STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 03/13/2024, with information gathered through 04/02/2024, Surveyors conducted a standard licensure survey and 3 complaint investigations at The Koselig House. Twelve deficiencies were identified. Two of 3 complaints were substantiated. Three of the 12 deficiencies were repeat violations (see Statement of Deficiency (SOD) GNOK11 and SOD2U5R12). Census: 25	N 000		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an admission agreement was completed before or at the time of admission for 2 of 2 residents (Resident 11 and Resident 12) reviewed. Findings include: On 03/26/2024, the Department received a complaint alleging that residents did not receive admission agreements upon admission. On 03/26/2024, at approximately 5:35 PM, Surveyor interviewed Resident 11's and Resident 12's Power of Attorney (POA) J. POA J stated	N 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 301	Continued From page 1	N 301		

Resident 11 and Resident 12 moved in on 03/18/2024. POA J stated, "I arrived at the facility around 10:00 AM so I could sign the contracts and start arranging [Resident 11's and Resident 12's] room, prior to the arrival around 5:00 PM. [Administrator A] stated s/he was unable to access the contracts, but [Administrator A] knew how much money we owed. On 03/21/2024, I discussed with [Administrator A] concerns I had regarding [Resident 11's and Resident 12's] first few days at the facility and that I had not been provided with their admission contract. On 03/24/2024, again I discussed concerns with [Administrator A] and still no admission contract. Finally, on 03/26/2024, I received an email from [Administrator A] at 10:28 AM, asking me to sign the attached admission agreements." POA J forwarded Surveyor a copy of the email with the admission agreements attached.

On 03/28/2024, Surveyor requested Resident 11's and Resident 12's record from Administrator A and Chief Operations Officer (COO) I.

On 03/29/2024, at 11:27 AM, POA J emailed Surveyor with a copy of the admission agreements for Resident 11 and Resident 12. POA J stated the admission agreements had been pre-filled with the move in dates, but s/he crossed out the dates and wrote in 03/28/2024 as that is the date the agreements were signed, two days after s/he received them. The attached admission agreements reflected that comment.

On 03/29/2024, Surveyor reviewed Resident 11's and Resident 12's record.

Resident 11's and Resident 12's admission agreements documented that they moved into the facility on 03/18/2024. On the signature pages,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 301	Continued From page 2 the date next to POA J appeared to be altered. The dates had the appearance of being whited out with a new date written in as one can see parts of a prior handwritten date. On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and COO I. Administrator A confirmed the contracts were not available when Resident 11 and Resident 12 moved in.	N 301		
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 observation, record review, and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 4 of 4 residents. Resident 6's Fluticasone-Salmeterol was marked open on 01/19/2024 and was documented as administered after the 30-day expiration date. Resident 6's Trulicity was not administered at the prescribed times. Resident 7's Iprat albuterol (medication used to treat chronic obstructive pulmonary disease [COPD]) was not administered at the prescribed times.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 3	N 352		

Resident 12 did not receive his/her Apap-Diphen (pain medication), Melatonin (sleep aid), and Ozempic (diabetes medication) as prescribed.

Resident 13's PRN (as needed) Olanzapine (psychotropic medication) was not administered at the prescribed times.

Findings Include:

Example 1: Resident 6

On 03/13/2024, at approximately 4:00 PM, Surveyors observed the medication carts with Administrator A.

Surveyors observed Resident 6's Fluticasone-Salmeterol inhaler with a label that read:
"Inhale (1) puff orally twice daily. May not use after thirty days after removing from foil package. Date Opened: 01/19/2024." The inhaler appeared to have 10 out of 120 doses remaining. Surveyor and Administrator A did not observe any other inhaler for Resident 6.

Administrator A stated s/he would need to review this concern with staff.

On 03/14/2024, Surveyor reviewed Resident 6's record.

Resident 6's January 2024 Medication Administration Record (MAR) documented:
"Fluticasone-Salmeterol 100-50. Inhale (1) puff orally twice daily. May not use after thirty days after removing from foil package."
01/12 - No Pass Reason: Out of Order
01/15 - Waiting For order Fill
Surveyor noted the MAR documented, starting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 4	N 352		

01/12, the medication was unavailable, and again on 01/15. The MAR documented all other dates/times were marked as administered. The inhaler in the med cart documented it was opened on 01/19.
The MAR documented 24 administration times starting 01/19/2024.

