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N 000	Initial Comments On 03/26/2025, with information gathered through 04/02/2025, Surveyor conducted a standard licensure survey and a complaint investigation. Six deficiencies were identified. One of 6 deficiencies was a repeat violation. See Statement of Deficiency (SOD) B24J11. Complaint was substantiated. Census: 25	N 000		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.	N 406		

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

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure expired medications were securely stored separately from other medications in use for 4 of 5 residents reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) B24J11, dated 07/01/2021.

Resident 1's Polyvinyl Alcohol 1.4% lubricating eye drops prescription expired 10/19/2024 and the bottle of eye drops expired 01/2025 and was stored with his/her current medications.

Resident 2's Refresh Tear eye drops prescription expired 01/23/2025 and was stored with his/her current medications.

Resident 3's Nitroglycerin sublingual tablets expired 03/2024 and was stored with his/her current medications.

Resident 4's Albuterol Sulfate HFA inhaler expired 01/2025 and was stored with his/her current medications.

Findings include:

On 03/26/2025, at approximately 12:50 PM, Surveyor, Med Passer C, and Med Passer D reviewed the medications in the med carts.

Example 1: Resident 1

Surveyor observed Resident 1's open bottle of Polyvinyl Alcohol 1.4% lubricating eye drops with a prescription that expired 10/19/2024 and the bottle of eye drops expired 01/2025. The

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prescription stated, "Instill 1 drop in both eyes every six hours as needed for dry eyes."

Surveyor reviewed Resident 1's Medication Administration Records since October 2024 and s/he was not administered these eye drops.

Example 2: Resident 2

Surveyor observed Resident 2's two bottles of Refresh Tear eye drops, each in their own plastic canister. One bottle's canister documented the prescription expired 01/23/2025 and the other bottle's canister label stated, "Use By 01/23/2025." The prescription stated, "Instill 1 drop in both eyes three times a day."

Example 3: Resident 3

Surveyor observed Resident 3's Nitroglycerin sublingual tablets expired 03/2024. The prescription stated, "Dissolve 1 tablet under tongue every 5 minutes as needed for chest pain."

Surveyor reviewed Resident 3's Medication Administration Records since March 2024 and s/he was not administered the as-needed medication.

Example 4: Resident 4

Surveyor observed Resident 4's Albuterol Sulfate HFA inhaler with an expiration date of 01/2025 which was stored with his/her current medications. The inhaler did not contain a label that defined Resident 4's name and the medication order.

On 03/26/2025, at approximately 2:15 PM,

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N 406	Continued From page 3 Surveyor interviewed Administrator A. Administrator A stated that the med cart had just been reviewed and did not understand why there were expired medications stored with current medications. Administrator A stated s/he would have the nurse review the medication cart and ensure there was a process in place for regular med cart audits.	N 406		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident received assistance with personal cares. Resident 5 did not receive cares as prescribed by hospice when s/he developed pressure wounds on his/her coccyx area.	N 425		

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N 425	Continued From page 4 Findings include: On 01/15/2025, the department received a concern alleging residents were not receiving adequate care. On 03/26/2025, at approximately 11:00 AM, Surveyor interviewed Administrator A. Surveyor asked if any residents were currently receiving wound care. Administrator A stated Resident 5 had received wound care but had passed in 02/2025. Surveyor requested his/her record. On 03/29/2025, Surveyor reviewed Resident 5's record. Resident 5 moved into the facility 07/30/2018. Resident 5's current, undated, "Care Plan" documented: "Reposition in bed & Change brief: Resident has pressure sore on buttocks. Staff is to keep resident in bed [NOT BRODA CHAIR] and rotate [him/her] onto [his/her] right side and/or back with a pillow behind [him/her] back every 2 hours. KEEP OFF OF LEFT SIDE. Make sure heels are floating off the bed. **BRIEF MUST BE CHANGED EVERY TIME [S/HE] IS REPOSITIONED** Schedule: Daily@ 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM." On 03/29/2025, Surveyor reviewed Resident 5's hospice documentation provided by the hospice agency, which documented: 11/29/2024: Writer provided teaching to staff and to [provider's Registered Nurse Manager C] about the importance of having staff members change [him/her] more frequently due to current wound in	N 425		

