STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018677	A. BUILDING: _____ B. WING _____	C 05/21/2024

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SENIOR LIVING MEQUON II	6729 W MEQUON RD MEQUON, WI 53092

(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 05/17/2024 with information gathered through 05/21/2024, Surveyor conducted 2 complaint investigations and a standard survey at Senior Living Mequon II. Eight deficiencies were identified. Both complaints were substantiated. Census: 30	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report a serious injury resulting in emergency room treatment to the Department within 3 days. Resident 1 sustained a right hip fracture on 11/12/2023. Findings include: On 12/20/2023, the Department received a complaint alleging concerns following a resident fall. On 05/17/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 admitted to the facility on 07/26/2023	N 165		

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

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N 165	Continued From page 1	N 165		

with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf.

Resident 1's individual service plan (ISP) dated 07/26/2023:
"Falls: Bathroom: emergency response cord or pendant reminder for people who need assistance for toileting. Grab bars in bathroom or at bedside. Reminders or assistance to use the bathroom before and after meals, activities or sitting down to relax. Scheduled toileting plan. Clothing: Proper fitting and clothing. Education: Emergency call system available at bedside. Remind to call for assistance. Use of a pendant. Remind resident to use hand rails. Environment: calming environment (soft music, dim light, aromatherapy, prayer, etc. Increased lighting in room/encourage use of night lights. Keep clutter out of walking paths and off the floor. Personal items within reach. Frequent nighttime checks (when applicable). Increases visual monitoring of resident (programming, rounds, groups)."

Resident 1's incident report dated 11/12/2023 documented:
"Resident was in activity area complaining about having unknown pain. Staff helped [him/her] to room and completed a body check. [S/he] stated it was coming from [his/her] right hip. [His/her] right hip was swollen and [his/her] right knee was swollen. Staff gave [him/her] PRN med, husband was notified and asked to send [him/her] to hospital."

Resident 1's hospital discharge summary dated 11/12/2023 documented:
" ...[His/her] cognitive decline has progressed into an element of dementia with behavioral disturbance. [S/he] is followed by a neurologist ...

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N 165	Continued From page 2 [S/he] had a fall and fracture hospitalization in October. [S/he] returned to [his/her] memory care center which added therapy. [S/he] was found down now again currently. Unwitnessed fall possible yesterday. X-rays revealed a right hip fracture ...[S/he] will be admitted again to the hospital for further evaluation." On 05/21/2024, Surveyor reviewed Department records, which indicated no self-reports were submitted regarding Resident 1's right hip fracture on 11/12/2023. On 05/17/2024 at 2:48 PM, Surveyor conducted an exit conference and shared findings with Assistant Wellness Director (AWD) A, Wellness Director B, and Interim Administrator C. The provider's management team acknowledged Resident 1's injury should have been reported to the Department. The provider's management team did not comment why the self-report was not submitted.	N 165		
N 219	83.17(1) Licensee conduct caregiver background check 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.	N 219		

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N 219	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure complete background checks were conducted upon hired for 3 of 3 employees reviewed. 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 professional service regarding a person's credentials (IBIS). Findings include: On 05/17/2024, Surveyor reviewed employee records and identified the following: -Caregiver D was hired 10/16/2023. Caregiver D's record did not include a BID or IBIS letter. -Caregiver E was hired 02/13/2024. Caregiver E's record did not include a BID or IBIS letter. -Caregiver F was hired 11/13/2023. Caregiver F's record did not include a BID or IBIS letter. The above employee records contained a letter from a third-party background check vendor but the letter did not include a search of any governmental findings. On 05/17/2024 at 2:48 PM, Surveyor interviewed Assistant Wellness Director (AWD) A, Wellness Director B, and Interim Administrator C. Interim	N 219		

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N 219	Continued From page 4 Administrator C stated after following up with their human resources (HR) department, they did not know BIDs and a search of any substantiated findings of misconduct were required as part of the complete background check process. Interim Administrator C acknowledged an understanding of the concern and stated s/he would work with HR to make sure the above requirements are included in their hiring process.	N 219		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees obtained orientation training which shall include the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s.	N 230		