Resident 6's February 2024 MAR, dated 03/01/2024 to 03/13/2024, documented:
"Fluticasone-Salmeterol 100-50. Inhale (1) puff orally twice daily. May not use after thirty days after removing from foil package."
The MAR documented 57 out of 58 administration opportunities.

Resident 6's March 2024 MAR, dated 03/01/2024 to 03/13/2024, documented:
"Fluticasone-Salmeterol 100-50. Inhale (1) puff orally twice daily. May not use after thirty days after removing from foil package."
The MAR documented that Resident 6 received all (13) 8:00 AM doses, but only received 4 out of 13 8:00 PM doses.
"Trulicity 1.5 MG/ 0.5 ML Pen. Inject (1) syringe subcutaneously once weekly on Thursday."
The MAR documented the medication was not available on Thursday, 03/07/2024.

Resident 6's pharmacy manifest documented:
Trulicity 1.5 MG - Quantity 2 delivered on 01/25/2024 and on 03/20/2024.
Fluticasone-Salmeterol delivered on 01/18/2024.

On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and Chief Operations Officer (COO) I. Administrator A stated staff are being retrained and monitored on how they conduct med administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 5	N 352		

Example 2: Resident 7

On 03/13/2024, at approximately 1:50 PM, Surveyor observed Resident 7 and his/her Power of Attorney (POA) F, in Resident 7's bedroom. Upon entrance, Surveyor observed what appeared to be a soiled urinal sitting next to a nebulizer, which was sitting on a nightstand next to Resident 7's bed.

On 03/13/2024, at approximately 2:00 PM, Surveyor interviewed POA F. POA F stated, "I was under the impression that [Resident 7] was to be receiving [his/her] nebulizer treatment twice a day. It had started as a PRN (as needed) but then was switched to a scheduled. If you look at [his/her] nebulizer, you can tell it has never been used. It is also frustrating because staff will tell me that [Resident 7] refused the nebulizer treatment. You can't just ask [him/her], do you want your treatment. [S/he] doesn't understand, [s/he] will always say [s/he] is okay. I have observed [him/her] having shortness of breath and I ask [him/her] if [s/he] wants to use an inhaler or a nebulizer and [s/he] doesn't really answer."

On 03/18/2024, Surveyor reviewed Resident 7's record.

Resident 7 was admitted to the facility, 11/10/2021, with diagnoses included dementia, anxiety, and chronic obstructive pulmonary disease (COPD).

Resident 7's "Individual Service Plan (ISP)," dated 06/15/2023, documented:
"Medication Management - Assist: Receives assistance from staff to administer medication."
The ISP did not document cognitive guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 6	N 352		

Resident 7's "Care Plan," dated 03/14/2024, documented:
"Medication Management - Assist: Receives assistance from staff to administer medication."
"Behavior - Anxiety: On occasion [Resident 7] can fixate on things [s/he] believes are real ... staff should talk with [Resident 7] about other things."
"Behavior - Depression: Withdrawn, not as talkative, decreased appetite."

Resident 7's February and March 2024 Medication Administration Record (MAR) documented:
"Iprat-Albut 0.5-3(2.5) MG (milligram) / 3 ML (milliliter). Nebulize 1 vial orally twice daily. Start Date: 02/11/2024. End Date: 03/12/2024."
Surveyor noted no documented administration of this scheduled medication.
"Iprat-Albut 0.5-3(2.5) MG / 3 ML. Nebulize (1) vial twice daily as needed for shortness of breath or wheezing. Start Date: 01/22/2024. End Date: 02/11/2024."
Surveyor noted no documented administration of this PRN medication.
"Iprat-Albut 0.5-3(2.5) MG (milligram) / 3 ML (milliliter). Nebulize 1 vial orally twice daily. Start Date: 03/12/2024."
03/12 8:00 PM - No Pass Reason: Not in Cart
03/13 8:00 AM - Documented "Scheduled"
03/13 8:00 PM - No Pass Reason: Doesn't want tonight
Surveyor noted s/he had observed Resident 7's nebulizer at 2:00 PM on 03/13/2024 and POA F had stated Resident 7 had not received a treatment that day.

On 03/18/2024, Surveyor reviewed the picture s/he had taken of Resident 7's Iprat-Albut that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 7	N 352		

was available in the med cart which displayed a box of Iprat-Albut with a label that read "Iprat-Albut 0.5-3(2.5) MG / 3 ML. Nebulize (1) vial twice daily as needed for shortness of breath or wheezing."
Surveyor did not observe a box of Iprat-Albut with a label that read Nebulize 1 vial orally twice daily.