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crack of buttocks. Dressings continue to keep falling off due to incontinence and positioning of wound and staff are not replacing them. Staff laying [Resident 5] down 2-3x (times) throughout the day to change positioning.
12/03/2024: Writer saw [Resident 5] for routine visit. [Resident 5] sitting in common area in Broda chair watching tv on and off. Writer had asked staff to help Writer get [him/her] into bed for [his/her] wound care. Writer had gotten pushback from one of the caregivers asking if I could come after lunch so they could just change [him/her] after lunch instead. Writer had mentioned to staff that writer was able to make it out at this time today. This specific staff member had given push back before about getting [Resident 5] in bed to change. It appears staff member was not going to change [Resident 5] prior to lunch if Writer wouldn't have came, staff members state they normally change [Resident 5] around 1030 so that is normal to get [him/her] into bed at that time. Writer continues to provide education to staff about the importance of changing [him/her] specifically every 2 hours due to the placement of [his/her] sores on [his/her] bottom, bandages continue to come off frequently due to them becoming soiled and due to difficult spot to have them heal.
12/09/2024: [Resident 5] has an unstageable pressure sore to [his/her] coccyx. ... Staff have not been replacing bandages if it becomes soiled or dislodged. Feces often getting into the wound. Writer continues to provide education. Worsening to wound has occurred with increase in drainage.
12/13/2024: Writer spoke with nurse about worsening to wound. [Resident 5] had a stomach virus on Monday which resulted in a lot of feces getting into wound that contained virus. Wound appears to be worsening.

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N 425	Continued From page 6 12/17/2024: Wound draining more and appears to be worsening. Staff do not replace bandage when bandage falls off of wound. Urine and feces get into the wound. [Resident 5] sits on [his/her] bottom throughout the day and transfers into [his/her] bed once per day and at nighttime for bed. 12/19/2024: Unable to get a good assessment of drainage to wound as PT (patient) was soaked through the bed sheets with urine, provided education to both [2 of provider's med technicians] regarding the importance of keeping PT clean and dry to keep wound dry. ...Unable to measure depth of wounds as both are unstageable. One with black eschar and the other with slough, with reports that wounds are getting worse. 12/23/2024: PT wounds have increased in size over the weekend. Reinforced training that PT needs to be put in bed after meals to offload pressure to buttocks. ... Provided education on foley catheter care. Placement and to make sure bag tubing is not under PT while in bed. [Staff member] verbalized understanding. 12/24/2024: Wound odor increased to the entire room smelling now. 01/13/2025: Ongoing education to facility on frequent position changes. Plan of care says to reposition every 2 hours but staff unsure if this is happening at night. PT brief was saturated today so providing ongoing education on position of foley cath (catheter) bag. It was folded under PT today. 01/21/2025: Arrived at facility PT in bed, grimacing, tense, grinding teeth, shivering, and appears distress, PT catheter is not draining, PT brief, bed, and gown were soaked. ...PT also had hard stool present PT impacted removed a large amount of stool from rectum provided peri care, changed sheets.	N 425		

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01/31/2025: PT sheets dirty and wet.
02/07/2025: PT brief was soaked as catheter tubing was positioned straight up. ... Changed brief and provided peri care. Providing ongoing education to caregivers on positioning catheter bag line and bag every visit. Caregivers verbalize understanding but need ongoing reinforcement.
02/10/2025: Pronounced [Resident 5] at 2049 (8:49 PM).

