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 _____	R-C 10/03/2024

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 000}	Initial Comments On 10/03/2024, Surveyors conducted one (1) complaint investigation and a verification visit at Senior Living Mequon II. As a result of the survey 1 complaint was substantiated resulting in 2 deficiencies and 4 of 6 previous deficiencies were repeat violations for a total of 6 deficiencies. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 25	{N 000}		
{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 2 of 2 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	{N 230}		

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

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{N 230}	Continued From page 1 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 is a repeat deficiency. See Statement of Deficiency (SOD) QZQU11, dated 05/21/2024. Findings include: On 10/03/2024, Surveyors reviewed employee records and identified the following: The record for Caregiver C, hired 09/17/2024, did not contain evidence of orientation topics which included documentation of orientation in 1) abuse, neglect and misappropriation of resident property 2) assessed needs and individual services 3) emergency and disaster plan and evacuation procedures prevention 4) policy and procedures 5) recognizing and responding to resident changes of condition. The record for Caregiver D, hired 08/28/2024, did not contain evidence of orientation topics which included documentation of orientation in 1) assessed needs and individual services 2) emergency and disaster plan and evacuation procedures prevention 3) policy and procedures 4) recognizing and responding to resident changes of condition. On 10/03/2024 at approximately 3:00 PM, Surveyors conducted an exit conference and shared findings with Wellness Director (WD) A and Executive Director (ED) B. WD A stated "[Caregiver C] has only worked in the community for 3 days. We do not currently have trainings on	{N 230}		

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{N 230}	Continued From page 2 [him/her]." WD A confirmed Caregiver C had worked 09/24/2024, 09/26/2024 and 10/01/2024, and Caregiver D was currently scheduled and working. WD A stated Caregiver C and Caregiver D will be removed from the schedule until they complete the required trainings.	{N 230}		
{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 3 of 3 residents reviewed received all prescribed medications in the dosages and at intervals prescribed by a practitioner. This is a repeat deficiency. See Statement of Deficiency (SOD) QZQU11, dated 05/21/2024. Findings Include: Between 09/07/2024 and 09/30/2024, Resident 3 missed 23 of 24 doses of Escitalopram 10 MG tablet due to unavailability. Between 09/07/2024 and 09/30/2024, Resident 3 missed 11 of 24 doses of Memantine HCl 10 MG tablet due to unavailability. On 10/03/2024 at approximately 3:20 PM, Surveyors reviewed the record for Resident 3.	{N 352}		

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{N 352}	Continued From page 3 The record indicated Resident 3 was admitted to the facility on 09/06/2024. The provider administered Resident 3's medication. Resident 3's medical record contained an order for Escitalopram 10 mg tablet. The order indicated: "Escitalopram 10 MG tablet (500 EA) tab / Give 1 tablet by mouth once daily (Indications for Use: Depression) / -Order date-09/06/2024 1244" Resident 3's medical record also contained an order for Memantine HCl 10 mg tablet. The order indicated: "Memantine HCl 10 MG tablet (500 EA) tab / Give 1 tablet by mouth once daily (Indications for Use: Dementia) / -Order date-09/06/2024 1246" On 10/03/2024 at approximately 3:20 PM, Surveyors reviewed Resident 3's September Medication Administration Record (MAR) and identified the following: Escitalopram 10 mg tablet administration was documented with a "12" at 8:00 AM from 09/07/2024-09/26/2024 and from 09/28/2024-09/30/2024. It was documented as administered on 09/27/2024. The MAR "Chart Codes" key indicates "12" means "Med Not Available Pharmacy Notified." Memantine HCl 10 mg tablet administration was documented with a "12" at 8:00 AM from 09/07/2024-09/16/2024 and on 09/28/2024. The MAR "Chart Codes" key indicates "12" means "Med Not Available Pharmacy Notified." Between 09/12/2024 and 09/30/2024, Resident 2 missed 1 of 19 doses of Sertraline HCl oral tablet	{N 352}		

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{N 352}	Continued From page 4 25 mg. On 10/03/2024 at approximately 3:25 PM, Surveyors reviewed the record for Resident 2. The record indicated Resident 2 was admitted to the facility on 08/30/2024. The provider administered Resident 2's medication. Resident 2's medical record contained an order for Sertraline HCl oral tablet 25 mg. The order indicated: "Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) / Give 1 tablet by mouth one time a day for Anxiety / -Order Date- 09/11/2024 1834 / -D/C Date- 09/16/2024 0637. A second order indicated: "Sertraline HCl 25 MG Tablet (500 EA) Tab / Give 1 tablet by mouth every morning (Indication for Use: Anxiety and Depression) / -Order Date- 09/11/2024 2001" On 10/03/2024 at approximately 3:25 PM, Surveyors reviewed Resident 2's September MAR and identified the following: Sertraline HCl oral tablet 25 mg administration was documented as administered from 09/13/2024-09/30/2024. No documentation was charted on 09/12/2024. On 10/03/2024 at 3:28 PM, Surveyors interviewed Wellness Director (WD) A and asked about the missing documentation on 09/12/2024. WD A was unable to provide an explanation for the missing documentation. Between 09/10/2024 and 09/13/2024, Resident 1 missed 3 of 14 applications of lidocaine external patch 4%. On 10/03/2024 at approximately 3:30 PM,	{N 352}		

