STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020962	A. BUILDING: _____ B. WING _____	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINWOOD MEMORY CARE	703 GREEN ST BRODHEAD, WI 53520

(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 03/04/2026, with information gathered through 03/06/2026, Surveyor completed a standard licensure survey at Collinwood Memory Care. Four deficiencies were identified. Census:13	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not follow the resident's Individual Service Plan (ISP) as written. Resident 4 appeared unkempt, and the provider could not say when s/he received his/her last shower with hair washed. Findings include: On 03/04/2026, at approximately 11:45 AM, Surveyor observed Resident 4 walking around the common area and his/her hair appeared to not have been recently washed. On 03/04/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility, 10/09/2025, with diagnosis including dementia. Resident 4's ISP, dated 12/26/2025, documented: "Bathing - Full Assistance - Provide full assistance bathing/showering. Assist with dressing and undressing, wash, shampoo and with all required physical assistance. Requires	N 388		

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

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N 388	Continued From page 1	N 388		

full assistance including physical and verbal assistance. Requires hands-on assistance with washing, shampooing and getting in and out of the tub/shower. [Spouse] says [s/he] can wash [his/her] hair in the sink better than the shower."

Resident 4's "Care History," dated 01/01/2026 to 03/04/2026, documented:
02/22/2026 - Helped resident shower

On 03/04/2026, at approximately 2:15 PM, Surveyor interviewed Med Passer C. Surveyor asked when the last time s/he assisted Resident 4 with a shower and washing his/her hair. Med Passer C stated that Resident 4 was very difficult to shower and could not recall the last time s/he had assisted Resident 4 with a shower and washing his/her hair. Med Passer C stated that Caregiver D could sometimes persuade Resident 4 to wash his/her hair in the sink.

On 03/04/2026, at approximately 2:25 PM, Surveyor conducted the exit interview with Consultant A, via telephone, and Administrator B. Surveyor discussed his/her observations of Resident 4 appearing unkempt. Administrator B stated that Resident 4 was known to refuse showers, but Caregiver D could at times persuade Resident 4 to wash his/her hair in the sink. Surveyor reviewed Resident 4's record with Consultant A and Administrator B. Administrator B stated, "I know staff have washed [Resident 4's] hair more than just on 02/22/2026 but staff had not properly documented completed cares." Administrator B agreed with Surveyor that Resident 4 currently appeared unkempt. Consultant A stated proper documentation would be discussed with staff.

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N 389	Continued From page 2	N 389		
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 observation, record review and interview, the provider did not ensure 1 of 1 residents' Individual Service Plan (ISP) was reviewed when the resident experienced a change of condition. Resident 4's ISP did not document his/her behaviors related to dietary and wandering concerns. Resident 4's ISP did not document that s/he consistently refused medication administration. Findings include: On 03/04/2026, at approximately 12:15 PM, Surveyor observed Resident 4 during the noon meal, sitting at the dining room table with his/her plate of food. Resident 4 was not eating his/her food. At approximately 12:55 PM, Surveyor observed Resident 4 still sitting at the dining room	N 389		

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table and had only taken a few bites of his/her food.

On 03/04/2026, Surveyor reviewed Resident 4's record.

Resident 4 moved into the facility, 10/09/2025, with diagnosis including dementia.

Resident 4's February 2026 Medication Administration Record (MAR) documented:
"Travoprost eye drops - Instill one drop on both eyes every morning."
The MAR documented refusal 10 out of 28 opportunities.
"Polyethylene Glycol - Dissolve 2 capfuls into 8 ounces of liquid 2 times daily for constipation. Start Date: 02/20/2026."
The MAR documented refusal 2 out of 9 opportunities.
The MAR documented s/he refused 2 out of 6 medications.

Resident 4's ISP, dated 12/26/2025, documented:
"Eating - As Needed Assistance - Will eat with fingers, sometimes a fork, probably will do best with cut up easily chewed foods. Encourage [him/her] to eat if you see [him/her] not eating."
"Wandering/Elopement - Supervision - Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs - determine follow-up plan. [S/he] wanders a lot. Make sure doors are CLOSED and armed at all times! Always one staff with eyes on awake residents."
"Medication Management - To receive assistance from staff administering medications."
The ISP did not document any behaviors that could occur when staff provided redirection or provided any guidance for staff if a behavior

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N 389	Continued From page 4	N 389		

should occur when staff provided redirection. The ISP did not document behaviors related to medication administration.

On 03/04/2026, at approximately 1:15 PM, Surveyor interviewed Administrator B. Surveyor explained his/her observations and Administrator B explained that Resident 4 had always been an individual who ate very little, and this had been discussed during his/her preadmission assessment with his/her family. Administrator B explained that Resident 4 can be difficult to redirect.