On 03/31/2025, at approximately 9:45 AM, Surveyor interviewed Hospice Registered Nurse (RN) D and Hospice Clinical Manager E. RN D explained that Resident 5's wounds started out as Stage 2 pressure wounds. RN D stated the wounds should have been able to heal but there were concerns with staff alternating between him/her sitting in his/her chair and him/her lying down. RN D explained that Resident 5 was often soiled when hospice arrived to do cares. When hospice would complete the peri care it would be determined that the wound bandage would be missing. RN D stated, "The provider has a nurse, the nurse could have replaced the wound bandage." RN D stated continuing education was provided to staff but the cares did not improve with the re-education.

On 04/01/2025 at 3:30 PM, Surveyor interviewed Administrator A. Surveyor explained the concerns that were documented in the hospice records. Administrator A stated s/he hoped that hospice staff had discussed the concerns with the nurse or management. Staff are always being re-educated on resident cares. Administrator A stated Resident 5 was bedbound during the end of his/her life and did not consume adequate amounts of food, which also played a role in his/her wound healing. Administrator A stated Resident 5 suffered from a kennedy wound which

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N 425	Continued From page 8 do not heal.	N 425		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 3 residents reviewed received appropriate medication administration. Resident 4's QVAR RediHaler did not contain a prescription label and was documented as administered when the medication was not available. Findings include: On 03/26/2025, at approximately 12:50 PM, Surveyor and Med Passer F reviewed the medications in the med carts. Surveyor observed Resident 4's QVAR RediHaler which displayed 0 actuations left. Med Passer F stated s/he had administered the last dose that morning. Med Passer F stated s/he would look in the med room to determine if there was another inhaler	N 432		

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available.

On 03/26/2025, at approximately 2:15 PM, Surveyor interviewed Administrator A. Surveyor explained his/her observation. Administrator A stated Med Passer F had given the last available dose to Resident 4 during the 8:00 AM med pass. Administrator A reviewed the medication on his/her computer system and showed Surveyor the medication had been reordered. Administrator A stated the medication would be delivered prior to his/her 8:00 PM med pass.

On 04/01/2025, Surveyor reviewed Resident 4's record.

Resident 4 moved into the facility 11/28/2022.

Resident 4's February and March 2025 Medication Administration Records (MAR) documented:
QVAR Rediha (redihaler) 80 MCG (micrograms) - Inhale 2 puffs into the lungs twice a day. Scheduled at 8:00 AM and 8:00 PM. Start Date: 06/14/2024.
02/02 8:00 AM - Documented as Other - Can't find in cart
02/03 8:00 AM - Documented as Other - Not in cart, on order
02/03 8:00 PM - Documented as Other - On order

03/26 8:00 PM - Documented as administered
03/27 8:00 AM - Documented as Other - No rationale
03/27 8:00 PM - Documented as administered
03/28 8:00 AM - Documented as Declined by Resident
03/28 8:00 PM - Documented as Declined by Resident - Other
03/29 8:00 AM - Documented as Other - No

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rationale
03/29 8:00 PM - Documented as administered
03/30 8:00 AM and 8:00 PM - Documented as administered
03/31 8:00 AM - Documented as med unavailable

"When the patient receives the inhaler, the number 120 will be displayed. The dose counter will count down each time a spray is released. The dose-counter window displays the number of sprays left in the inhaler in units of two (e.g., 120, 118, 116, etc). When the counter displays 20, the color of the numbers will change to red to remind the patient to contact their pharmacist for a refill of medication or consult their healthcare provider for a prescription refill. When the dose counter reaches 0, the background will change to solid red. Inform patients to discard QVAR REDIHALER when the dose counter displays 0 or after the expiration date on the product, whichever comes first." (Source: QVAR RediHaler Dosing Card, QVAR RediHaler (beclomethasone dipropionate HFA) Breath-Actuated Inhalation Aerosol 40 MCG - 80 MCG, 2021, https://hcp.qvar.com/globalassets/qvar-hcp/pdf/dosing-card.pdf (retrieval date - April 01, 2025).)

