. Surveyor noted Quetiapine was not included in the reviews.

On 04/25/2024 at approximately 3:00 p.m., Surveyor interviewed Nurse Practitioner FF. Surveyor asked Nurse Practitioner FF when s/he had completed the scheduled psychotropic reviews. Nurse Practitioner FF stated s/he was asked since Surveyor's visit to the facility on 04/19/2024 to go back and sign the psychotropic reviews sent to Surveyor on 04/22/2024. Nurse Practitioner FF stated s/he would sign off on them quarterly moving forward and asked Surveyor to review the regulation with VP of Compliance M.

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N 408	Continued From page 21	N 408		
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 the individualized serve plans (ISP) of 2 of 3 residents reviewed included the rational for use and a detailed description of behaviors which would indicate the need for administration of the PRN psychotropic medication. Resident 19 and Resident 23's ISPs did not include the use of their PRN psychotropic medications. This is a repeat deficiency. See Statement of Deficiency (SOD) 2G1Q11, dated 11/11/2021 and SOD 2GIQ12, dated 05/02/2022.	N 408		

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N 408	Continued From page 22 Findings include: On 04/19/2024 at approximately 12:00 p.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 19: Resident 19 was admitted to the provider's facility on 02/22/2024. Resident 19's ISP, dated 02/26/2024, stated s/he took psychotropic medications related to specific behaviors and stated "See [Medication Administration Record] for Medications." Resident 19's Medication Administration Record (MAR) listed "Lorazepam 2 mg/ml (Start Date: 03/12/2024) - Take .5 ml by mouth every 4 hours as needed *Hospice Patient." Neither the ISP, nor the MAR indicated the rationale for use and a detailed description of the behaviors which indicated the need for administration of PRN psychotropic medication. The April 2024 MAR indicated Resident 19's Lorazepam was administered on 04/09/2024 because Resident 19 had hit another resident. Example 2 - Resident 23: Resident 23 was admitted to the provider's facility on 02/09/2024. Resident 23's physician orders included Olanzapine 2.5 mg (Start Date: 02/14/2024) - Take 1 time daily at bed time as needed for sundowning. Resident 23's ISP, dated 02/09/2024, did not include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M.	N 408		

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N 408	Continued From page 23 Surveyor shared observation that ISPs reviewed did not include the use of PRN psychotropic medications. VP of Compliance M stated s/he would review documentation to see if s/he had anything additional to provide Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to psychotropic medications was not received.	N 408		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure a daily activity program was provided and promoted. The provider did not follow and promote the posted activity schedule. This is a repeat deficiency. See Statement of Deficiency (SOD) LBS211, dated 12/23/2020 and 2G1Q13, dated 10/26/2022.	N 427		

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N 427	Continued From page 24 Findings include: On 04/19/2024 at approximately 8:30 a.m., Surveyor reviewed the provider's activity calendar posted in the dining room. The activity calendar listed the following morning events: "9:00 a.m. Daily Chronicles, 10:00 a.m. Morning Walks, 11:00 a.m. Exercise." On 04/19/2024 from 9:00 a.m. to 11:00 a.m., Surveyor did not observe daily chronicles or morning walks take place. Surveyor observed 7 residents situated in recliners or wheelchairs in front of a common area television. On 04/19/2024 at approximately 11:00 a.m., Surveyor observed a caregiver change the channel on the television and begin playing music videos at a higher volume. Surveyor then observed Caregiver AA, Caregiver BB and Caregiver CC begin dancing around the residents, occasionally holding the hands of a resident and moving the arms back and forth. Caregivers did not offer any explanation to residents that "Exercise" was now taking place or encourage residents to participate. On 04/19/2024 at approximately 1:30 p.m., Surveyor reviewed concern with VP of Compliance M that the provider's activity schedule did not appear followed and the 1 activity that did take place was not explained to residents. VP of Compliance M stated s/he thought the morning activities took place. VP of Compliance M stated s/he agreed that caregivers should explain/lead activities rather than changing the television channel and beginning to dance. VP of Compliance M was given until 04/20/2024	N 427		

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N 427	Continued From page 25 at 1:30 p.m. to follow up on concerns identified on 04/19/2024, including leisure time activities not occurring. No follow up related to leisure time activities was received.	N 427		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was in a clean condition. The provider's doorways had missing paint. The provider's bathroom had gray marks around the sink, a missing towel bar and nothing to dry hands with. This is a repeat deficiency. See Statement of Deficiency (SOD) LBS211, dated 12/23/2020. Findings include: On 04/19/2024 at approximately 8:35 a.m., Surveyor toured the provider's facility. Surveyor observed a doorway with missing paint (Photo 5). In the shower room, Surveyor observed gray speckled marks surrounding the sink, a broken towel bar and no towels or paper towels to dry one's hands with after using the restroom (Photo 1, Photo 2, Photo 3 and Photo 4). On 04/22/2024 at approximately 1:30 p.m.,	N 481		