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{N 352}	Continued From page 5 Surveyors reviewed the record for Resident 1. The record indicated Resident 1 was admitted to the facility on 02/21/2021. The provider administered Resident 1's medication. Resident 1's medical record contained an order for Lidocaine External Patch 4%. The order indicated: "Lidocaine External Patch 4% (Lidocaine) / Apply to Lower Back topically one time a day for Back Pain for 14 Days Remove at same time each night and remove per schedule. / -Order Date- 08/30/2024 0948 / -D/C Date- 09/16/2024 0638." On 10/03/2024 at approximately 3:30 PM, Surveyors reviewed Resident 1's September MAR and identified the following: Lidocaine External Patch 4% administration was documented with a "12" at 8:00 AM on 09/10/2024. The MAR "Chart Codes" key indicates "12" means "Med Not Available Pharmacy Notified." The documentation indicates the Lidocaine patch was removed at 8:00 PM on 09/10/2024 despite not being applied at 8:00 AM. The documentation indicates a Lidocaine patch was administered at 8:00 AM on 09/11/2024; however, there is no documentation indicating it was removed at 8:00 PM on 09/11/2024. No documentation was charted on 09/12/2024 or 09/13/2024. On 10/03/2024 at 3:28 PM, Surveyors interviewed WD A and asked about the Lidocaine patch not being available on 09/10/2024 and the missing documentation from 09/11/2024-09/13/2024. WD A was unable to provide an explanation.	{N 352}		

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{N 389}	Continued From page 6	{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 Individual Service Plans (ISPs) were updated to reflect the needs of Resident 1 and Resident 9. Resident 1's ISP was not updated to reflect mobility, approaches to mitigate his/her high fall risk, bathing assistance, dressing assistance, and toileting needs. Resident 9's ISP was not updated to reflect the use of a wheelchair as an assistive mobility device. This is a repeat deficiency. See Statement of Deficiency (SOD) QZQU11, dated 05/21/2024. Findings include: On 10/03/2024 at approximately 3:00 PM,	{N 389}		

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{N 389}	Continued From page 7 Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/24/2021 with diagnoses including Alzheimer's disease and age-related osteoporosis. Resident 1's ISP was updated on 08/09/2024. Resident 1's ISP stated the following: -Escort/Mobility Interventions: "Resident requires assistance with: (specify: stairs, escorts, etc.). Staff are present for duration of activity." -Falls: Goal - "Will reduce chance of falls within the community." / Interventions - "Is at risk for falls due to: (related to instability and previous leg right leg fracture)" -Bathing Interventions: "Resident requires assistance with: (specify: transferring in/out, steadying, washing/drying self, applying lotion.)" -Dressing Interventions: "Resident requires assistance with: (specify: upper/lower body dressing, choosing appropriate seasonal clothing, tying shoes, buttons, snaps, etc.) Staff are present for entire duration of activity." -Toileting Interventions: "Resident requires reminders for: (specify: toileting activity, toileting schedule, peri-care, etc.) On 10/03/2024 at approximately 3:05 PM, Surveyors interviewed Wellness Director (WD) A and asked about Resident 1's needs. WD A identified the following needs: -Escort/Mobility: Uses walker and wheelchair. -Falls: Had 2 falls when transferring. Acknowledged that no fall interventions were listed on ISP. -Bathing: Requires total assistance. -Dressing: Requires verbal cueing and needs assistance with buttons. -Toileting: Incontinent of urine. Wears pull up briefs.	{N 389}		

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{N 389}	Continued From page 8 On 10/03/2024 at approximately 3:00 PM, Surveyors reviewed Resident 9's record. Resident 9 was admitted to the facility on 08/27/2024. Resident 9's ISP was created on 08/28/2024 and revised on 08/29/2024 and 10/03/2024. Resident 9's ISP stated the following: -Escort/Mobility: Goal - "Will be able to move about the community with assistance" / Interventions: "Resident requires assistance with: (specify: stairs, escorts, etc.). Staff are present for duration of activity." Surveyors also reviewed Resident 9's progress notes. An incident note written by WD A dated 09/30/2024 stated the following: "Resident wheelchair was moved out of reach in hopes that resident will not reach for chair to assist up." Resident 9's ISP does not indicate that s/he uses a wheelchair. WD A acknowledged the ISPs should be more specific and should reflect residents' needs. WD A will work on updating ISPs so caregivers can easily identify how to care for residents.	{N 389}		
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.	N 425		