Based on this information, Resident 4's QVAR RediHaler would provide 30 days of actuations. The QVAR RediHaler would have lasted approximately 02/04/2025 to 03/05/2025.

On 04/01/2025 at 6:13 AM, Surveyor emailed Administrator A and requested the pharmacy delivery report for Resident 4's QVAR RediHaler prior to the 03/2025 reorder that was discussed on 03/26/2025.

On 04/01/2025 at 12:42 PM, Administrator A

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N 432	Continued From page 11 emailed Surveyor and stated prior to the March reorder date, Resident 4's QVAR RediHaler was delivered on 02/04/2025. On 04/01/2025 at 3:30 PM, Surveyor interviewed Administrator A. Surveyor stated Resident 4's MARs did not consistently document proper medication administration and rationale if medication was not administered. Surveyor explained that Resident 4's QVAR RediHaler, with an open date of 02/04/2025, and documented as administered as prescribed, would have lasted until 03/05/2025, but the inhaler was not reordered until 03/26/2025, as staff continued to document that it was administered. Administrator A stated s/he would re-educate staff.	N 432		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.	N 525		

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N 525	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills, including at least one fire evacuation drill simulating the conditions during usual sleeping hours, with both employees and residents in 2023 and 2024. Findings include: The provider is licensed as a Class CNA (nonambulatory) CBRF (community-based residential facility) able to serve up to 18 residents within the client groups: advanced aged, irreversible dementia/Alzheimer's, physically disabled, and terminally ill. The facility is adjoined with other licensed assisted living facility. On 03/26/2025, Surveyor reviewed the provider's evacuation drills with Administrator A which documented: 11/07/2024 - 3:00 PM - Walk through simulation of evacuation procedures. 08/14/2024 - 2:30 PM - Reviewed policies of fire evacuation for both communities and did a simulation of evacuation. Staff walked through community and safely found residents, removed residents in danger. 03/16/2024 - 10:00 PM - Fire Drill and Tornado Drill 01/10/2024 - 1:00 PM - Missing Resident and Fire Drill. Fire Drill was conducted as a surprise walk through following our emergency response. 09/11/2023 - 1:00 PM 04/10/2023 - 2:27 PM - Residents were sheltered in place behind fire doors. All residents in immediate fire danger were relocated.	N 525		

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N 525	Continued From page 13	N 525		

01/13/2023 - 10:40 PM - [Lead B] walked shift through in event of the at night [sic] Also discussed power outage.
The drills did not contain information regarding those residents requiring more than 4 minutes to evacuate.

On 03/26/2025, at approximately 11:30 AM, Surveyor interviewed Licensee A. Surveyor asked Licensee A to explain the fire drill process. Licensee A stated that residents evacuated in place. The only residents moved would be those in a community area close to the simulated fire and they would be moved behind a fire door. Surveyor asked if there were any residents who required more than 4 minutes to evacuate. Licensee A stated the resident's evacuation assessment defined that. Surveyor asked for clarification on how two different drills, such as tornado and fire, were completed at one time. Licensee A stated the residents shelter in place. Licensee A stated, "We discuss the evacuation process."

On 03/27/2025, Surveyor reviewed the department records and did not see evidence that a waiver had been approved for the use of horizontal evacuation.

On 04/01/2025 at 3:30 PM, Surveyor interviewed Administrator A. Surveyor explained that fire drills are to be conducted with staff and residents, with documentation of those residents who require an evacuation time greater than 4 minutes. Administrator A stated the drills were completed with staff and the process would be reviewed. Administrator A stated, "Are residents moved, no, but the process is discussed. This process has been discussed during other surveys and there were no concerns." Administrator A explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017235	A. BUILDING: _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTERHAUS	N109 W17000 AVA CIRCLE GERMANTOWN, WI 53022