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N 230	Continued From page 5 HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. Findings include: On 05/17/2024, Surveyor reviewed employee records and identified the following: The record for Caregiver D, hired 10/16/2023, did not contain evidence of orientation topics which included documentation of orientation in:1) emergency and disaster plan and evacuation procedures prevention 2) recognizing and responding to resident changes of condition. The record for Caregiver E, hired 02/13/2024, did not contain evidence of orientation topics which included documentation of orientation in:1) emergency and disaster plan and evacuation procedures prevention 2) recognizing and responding to resident changes of condition. The record for Caregiver G, hired 11/13/2023, did not contain evidence of orientation topics which included documentation of orientation in:1) emergency and disaster plan and evacuation procedures prevention 2) recognizing and responding to resident changes of condition. On 05/17/2024 at 2:48 PM, Surveyor conducted an exit conference and shared findings with Assistant Wellness Director (AWD) A, Wellness Director B, and Interim Administrator C. The management team acknowledged an understanding of the concern. The management team stated further follow up would need to be completed with HR. Surveyor noted documentation would need to be submitted no later than 05/20/2024.	N 230		

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N 230	Continued From page 6 On 05/21/2024, Wellness Director B submitted a power point of the required orientation training topics, however there was no evidence submitted that Caregiver D, Caregiver E, or Caregiver F received orientation training in emergency and disaster plan and evacuation procedures prevention 2) recognizing and responding to resident changes of condition. Cross Reference: N0243 DHS 83.21(1)-(3) All Employee Training	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and	N 243		

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N 243	Continued From page 7	N 243		

vocational abilities. Client group specific training shall be completed within 90 days after starting employment.
Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.
Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed completed training in all employee training. Caregiver D, Caregiver E, and Caregiver F did not have documentation for completion of training in client groups and challenging behaviors.

Findings include:

On 05/17/2024, Surveyor conducted a review of employee files to verify compliance with all employee training requirements. Surveyor requested training records from Assistant Wellness Director (AWD) A and Wellness Director B.

Client Group:

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N 243	Continued From page 8 The record for Caregiver D, hired 10/16/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver E, hired 02/13/2024, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver F, hired 11/13/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors: The record for Caregiver D, hired 10/16/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behavior training. The record for Caregiver E, hired 02/13/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behavior training. The record for Caregiver F, hired 11/13/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behavior training. On 05/17/2024 at 2:48 PM, Surveyor conducted an exit conference and shared findings with AWD A, Wellness Director B, and Interim Administrator C. The management team acknowledged an understanding of the concern. The management team stated they would work with human resources to include all employee training as part of their on-boarding documentation. No further comment was noted.	N 243		

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N 243	Continued From page 9 Cross Reference: N0230 DHS 83.19 Orientation	N 243		
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 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 Resident 2's right to receive all medications prescribed when Resident 2's psychotropic medication was not available. Findings include: On 03/11/2024, the department received a complaint alleging concerns with residents not receiving their medications. On 05/17/2024, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted on 01/11/2024 with diagnoses including anxiety disorder, suicidal ideations, vascular dementia, and major depressive disorder. Resident 2's individual service plan (ISP) dated 02/15/2024 stated the provider was to administer all medications. Resident 2's physician orders included: Buspirone 10mg tablet, with directions to give 1 tablet by mouth 3 times daily with an unknown start date.	N 352		

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N 352	Continued From page 10 On 05/17/2024 at 2:00 PM, Surveyor interviewed Wellness Director B and discussed the complaint. Surveyor asked if s/he was aware of Resident 2's mental health incident on 03/03/2024 after their medications were not available. Wellness Director B stated Resident 2 called 911 as s/he was a risk to him/herself. Wellness Director B noted Resident 2 experienced an anxiety attack and made comments to harm his/herself. Wellness Director B stated Resident 2 continued to have suicidal ideations. Resident 2's after visit summary dated 03/03/2024 documented: "Reason for visit: Suicidal. Diagnoses: Loneliness, depression." Surveyor reviewed Resident 2's record including his/her medication administration record (MAR) from 03/01/2024-05/16/2024. The provider's charting codes for MARs indicated "12=Med Not Available Pharmacy Notified." March 2024: - 2 entries in the administration of Buspirone from 03/03/2024 at 8am and 1400, staff indicated "12." On 05/17/2024 at 2:48 PM, Surveyor conducted an exit conference and shared findings with Assistant Wellness Director (AWD) A, Wellness Director B, and Interim Administrator C. The provider's management team acknowledged Resident 2 did not receive his/her Buspirone on 03/03/2024 and experienced a mental health crisis. Wellness Director B stated s/he would need to look over Resident 2's record more to determine the cause of staff not administering. AWD A noted when printing resident records for the Surveyor, s/he observed in many resident records where staff indicated "12" on the MAR.	N 352		

