STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019869	A. BUILDING: _____ B. WING _____	C 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SONNET AT TENNYSON (THE)	1936 TENNYSON LN MADISON, WI 53704

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N 000	Initial Comments On 07/17/2025, with information gathered through 07/21/2025, the Bureau of Assisted Living, Southern Regional Office conducted 2 complaint investigations at The Sonnet at Tennyson, located at 1936 Tennyson Lane in Madison, WI. One citation of noncompliance was issued. Both complaints were substantiated. Census: 35	N 000		
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, interview, and record review, the provider did not ensure Resident 1's and Resident 2's individual service plans (ISPs) were revised when Resident 1 experienced a change in condition and Resident 2's dietary needs changed. The findings include:	N 389		

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

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N 389	Continued From page 1 Example 1: Resident 1 On 06/26/2025, the department received an allegation regarding concerns with personal cares provided to residents. On 07/17/2025 at 9:15 A.M., Surveyor observed Resident 1 seated in a wheelchair located in a common area/television area of the facility. Surveyor observed Resident 1's eyes to be watery with a small amount of clear, watery drainage from both of Resident 1's eyes. On 07/17/2025 at 9:20 A.M., Surveyor conducted an interview with Caregiver C regarding Resident 1's cares and services. Caregiver C told Surveyor Resident 1 required full assistance with all cares, including grooming and personal hygiene. Caregiver C told Surveyor Resident 1 received additional cares and services from Resident 1's hospice agency during the week. Caregiver C said Resident 1 experienced an issue with both eyes in June 2025 that caused additional eye drainage and required administration of an eye ointment for approximately 7 days. Caregiver C said s/he understood Resident 1 had chronic eye issues. On 07/17/2025 at 12:04 P.M., Surveyor observed Hospice Agency Caregiver F assisting Resident 1 to eat lunch within the facility's dining room with Hospice Agency Nurse D present. Surveyor conducted an interview with Hospice Agency Nurse D regarding Resident 1's cares and services. Hospice Agency Nurse D said a hospice agency caregiver visited Resident 1 five days per week and a hospice agency nurse visited Resident 1 twice weekly. Hospice Agency Nurse D told Surveyor s/he was aware Resident 1	N 389		

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N 389	Continued From page 2	N 389		

had a history of drainage from Resident 1's eyes and nose. Hospice Agency Nurse D said hospice caregivers were cleansing Resident 1's eyes as part of providing Resident 1's personal cares on week days. Hospice Agency Nurse D said Resident 1 was diagnosed with conjunctivitis (an inflammation or infection of the eye) in June 2025 and was prescribed an eye ointment to be administered to both eyes for approximately 10 days. Hospice Agency Nurse D told Surveyor s/he was made aware Resident 1 accumulated a large amount of eye drainage over a weekend in June 2025 just prior to the diagnosis of conjunctivitis. Hospice Agency Nurse D told Surveyor Resident 1's eyes continued to drain clear liquid but had improved since being treated for conjunctivitis.

On 07/17/2025, Surveyor reviewed Resident 1's record, as provided by Executive Director A. Resident 1 was admitted to the facility in September 2023 with diagnoses including dementia. A "Clients Rights Formal Grievance Form" dated 05/19/2025 submitted by Resident 1's Legal Representative G included, "Dirty face..." The associated "investigation" documentation on 05/20/2025 included, "[Facility Nurse B] speaking with staff about being sure to check [Resident 1's] eyes for allergy issues [and] clean appropriately." The associated "resolution" included Facility Nurse B addressed the issue with staff and "will implement education/discipline as appropriate. [Facility Nurse B] advised [Resident 1's Legal Representative G] of the above."
At 3:00 P.M., Executive Director A told Surveyor the "education" of staff would have included how to properly clean Resident 1's eyes. Executive Director A told Surveyor Resident 1's Legal Representative G approached him/her on

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N 389	Continued From page 3 06/16/2025, a Monday, after Resident 1 had attended an activity on the first floor and was seated in the facility's main lobby area. Executive Director A said Resident 1's Legal Representative G asked him/her to observe Resident 1's eyes. Executive Director A told Surveyor Resident 1's eye drainage was milky and thick, and s/he asked a caregiver to clean Resident 1's face immediately. Executive Director A told Surveyor s/he believed the caregivers did not see Resident 1's eye drainage prior to Resident 1 attending the activity because Resident 1 wears glasses. Executive Director A said s/he did not document this concern brought to him/her by Resident 1's Legal Representative G as a grievance because it did not feel like a grievance and it was never documented within Resident 1's record. A hospice agency practitioner's order dated 06/17/2025 included, "Erythromycin 5 mg [milligrams]/[per] gram (0.5 %) eye ointment. Apply a 1 inch ribbon to each eye 6 times a day for 10 days for conjunctivitis." Resident 1's June 2025 medication administration record (MAR) included this order and documentation of administration of this medication to Resident 1 from 06/17/2025 through 06/27/2025. Resident 1's "observations" documentation from 06/01/2025 through 07/17/2025 did not include any documentation regarding Resident 1's history of chronic eye drainage and cares required in response to Resident 1's eye drainage and/or diagnoses of conjunctivitis. Executive Director A and Surveyor reviewed Resident 1's individual service plan [ISP], dated 05/13/2025 and signed by Resident 1's Legal Representative G. Resident 1's ISP included, "[Resident 1] requires full assistance from staff to complete grooming tasks" and "Care staff are to assist with grooming tasks such as washing face and brushing hair." Executive Director A told	N 389		