On 03/04/2026, at approximately 2:15 PM, Surveyor interviewed Med Passer (MP) C. Surveyor asked if s/he had experienced Resident 4 refusing cares and/or redirection. MP C explained that if staff sit down to assist Resident 4, s/he will become behavioral as s/he does not want any assistance. MP C stated, "It is the same with [his/her] wandering behaviors. If we see [him/her] wandering towards another resident's room or an area [s/he] should not enter, redirection can be difficult as [s/he] will become behavioral with redirection. [S/he] doesn't want to be told that [s/he] cannot do something."

On 03/04/2026, at approximately 2:25 PM, Surveyor conducted the exit interview with Consultant A, via telephone, and Administrator B. Surveyor discussed his/her observations and Consultant A stated resident ISPs would be reviewed to ensure behaviors were documented and staff guidelines provided. Surveyor reviewed Resident 4's MAR with them and commented that s/he often refused medications. Administrator B confirmed that Resident 4 had been known to refuse medications. Surveyor reviewed Resident

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N 389	Continued From page 5 4's ISP with Consultant A and Administrator B. Administrator B stated s/he would review ISPs to ensure resident behaviors were properly documented.	N 389		
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 observation, record review and interview, the provider did not ensure that 1 of 1 resident's (Resident 4) prescribed PRN (as needed) psychotropic medications (Hydroxyzine and Quetiapine) were documented with a detailed description of the behaviors, which indicated the need for administration, on the resident's Individualized Service Plan (ISP). The provider	N 408		

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N 408	Continued From page 6	N 408		

did not monitor Resident 4's Hydroxyzine and Quetiapine at least monthly for potential inappropriate use.

Findings include:

OBSERVATION:

On 03/04/2026, at approximately 11:30 AM, Surveyor and Med Passer C observed Resident 4's PRN Hydroxyzine and PRN Quetiapine in the med cart.

RECORD REVIEW:

On 03/04/2026, Surveyor reviewed Resident 4's record.

Resident 4 moved into the facility 10/09/2025.

Resident 4's ISP, dated 12/26/2025, documented "Medication Management - Assist: staff must pass all meds."
"Psychotropic Medications - Using: New psychotropic medication starting 10/10/2025 Hydroxyzine hcl (hydrochloride) 2.5-5 ML (milliliter) as needed, NIGHTLY for agitation. [S/he] has PRN (as needed) and scheduled meds for agitation/insomnia. Hydroxyzine is PRN BID (twice a day) and Scheduled one time per day. Olanzapine starting 10/15/2025 is for the same and is scheduled one time daily. Using psychotropic medications related to specific behaviors: Agitation/Insomnia."
"Staff are to chart any concerns with all psychotropic medications in the residents observations notes. Document effectiveness."

Resident 4's February 2026 Medication Administration Record (MARs) documented:

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N 408	Continued From page 7 -Hydroxyzine 10 MG (milligram)/5ML (milliliter) syrup - Take 2 Times Daily as needed for agitation and or insomnia. Start Date: 11/09/2025. Administered on: 02/10/2026 10:47 PM - No rationale listed. Follow-up: Sleeping 02/11/2026 11:34 AM - No rationale listed. Follow-up: Resting comfortably on the couch 02/12/2026 3:25 PM - No rationale listed. Follow-up: Calm 02/14/2026 1:49 AM - No rationale listed. Follow-up: Asleep and no longer waking up other residents 02/18/2026 8:37 PM - No rationale listed. Follow-up: Sleeping 02/19/2026 8:22 PM - No rationale listed. Follow-up: Still pacing around doors and going in resident rooms 02/22/2026 10:35 AM - No rationale listed. Follow-up: Happy and laughing with staff and peers 02/24/2026 6:10 PM - No rationale listed. Follow-up: Still pacing around -Quetiapine Fumarate 50 MG tablet - Take 1 tablet by mouth night [sic] as needed for insomnia. Start Date: 11/18/2025. Administered on: 02/13/2026 9:42 PM - No rationale listed. Follow-up: Still up but is sitting on couch watching tv. 02/20/2026 12:44 AM - No rationale listed. Follow-up: Is no longer trying to wake residents up. The MAR did not document that Resident 4 was prescribed Olanzapine. The ISP did not document what behaviors would indicate a need for the administration of a PRN	N 408		

