Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016266	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS ASSISTED LIVING CENTER INC	519 COMMERCE DR MADISON, WI 53719

(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 02/28/2024 to 02/29/2024, Surveyor conducted a complaint investigation at All Saints Assisted Living Center Inc, a CBRF in Madison. One deficiency was identified. The complaint was substantiated. Census: 46	N 000		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was able to return to the facility when s/he was medically ready to discharge from the hospital on 02/09/2024. The provider delayed Resident 1's return to the facility because the provider did not have a staff member available to readmit Resident 1 until 02/12/2024. Findings include: From 02/28/2024 to 02/29/2024, Surveyor conducted a complaint investigation alleging the facility did not allow residents to return to the facility over the weekend.	N 355		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016266	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS ASSISTED LIVING CENTER INC	519 COMMERCE DR MADISON, WI 53719

(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 355	Continued From page 1 On 02/28/2024 at approximately 1:30 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/28/2012. Resident 1's progress notes, dated 01/01/2024 through 02/28/2024, documented the following: - 02/08/2024: Resident was hospitalized for likely GI bleed. - 02/12/2024 (Monday): Returned from hospital. On 02/28/2024 at approximately 1:45 p.m., Surveyor reviewed hospital records, which documented the following: - 02/09/2024 at 8:39 a.m. Care Coordination Note: Facility is not able to accept Resident 1 back on Friday afternoon or on the weekend. Resident 1 can return on Monday if stable. - 02/09/2024 at 2:56 p.m. Physician Note: Medically stable for discharge, but facility canot accept resident back until Monday so resident will be here through the weekend. On 02/28/2024 at approximately 1:45 p.m., Surveyor interviewed Administrator A regarding residents returning to the facility over the weekend. Administrator A stated the facility did not accept residents back to the hospital from 3:00 p.m. on Fridays to Monday morning. Administrator A stated it was their procedure that a RN complete resident re-admissions and the RN was not available over the weekends. Administrator A stated the caregivers would not know how to readmit a resident back to the facility. Surveyor asked if it was appropriate for a resident to remain hospitalized for 24-72 hours when not medically necessary because the facility would not readmit over the weekend. Administrator A replied, "Hospitals need to work	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016266	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS ASSISTED LIVING CENTER INC	519 COMMERCE DR MADISON, WI 53719

(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 355	Continued From page 2 with us." Surveyor shared concern that that the provider did not ensure Resident 1 received treatment and services at the facility from 02/09/2024 to 02/12/2024 when s/he was ready to return to the facility but not allowed to do so based on the facility's staffing pattern. Administrator A replied, "We have been doing it this way for 10 years. I have no idea how we will fix this."	N 355		