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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 individual service plan (ISP) was not updated for 2 of 2 resident records reviewed when there was a change in resident needs and abilities. Resident 1's ISP was not updated to include interventions for his/her fall risk. Resident 2's ISP was not updated to include interventions for suicidal ideations. Findings include: On 05/17/2024, Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 admitted to the facility on 07/26/2023 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney that made	N 389		

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N 389	Continued From page 12 decisions on his/her behalf. Resident 1's individual service plan (ISP) dated 07/26/2023: "Falls: Bathroom: emergency response cord or pendant reminder for people who need assistance for toileting. Grab bars in bathroom or at bedside. Reminders or assistance to use the bathroom before and after meals, activities or sitting down to relax. Scheduled toileting plan. Clothing: Proper fitting and clothing. Education: Emergency call system available at bedside. Remind to call for assistance. Use of a pendant. Remind resident to use hand rails. Environment: calming environment (soft music, dim light, aromatherapy, prayer, etc. Increased lighting in room/encourage use of night lights. Keep clutter out of walking paths and off the floor. Personal items within reach. Frequent nighttime checks (when applicable). Increases visual monitoring of resident (programming, rounds, groups)." Resident 1's incident reports documented: "11/12/2023: Resident was in activity area complaining about having unknown pain. Staff helped [him/her] to room and completed a body check. [S/he] stated it was coming from [his/her] right hip. [His/her] right hip was swollen and [his/her] right knee was swollen. Staff gave [him/her] PRN med, [spouse] was notified and asked to send [him/her] to hospital. 11/07/2023: Fall, witnessed by care staff. Resident was seen falling while walking in the hallway. Resident did hit [his/her] head. Resident was walking in the hallway with staff, coming from the dining room. Resident lost [his/her] balance, fell, hit [his/her] head on a door. Resident c/o headache, has new area of swelling to back of head.	N 389		

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N 389	Continued From page 13 10/24/2023: Fall. Unwitnessed. Resident heard yelling and when care staff arrived, resident was sitting on the floor next to bed. No c/o pain, no injury noted, did not hit head; resident states [s/he] was going to the bathroom and slipped on the floor. Walker not within reach. 10/11/2023: Resident was walking around the table with [his/her] walker in the dining room when [s/he] lost [his/her] balance and fell. Resident fell backwards and fell on [his/her] right hip and upper back. Resident tucked [his/her] head inwards. Resident unable to give description. 10/10/2023: Res standing up in common area when staff heard res yell out, staff responded to find res sitting on another res' lap after losing [his/her] balance. Staff assisted res up. No apparent injuries noted, no complaints of pain/discomfort voiced. Resident unable to give description. 10/01/2023: ...Resident observed on floor outside of bathroom in resident room on back by staff. ...Resident c/o pain to right arm with no visible injuries. 08/24/2023: Staff looked up from passing medication and saw [Resident 1] stand up and start walking on the far side of the fireplace. Before staff could get to [him/her], [Resident 1] tried to step up on the fireplace and fell. Resident was observed hitting head on the baseboard edges. On [his/her] left temple, [s/he] had a cut." The ISP did not identify updated interventions or approaches for staff to utilize in managing Resident 1's fall risk. Resident 1's ISP had not been updated since July 2023 and s/he	N 389		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING MEQUON II	6729 W MEQUON RD MEQUON, WI 53092

(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 389	Continued From page 14	N 389		

experienced 7 falls between August 2023-November 2023. The lack of updated interventions led to negative outcome for Resident 1 with a right hip fracture on 11/12/2023.

Example 2: Resident 2

On 05/17/2024 at 2:00 PM, Surveyor interviewed Wellness Director B and discussed the complaint. Surveyor asked if s/he was aware of Resident 2's mental health incident on 03/03/2024 after their medications was not available. Wellness Director B stated Resident 2 called 911 as s/he was a risk to him/herself. Wellness Director B noted Resident 2 experienced an anxiety attack and made comments to harm him/herself after his/her Buspirone was unavailable. Wellness Director B stated Resident 2 continued to have suicidal ideations.

Resident 2 was admitted on 01/11/2024 with diagnoses including anxiety disorder, suicidal ideations, vascular dementia, and major depressive disorder. Resident 2's individual service plan (ISP) dated 02/15/2024 did not identify interventions for staff to utilize in managing Resident 2's suicidal ideations.