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N 408	Continued From page 8 psychotropic. Resident 4's February 2026 Progress Notes documented: 02/20/2026 2:45 AM - When resident wakes up during the night (s/he) has been going into other resident's rooms and turning their lights on trying to wake other residents up, is also taking snacks out of other resident's room, and going into the bathroom and locking (him/herself) in there. 02/24/2026 12:30 PM - Resident was seen going to [resident room]. When Writer tried to open door, it was locked. When Writer unlocked door Resident was having a BM (bowel movement) on Resident's chair in (his/her) room. Resident was not easily redirected out of the room and into the bathroom. 02/24/2026 5:15 PM - Resident will completely empty boxes of Kleenex or gloves or dump water cups if left unattended. One on one is required almost throughout the day, (S/he) feels this is a productive activity and can become upset when redirected. The progress note dated 02/20/2026 correlated with a PRN Quetiapine administration. The progress note described behaviors and not difficulty sleeping. The progress notes did not document behaviors on the days that the PRN Hydroxyzine had been administered except for 02/24/2026. INTERVIEWS On 03/04/2026, at approximately 2:15 PM, Surveyor interviewed Med Passer C. Surveyor asked how staff knew which medication to administer to Resident 4 for insomnia versus agitation. Med Passer C stated the medications were needed during evening hours and s/he did	N 408		

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N 408	Continued From page 9 not work those hours. On 03/04/2026, at approximately 2:25 PM, Surveyor conducted the exit interview with Consultant A, via telephone, and Administrator B. Surveyor asked for clarification on when Resident 4's prescribed PRN Hydroxyzine and Quetiapine were to be administered, as each stated the medication could be administered for insomnia. Consultant A stated that contact would be made with the prescribing physicians to gain additional guidance as staff should not have to make that decision. Surveyor commented that based on the documentation, the ISP did not include a rationale as to when the Hydroxyzine should be administered for agitation and the MARs did not describe a rationale for when it was administered. Also, the Hydroxyzine and the Quetiapine 'Follow-Up' responses were similar, so how were the medications monitored to determine if both medications had been administered as prescribed. Consultant A stated Resident 4's record would be reviewed to ensure compliance with the administration of his/her PRN psychotropics.	N 408		
N 439	83.39(1) Infection control program. The licensee shall establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. This Rule is not met as evidenced by: Based on observation, record review and interviews, the provider did not follow an infection	N 439		

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N 439	Continued From page 10 control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. Staff did not properly wash hands or use hand sanitizer while administering resident medications. Findings include: The provider is licensed to care for 13 adults in the client groups: irreversible dementia/Alzheimer's disease, developmentally disabled, advanced aged, traumatic brain injury, emotionally disturbed/mental illness, physically disabled, and terminally ill. OBSERVATION On 03/04/2026, Surveyor observed Med Passer (MP) C administer Resident 1's, Resident 2's, and Resident 3's noon medications between approximately 11:45 AM and 11:55 AM. Surveyor observed MP C enter the medication room and utilize hand sanitizer prior to the med pass. MP C then opened the med cart drawers, retrieved medication blister cards and utilized the computer. MP C then proceeded to remove the medications from the blister cards into a pill cup. When the medication would not 'pop' out of the blister card, MP C removed the tablet with his/her finger prior to washing his/her hands or utilizing hand sanitizer. MP C would lock the med cart and walk into resident rooms/common area and administer medications. MP C would then walk back to the med cart and repeat the process. RECORD REVIEW	N 439		

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N 439	Continued From page 11 On 03/04/2026, at approximately 2:00 PM, Surveyor reviewed Resident 1's, Resident 2's and Resident 3's record. Resident 1 moved into the facility 12/21/2023. Resident 1's Medication Administration Record (MAR), dated 03/04/2026, documented his/her noon dose of acetaminophen, 500 milligrams (MG), had been administered. Resident 2 moved into the facility 08/15/2018. Resident 2's MAR, dated 03/04/2026, documented his/her noon dose of acetaminophen, 650 MG, had been administered. Resident 3 moved into the facility 03/05/2024. Resident 3's MAR, dated 03/04/2026, documented his/her noon dose of aspirin, 325 MG, had been administered. INTERVIEWS On 03/04/2026, at approximately 2:20 PM, Surveyor discussed the concern with MP C. MP C stated s/he understood s/he should have re-washed his/her hands or utilized hand sanitizer when s/he needed to touch the resident's medications to retrieve them from the blister card and would be more observant of that. On 03/04/2026, at approximately 2:25 PM, Surveyor conducted the exit interview with Consultant A, via telephone, and Administrator B. Surveyor discussed his/her observations and Consultant A stated that staff would be re-educated on hand hygiene requirements during med administration. According to the CDC (Centers for Disease Control and Prevention), hand hygiene means	N 439		

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N 439	Continued From page 12 cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis. Gloves are not a substitute for hand hygiene. The clinical indications for hand hygiene include: - Immediately before touching a patient - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids or contaminated surfaces - Immediately after glove removal (Source: CDC website, Clinical Safety: Hand Hygiene for Healthcare Workers, February 27, 2024, https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. (retrieval date - March 08, 2025).)	N 439		