(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 525	Continued From page 14 that, although a resident may be ambulatory, there are other factors that can hinder them from participating in a fire drill. Cross Reference: 0527 DHS 83.47(2)(f) Horizontal Evacuation	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure evacuation drills, such as tornado, flooding or other emergency or disaster, were completed at least semi-annually in 2024. Findings include: The provider is licensed as a Class CNA (nonambulatory) CBRF (community-based residential facility) able to serve up to 18 residents within the client groups: advanced aged, irreversible dementia/Alzheimer's, physically disabled, and terminally ill. On 03/26/2025, Surveyor reviewed the provider's evacuation drills with Administrator A which documented: 03/16/2024 - 10:00 PM - Fire Drill and Tornado Drill 08/14/2024 - 1:59 PM - Tornado Drill - Ran through tornado drill, procedures, and simulation. On 03/26/2025, at approximately 11:30 AM, Surveyor interviewed Licensee A. Surveyor	N 526		

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N 526	Continued From page 15 asked Licensee A to explain the other evacuation process. Licensee A stated that residents evacuated in place. The only residents moved would be those in a community area that would be in immediate danger. Surveyor asked for clarification on how two different drills, such as tornado and fire, were completed at one time. Licensee A stated the residents shelter in place. Licensee A stated, "We discuss the evacuation process." On 03/27/2025, Surveyor reviewed the department records and did not see evidence that a waiver had been approved for the use of horizontal evacuation. On 04/01/2025 at 3:30 PM, Surveyor interviewed Administrator A. Surveyor explained that drills are to be conducted with staff and residents. Administrator A stated the drills were completed with staff and the process would be reviewed. Administrator A stated, "Are residents moved, no, but the process is discussed. This process has been discussed during other surveys and there were no concerns." Cross Reference: 0527 DHS 83.47(2)(f) Horizontal Evacuation	N 526		
N 527	83.47(2)(f) Horizontal evacuation. Horizontal evacuation. The CBRF shall have approval from the department before including horizontal evacuation in the emergency and disaster plan. CBRFs using horizontal evacuation shall document the total evacuation time of the fire zone evacuated. This Rule is not met as evidenced by:	N 527		

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N 527	Continued From page 16	N 527		

Based on record review and interview, the provider did not obtain department approval before including horizontal evacuation in the emergency disaster plan.

Findings include:

The provider is licensed as a Class CNA (nonambulatory) CBRF (community-based residential facility) able to serve up to 18 residents within the client groups: advanced aged, irreversible dementia/Alzheimer's, physically disabled, and terminally ill.

On 03/26/2025, Surveyor reviewed the fire drills and other evacuation drills documentation. The fire drills did not identify the location of the simulated fire to determine the evacuation time of all residents in that zone. Surveyor identified through staff interviews and a review of the evacuation drills; the provider was utilizing a horizontal evacuation process for the facility.

On 03/26/2025, at approximately 11:30 AM, Surveyor interviewed Licensee A. Surveyor asked Licensee A if their emergency procedures identified that they utilized a horizontal evacuation process and if the fire department was aware that all residents were sheltering in place, making them a point-of-rescue (POR). Licensee A provided Surveyor with the policy and procedure. Licensee A stated the provider had always completed fire drills and other evacuation drills in this manner.

On 03/26/2025, Surveyor reviewed the provider's policy and procedure, "Emergency Plan - Fire Drill Assignments," which documented:
"Shut all doors and windows accessible on the floor. Instruct and assist residents to return to

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N 527	Continued From page 17 their rooms and shut all windows. Complete visual count of all residents on your floor." On 03/27/2025, Surveyor reviewed the provider's resident list that is provided to the fire department, in case of an emergency, provided by Administrator A. The list documented that 4 out of 25 residents were documented as POR. On 03/27/2025, Surveyor reviewed the department records and did not see evidence that a horizontal evacuation plan had been approved. On 04/01/2025 at 3:30 PM, Surveyor interviewed Administrator A. Surveyor explained if a provider is going to utilize a horizontal evacuation plan, the plan needs to be approved by the department. Administrator A stated s/he had not been informed that this was a requirement during previous surveys.	N 527		