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N 389	Continued From page 4 Surveyor Resident 1's ISP had not been updated with Resident 1's history of eye drainage and/or Resident 1's diagnosis of conjunctivitis on 06/17/2025 resulting in increased eye drainage and practitioner ordered treatment. On 07/17/2025 at approximately 3:30 P.M., Executive Director A told Surveyor Resident 1's record, including Resident 1's ISP, should have included specific documentation of observations and interventions related to Resident 1's chronic eye drainage and surrounding the diagnosis of conjunctivitis. Example 2: Resident 2 On 06/05/2025, the Department received a complaint about dietary services provided by facility. On 07/17/2025 at 9:50 AM, Surveyor interviewed Caregiver H and Caregiver I at the level 1 staff desk. Caregiver H stated s/he had taken care of Resident 2. Caregiver H stated Resident 2 was on a puree diet. Caregiver H and Caregiver I reported Resident 2's family had a camera and his/her room. Caregiver H nor Caregiver I could recall Resident 2's family reporting concerns related to Resident 2's diet. Caregiver H reported s/he did recall a few instances where the facilities dietary department sent solid food to the floor for Resident 2. Caregiver H reported in these instances staff would use a unit blender to puree food for Resident 2. Caregiver H reported Resident 2 did have a history of being combative towards staff during cares. Caregiver H stated Resident 2's combative behavior was related to his/her decline in condition.	N 389		

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N 389	Continued From page 5 On 07/17/2025, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted on 12/06/2021 and then discharged from the facility 05/18/2025. Resident 2 had an activated healthcare power of attorney and received hospice services. On 07/17/2025, Surveyor reviewed Resident 2's individualized service plan (ISP). Resident 2's ISP was signed on 01/14/2025. Under the subsection titled, "DIET - SPECIFY," the following was documented, "[Resident 2] is on a general diet ...Maintain current diet ... [Resident 2] will continue to be on a general diet for one year ...Care staff to monitor eating and document any concerns or changes..." Under the subsection titled, "EATING - MONITOR AND CUE," the following was documented, "[Resident 2] requires staff monitoring and reminders and cues to complete eating tasks ...To maintain adequate food/nutrition intake ..." On 07/17/2025 at 2:00 PM, Surveyor requested a copy of Resident 2's most recent dietary order from Executive Director A. On 07/17/2025 at 3:00 PM, Surveyor discussed Resident 2's dietary order with Executive Director A. Executive Director A stated s/he could not locate Resident 2's most recent dietary order. Executive Director A stated to the best of his/her knowledge Resident 2 had been on a general diet. Executive Director A stated s/he would contact Resident 2's hospice provider to obtain a copy of his/her most recent dietary order. On 07/18/2025 at 11:55 AM, Executive Director A called Surveyor and reported s/he had found Resident 2's dietary order.	N 389		

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N 389	Continued From page 6 On 07/18/2025 at 12:31 PM, Executive Director A emailed Surveyor Resident 2's dietary order dated 06/06/2024. The order was electronically signed by Doctor J. The dietary order was, "Initiate mechanical diet with 1:1 meal assist." On 07/18/2025 at 3:50 PM, Surveyor emailed Executive Director A. Surveyor explained that Resident 2's ISP had not been updated with Resident 2's prescribed diet. Surveyor instructed Executive Director A to contact him/her with any questions or concerns. On 07/22/2025, Surveyor had not received any correspondence from Executive Director A. On 07/22/2025, Surveyor reviewed Resident 2's hospice record. On 02/12/2025 at 6:41 PM, Hospice Nurse E documented the following, "Nutrition ...Diet type: mechanical soft, puree ...Additional comments: 11/13/24 [Resident 2] was eating from [his/her] breakfast food, but then stopped eating when writer walked in the room and preteneded (sic.) to be sleeping. 11/22/24- [Family Member K] reports that [s/he] has been eating all food with [his/her] hands including peas and corn. Does better when [s/he] is fed. Faxed orders for pureed diet. 1/15- [Resident 2] eating when in bed upon arrival, update to facility. 1/22/25 [Resident 2] had breakfast food on the tray untouched and [Resident 2] is sleeping. After cares, team offered fluids and a few bites and then [s/he] fell asleep. 2/12/25- Staff report [Resident 2] is not eating."	N 389		