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(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 481	Continued From page 26 Surveyor discussed the environmental and bathroom concerns with VP of Compliance M. VP of Compliance M confirmed the shower room was used routinely by residents and s/he was unsure why it was in the condition it was or how long the shower room had been in the condition it was in.	N 481		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's furnace was serviced at least once every 3 years and that documentation was available to the department. Findings include: On 04/19/2024 at approximately 8:35 a.m., Surveyor reviewed the provider's environmental records. The records did not include a furnace inspection completed in the past 3 years. On 04/19/2024 at approximately 1:30 p.m.,	N 504		

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	110524	A. BUILDING: _____ B. WING _____	R-C 04/26/2024

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N 504	Continued From page 27 Surveyor interviewed VP of Compliance M. Surveyor asked VP of Compliance M if the provider had a furnace inspection completed in the past 3 years. VP of Compliance M stated s/he would need to follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to the provider's furnace was not received.	N 504		
N 558	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's sprinkler system was maintained. The facility's sprinkler system had 5 unaddressed deficiencies. Findings include: On 04/19/2024 at approximately 8:35 a.m., Surveyor reviewed the provider's environmental records. The records included a sprinkler system inspection, dated 10/04/2023. The inspection identified 5 deficiencies, one of which stated the local alarm service did not receive any signals	N 558		

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N 558	Continued From page 28 from the system. On 04/19/2024 at approximately 1:30 p.m., Surveyor interviewed VP of Compliance M. Surveyor asked VP of Compliance M if the provider had followed up on the deficiencies identified during the 10/04/2023 sprinkler system inspection. VP of Compliance M stated s/he would need to follow up with Surveyor. VP of Compliance M was given until 04/20/2024 at 1:30 p.m. to provide follow up documentation. As of 04/20/2024 at 1:30 p.m., documentation related to the provider's sprinkler system was not received.	N 558		
Y3234	50.09(1)(e) Treatment (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: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure each resident was treated	Y3234		

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with courtesy and respect. Caregivers completed tasks for or with residents without explanation of what they were doing.

This is a repeat deficiency. See Statement of Deficiency (SOD) NKN513, dated 01/02/2020; SOD 2GIQ13 dated, 10/26/2022, SOD KFI313, dated 10/24/2023 and SOD KFI314, dated 01/22/2024.

Findings include:

On 04/19/2024 from approximately 8:30 a.m. to 1:30 p.m., Surveyor was present at the facility and identified the following treatment concerns:

- At 8:55 a.m. and 9:08 a.m., Surveyor observed Caregiver AA and Caregiver CC transfer Resident 12 with a hoyer lift. Caregiver AA and Caregiver CC did not provide any communication/explanation of what they were doing for Resident 12.
- At 9:25 a.m., Surveyor heard Caregiver AA state, "Vamo, [Resident 11]." Resident 11 had no response to Caregiver AA. VP of Compliance M confirmed the language Caregiver AA spoke to Resident 11 was not spoke or understood by Resident 11.
- At 9:36 a.m., Caregiver AA put his/her arm around Resident 16, turned Resident 16 around and guided Resident 16 to a chair. Caregiver AA did not provide any communication/explanation of what s/he was doing for Resident 16 or what s/he wanted Resident 16 to do.
- At 9:53 a.m. the facility's fire alarms were going off intermittently when there were 7 residents watching television in a common area. Caregiver AA came into the common area, raised his/her hands in an effort to calm residents and began speaking in a language not spoken by 6 of the

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residents. Six residents, who had memory deficits, were not provided explanation as to why the alarms were going off each time they sounded.
- At 10:15 a.m. Surveyor observed Caregiver AA move Resident 24, who was sitting in his/her wheelchair. Resident 24 responded, "What are you doing? It was set." Caregiver AA walked away without acknowledging or answering Resident 24's question. Caregiver AA did not move Resident 24 back to how s/he had previously been situated.
- At 12:38 p.m., Resident 24 and Resident 25 requested a second serving from Caregiver AA while eating lunch. Caregiver AA walked away without acknowledging Resident 24 and Resident 25's request. Caregiver AA then returned to the table with 2 cups of ice cream. Resident 24 reiterated that s/he would like a second serving of the main course. Caregiver AA did not provide Resident 24 with a response. Surveyor heard Resident 24 state to Resident 25, "[Caregiver AA] doesn't understand" as Caregiver AA walked away.

On 04/19/2024 at approximately 1:30 p.m., Surveyor reviewed concerns regarding the interactions and lack of acknowledgment between residents and caregivers with VP of Compliance M. VP of Compliance M stated caregivers should be communicating with residents as they complete cares. VP of Compliance M stated the facility just obtained new translation devices that caregivers should have been using if they did not speak the same language as the resident. Surveyor shared observation that from 8:30 a.m. to 1:30 p.m. Surveyor did not see translation devices used, including when Surveyor attempted to communicate with caregivers.

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