STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014094	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 1	3828 EAST ROTAMER ROAD JANESVILLE, WI 53546

(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 04/08/2025 through 04/16/2025, Surveyor conducted a standard survey at Huntington Place Memory Care 1, a CBRF located in Janesville, WI. Three deficiencies were identified. One deficiency was a repeat - See Statement of Deficiency (SOD) RWY711, dated 01/09/2023. Census: 10	N 000		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident care staff received at least 15 hours per calendar year of continuing education, which included, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency	N 277		

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

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N 277	Continued From page 1 procedures, including first aid. FINDINGS INCLUDE: On 04/08/2025 Surveyor arrived at the facility for a standard survey. On 04/08/2025 at approximately 9:00 a.m., Surveyor received a staff roster and records from Executive Director A. Surveyor reviewed Caregiver C's staff record. Caregiver C was hired on 02/04/2022. On 04/08/2025 at 10:15 a.m., Surveyor reviewed Caregiver C's staff record for continuing education for 2024. Caregiver C had 2 documented courses for 2024 with no documented hours. Caregiver C did not receive training in standard precautions, medications, resident rights, prevention and reporting of abuse, neglect and misappropriation or fire safety and emergency procedures, including first aid. On 040/08/2025 at approximately 1:00 p.m., Surveyor interviewed Executive Director A. Executive Director A stated that s/he provided all the training that was documented. On 04/08/2025 at approximately 2:30 p.m., Surveyor discussed the continuing education concern with Executive Director A. Executive Director A acknowledged Caregiver C did not receive at least 15 hours of continuing education training in the calendar year of 2024.	N 277		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats.,	N 352		

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N 352	Continued From page 2 each resident shall have all of the following rights: Receive medication. Receive all prescribed 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 observation, record review and interview, the provider did not ensure 1 of 3 residents reviewed received their medications as prescribed. Resident 1 did not receive his/her Carboxymethylcellulose Sodium PF Ophthalmic Solution eye drops as prescribed. Findings include: On 04/08/2025 at approximately 9:00 a.m., Surveyor arrived at the facility to conduct a standard survey. Surveyor requested a resident roster from Executive Director A. On 04/08/2025 at approximately 12:00 p.m., Surveyor completed a medication cart audit with Caregiver D. Surveyor observed 2 bottles of Carboxymethylcellulose Sodium PF Ophthalmic Solution in the medication cart dated 06/03/2024 and 08/13/2024 for Resident 1. Each bottle of Carboxymethylcellulose Sodium PF Ophthalmic Solution contained 31 days of dosing. At approximately 12:30 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 06/30/2023. Resident 1's physician order included the following: - Carboxymethylcellulose Sodium PF Ophthalmic Solution (Start Date: 09/26/2023) - Instill 1 drop in both eyes 2 times daily for dry eyes.	N 352		

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N 352	Continued From page 3 Surveyor reviewed the Medication Administration Record (MAR), dated 02/01/2025 through 04/08/2025 and the MAR indicated that the Carboxymethylcellulose Sodium PF Ophthalmic Solution eyed drops had been administered daily. At approximately 1:50 p.m., Surveyor interviewed Caregiver D. Caregiver D acknowledged that the date on 2 bottles of Carboxymethylcellulose Sodium PF Solution were from over 6 months ago. Caregiver D said, "both of those bottles should be gone by now." Caregiver D stated that "some of the staff forget the drops and creams." Caregiver D stated that new eye drops should be ordered and it was hard to monitor if the eye drops were given or not. At approximately 2:35 p.m., Surveyor discussed concern with Executive Director A and Health and Wellness Director B that Resident 1 had eye drops that were prescribed daily, with a quantity of 31-day dose amount, dated 08/13/2024 in the medication cart. Health and Wellness Director B confirmed that the Carboxymethylcellulose Sodium PF Ophthalmic Solution was not supplied with the monthly stock medications. Health and Wellness Director B confirmed that the eye drop medication was only ordered when the bottle was empty. Executive Director A confirmed Resident 1 did not receive his/her Carboxymethylcellulose Sodium PF Ophthalmic Solution as prescribed. On 04/16/2025 at 4:31 p.m., Surveyor interviewed Pharmacy Tech E. Pharmacy Tech E stated that the Carboxymethylcellulose Sodium PF Ophthalmic Solution was dosed in a 31-day bottle. Pharmacy Tech E confirmed that the last order date for the medication was 08/13/2024.	N 352		

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N 389	Continued From page 4	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 record review and interview, the provider did not ensure an individual service plan (ISP) was updated when there was a change in condition or need. Resident 1's ISP was not updated to address fall interventions that were put in place at the facility. This is a repeat violation. See Statement of Deficiency RWY711, dated 01/09/2023. Findings include: On 04/08/2025 at approximately 12:30 p.m., Surveyor reviewed Resident 1's record. S/he was admitted to the facility on 06/30/2023, with a diagnosis of Hypothyroidism, hypertension, coronary heart disease and anxiety. The Individual Service Plan (ISP), dated 12/27/2024, documented the following fall risk interventions	N 389		

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N 389	Continued From page 5 for Resident 1: -Staff to remind me to use call device for assistance, caregivers to provide safe environment, clutter free, assistive devices are available and in good repair, call device within reach, staff to become familiar with daily routine to anticipate and meet daily needs, wear glass, wear appropriately fitting clothing and footwear that fit, and rise and change positions slowly. The ISP did identify Resident 1 as moderate to high fall risk. On 04/08/2025 at approximately 1:00 p.m., while reviewing progress notes, Surveyor noted that Resident 1 had a progress note, dated 04/01/2025, that stated Hospice nurse was here seeing the resident today and had concern that his/her fall mat was under the bed while the patient was in bed and his/her alarm was not attached. Surveyor observed that these interventions were not documented in Resident 1's ISP. On 04/08/2025 at approximately 2:00 p.m., Surveyor interviewed Executive Director A regarding the ISP. Executive Director A acknowledged that the floor mat and alarm were not documented in the ISP. Executive Director A stated that "those interventions should have been added." On 04/08/2025 at approximately 2:30 p.m., Surveyor discussed concern of Resident 1's ISP not updated regarding fall risk interventions with Health & Wellness Director B and Executive Director A. Health & Wellness Director B stated that the alarm and mat was added when hospice started.	N 389		