Resident 2's after visit summary dated 3/3/2024 documented:
"Reason for visit: Suicidal. Diagnoses: Loneliness, depression."

Resident 2's progress notes documented:
04/02/2024: "Resident called 911 on [him/herself] stating [s/he] was not alive and wished [s/he] would kill [him/her self]. EMS and police arrived to attend to resident."

On 05/17/2024 at 2:48 PM, Surveyor conducted

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N 389	Continued From page 15 an exit conference and shared findings with Assistant Wellness Director (AWD) A, Wellness Director B, and Interim Administrator C. The provider's management team acknowledged Resident 1's and Resident 2's ISPs should have been updated after the above repeated occurrences. Wellness Director B confirmed s/he was in charge of updating ISPs but stated s/he would need to look at resident records before commenting why they were not updated. AWD A stated all resident records would be reviewed to ensure care plans reflect all assessed needs.	N 389		
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 2 of 2 residents were reassessed by a pharmacist, practitioner, or registered nurse as needed, but at least quarterly for the desired response and possible side effects of scheduled psychotropic medications. Findings include:	N 407		

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N 407	Continued From page 16 On 05/17/2024, Surveyor reviewed resident records and identified the following: Resident 1 admitted to the facility on 07/26/2023 with a diagnosis of dementia. Resident 1 passed away on 12/17/2023. Resident 1's individual service plan (ISP) dated 07/26/2023 stated the provider was to administer all medications. Resident 1's physician orders for Quetiapine Fumarate 25mg tablet for unknown indicated with a start date of 10/03/2023, Bupropion 150mg tablet for depression with a start date of 07/26/2023, and Sertraline 50mg tablet for depression with a start date of 07/26/2023. Resident 1's record did not contain psychotropic medication reviews for 3rd and 4th quarters of 2023. Resident 2 was admitted on 01/11/2024 with diagnoses including anxiety disorder, suicidal ideations, vascular dementia, and major depressive disorder. Resident 2's individual service plan (ISP) dated 02/15/2024 stated the provider was to administer all medications. Resident 2's physician orders for Buspirone 10mg for anxiety with a start date of 01/11/2024, Escitalopram 10mg tablet, and Mirtazapine 30mg tablet. Resident 2's record did not contain psychotropic medication reviews for 1st quarter of 2024. On 05/17/2024 at 2:48 PM, Surveyor conducted an exit conference and shared findings with Assistant Wellness Director (AWD) A, Wellness Director B, and Interim Administrator C. The provider's management team acknowledged quarterly psychotropic reviews were not being completed for all residents. Wellness Director B did not comment why psych reviews were not	N 407		

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N 407	Continued From page 17 being completed. Other members of the management team noted they only had recently been hired at the facility and did not have an answer either.	N 407		
Y3100	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES (2) The department, in establishing standards for nursing homes and community based residential facilities may establish, by rule, rights in addition to those specified in sub. (1) for residents in such facilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all residents had the right to physical and emotional privacy in treatment, living arrangements and in caring for personal needs. The facility was equipped with video cameras and facing resident rooms. Electronic video monitoring is the use of cameras or other equipment to transmit images of residents, visitors, or staff within or around a Community Based Residential Facility (CBRF) for possible instant viewing at another location or recording to view at another time.	Y3100		

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Y3100	Continued From page 18 Findings include: On 05/17/2024 at 9:20 AM, Surveyor toured the facility and identified the following: Surveyor observed 2 cameras on the west side of the building facing resident rooms. On 05/17/2024 at 9:30 AM, Surveyor interviewed Maintenance Director G. Maintenance Director G and Surveyor observed both cameras and noted each camera was in a fixed position facing resident rooms. Maintenance Director G attempted to adjust the angle of the view, but was unable. Maintenance Director G stated s/he was new to the role and the cameras had been installed prior. On 05/17/2024 at 2:48 PM, Surveyor conducted an exit conference and shared findings with Assistant Wellness Director (AWD) A, Wellness Director B, and Interim Administrator C. The provider's management team acknowledged an understanding of the concern. Surveyor discussed the camera angles would need to be reviewed to ensure the area of filming was within the permissible areas as outlined in DQA Memo 16-001 Electronic Video Monitoring and Filming in BAL Regulated Facilities. The provider did not protect residents' privacy. Residents were filmed when entering/exiting their bedrooms.	Y3100		