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N 425	Continued From page 9 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 observation and interview, the provider did not ensure 4 of 4 residents received supplies adequate for personal cares. Resident 1, Resident 4, Resident 5 and Resident 8 did not have toilet paper available to use in the bathroom. Findings include: On 09/19/2024, the Department received a complaint alleging no toilet paper was available in resident bathrooms. On 10/03/2024 at approximately 9:00 AM, Surveyors toured the facility and observed: - Resident 1's bathroom had no toilet paper - Resident 4's bathroom had no toilet paper - Resident 5's bathroom had no toilet paper - Resident 8's bathroom had no toilet paper On 10/03/2024 at 10:44 AM, Surveyors interviewed Family E. Family E stated s/he has shared concerns about Resident 8's bathroom being cleaned. Family E stated Resident 8 does seek for a bathroom and s/he has issues with BM. Family E showed Surveyors Resident 8's bathroom and the washcloths hanging on the grab bar with BM on them. Family E stated s/he had bought Resident 8 - 12 washcloths, but there	N 425		

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	0018677	A. BUILDING: _____ B. WING _____	R-C 10/03/2024

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N 425	Continued From page 10 were only 3 left. Family E was unsure if staff are throwing them away. Family E stated s/he brings toilet paper and Kleenex for Resident 8, as staff state they need to find toilet paper and Kleenex. On 10/03/2024 at 11:00 AM, Surveyors interviewed Resident 1. Resident 1 stated s/he had run out of toilet paper and was hoping staff would bring toilet paper in before s/he needs toilet paper. Surveyors observed Resident 1's bathroom did not have toilet paper. On 10/03/2024 at approximately 3:00 PM, Surveyors conducted an exit conference and shared findings with Wellness Director (WD) A and Executive Director (ED) B. WD A stated when s/he started, previous management stated residents need to provide their own toilet paper and Kleenex. WD A acknowledged s/he did not have documentation informing residents, power of attorneys or guardians the resident was responsible for supplies. WD A stated s/he will address the concerns with management and staff, and ensure residents have toilet paper in their bathrooms.	N 425		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 5 of 5 resident bathrooms were clean and in good working order. Findings include: On 10/03/2024 at approximately 9:15 AM,	N 490		

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N 490	Continued From page 11 Surveyors conducted a tour of the facility and observed the following: - Resident 1's bathroom had BM on toilet seat - Resident 5's bathroom wash basket overflowing with soiled clothes, odor in bathroom, BM smeared on toilet and rug - Resident 7's bathroom dirty and wall had stains on them. - Resident 8's bathroom had BM on toilet, floor, wall and washcloths hanging on grab bar by toilet On 10/03/2024 at 10:44 AM, Surveyors interviewed Family E. Family E stated s/he has shared concerns about Resident 8's bathroom being cleaned. Family E stated Resident 8 does seek for a bathroom and s/he has issues with BM. Family E showed Surveyors Resident 8's bathroom and the washcloths hanging on the grab bar with BM on them. Family E stated s/he had bought Resident 8 - 12 washcloths, but there were only 3 left. Family E was unsure if staff are throwing them away. On 10/03/2024 at 11:00 AM, Surveyors interviewed Resident 1. Resident 1 stated s/he had run out of toilet paper and was hoping staff would bring toilet paper in before s/he needs toilet paper. Surveyors observed Resident 1's bathroom did not have toilet paper and observed BM on the toilet. On 10/03/2024 at approximately 3:00 PM, Surveyors conducted an exit conference and shared findings with Wellness Director (WD) A and Executive Director (ED) B. WD A stated s/he will address staff cleaning resident bathrooms.	N 490		
{Y3100}	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES	{Y3100}		

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{Y3100}	Continued From page 12 (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 residents maintained the right to privacy in treatment, living arrangements and in caring for personal needs. This requirement is being cited for the third time. See Statement of Deficiency (SOD) OCDN11, dated 07/13/2022 and SOD QZQU11, dated 05/21/2024. Findings Include: On 10/03/2024 at approximately 1:00 PM, Surveyors toured the facility and observed a camera in the main entrance area and a camera near the courtyard door. At 2:42 PM, Surveyors interviewed Wellness Director (WD) A. WD A showed Surveyors the images from 2 of 2 cameras. The camera at the front door picked up 2 residents sitting on a couch, and the camera by the courtyard exit picked up 1 resident sitting by	{Y3100}		

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{Y3100}	Continued From page 13 the window. WD A stated s/he will work to have the cameras adjusted to only pick up the doors. The provider did not protect resident privacy within the facility. Residents were filmed, sitting by the main entrance and common hallway leading to resident rooms and in the sitting area by the courtyard exit.	{Y3100}		