On 03/22/2024, at approximately 9:40 AM, Surveyor interviewed Resident 7's managed care organization Registered Nurse (RN) H. RN H stated, "[Resident 7's] nebulizer treatment was changed to a scheduled medication due to [Resident 7's] cognition level back on 02/09/2024, based on [his/her] [medical documentation documented in Resident 7's electronic medical chart], and was scheduled for 8:00 AM and 8:00 PM. [Resident 7] doesn't know/understand when [s/he] should ask for a PRN nebulizer treatment."

On 03/22/2024, Surveyor requested Resident 7's medical documentation from his/her primary home health providers.

On 03/22/2024 at 12:26 PM, COO I emailed Surveyor and stated, "On the PO (physician order) for [Resident 7], you will see that the order was last updated on 03/12/2024. From what I am seeing in our electronic system, it was listed as PRN up until new orders must've been received to increase to twice daily scheduled at 8am and 8pm. I did review the MAR since then and it looks like [s/he] is refusing this medication since being scheduled so a fax to [his/her] PCP (primary care physician) was sent out."

On 03/25/2024, Surveyor reviewed Resident 7's home health medical documentation which stated:
"01/24/2024: Albuterol-ipratropium (Duo-Neb)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 8	N 352		

0.5-3(2.5) MG / 3 ML nebulizer solution. Inhale 3mL by mouth 2 times daily as needed for shortness of breath or wheezing reasons. Discontinued on 02/09/2024."
"Cognitive Functioning: Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. "Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours,
significant memory loss so that supervision is required, 2 - Impaired decision-making: failure to perform usual ADLs (activities of daily living) or IADLs (instrumental activities of daily living), inability to appropriately stop activities, jeopardizes safety through actions."
"02/09/2024: Patient received nebulizer machine yesterday, however, medication (DuoNeb) is scheduled as PRN. Due to patients cognition/memory impairment [s/he] will not remember to ask for treatments. Patient resided at an ALF (assisted living facility) and staff are unable to determine when treatment is appropriate."
"02/16/2024: [Doctor] changed DuoNebs to scheduled 2x (2 times) daily last week."

On 03/25/2024 at 4:40 PM, RN H emailed Surveyor and stated, "I met with [Administrator A], [Resident 7], and [Power of Attorney F] today. In review of the MAR, I found that the nebulizer was moved to scheduled on 3/12/24. From 3/12/24-3/25/24 there were 17 times the medication was documented as given, 3 times where the documentation was blank, and 6 times where the medication was documented as refused or other. We all looked at the nebulizer machine and supplies and it in fact was not used at all. [Resident 7] confirmed [s/he] had never

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 9	N 352		

used the nebulizer. [Administrator A] advised [s/he] would be following up with the employees that had documented the medication as given and the ones who did not mark any documentation."

Example 3: Resident 12

On 03/29/2024, at approximately 4:05 PM, Surveyor interviewed Resident 12's Power of Attorney (POA) J. POA J stated s/he had concerns with Resident 12's medications. POA J stated, "While visiting on 03/28/2024 (Thursday), [Resident 12] mentioned to me while I was cutting [his/her] hair that [s/he] hadn't had [his/her] Ozempic shot yet. I had given the Ozempic [Resident 12] had at [his/her] previous apartment to [Administrator A] on March 21. I told [him/her] that [Resident 12] had [his/her] shot the 21st and took it every Thursday morning [him/herself]. [S/he] said [s/he] would have the nurse/aide dial the dose for [him/her] and [Resident 12] could administer it [him/herself]. I spoke with [Resident 12] today, 03/29/2024, and [s/he] said [s/he] didn't receive [his/her] Ozempic yesterday. [S/He] stated s/he asked about it last night and was told [s/he'd (staff)] would check on it; the person never came back. [Resident 12] stated s/he didn't get it with [his/her] morning meds, asked about it and was told [s/he] remembered seeing it and would check on it. No one came with it, so [s/he] went to [Administrator A] about it. [S/he] brought it to [him/her] and he gave himself the shot.

On 03/30/2024, Surveyor requested Resident 12's record from Administrator A and COO I.

On 04/01/2024, Surveyor reviewed Resident 12's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 10	N 352		

Resident 12 moved into the facility, 03/18/2024, with diagnoses including Type 2 diabetes and joint pain.

Resident 12's March 2024 MAR documented:
"Apap-Diphen 500 - 25 MG Caplet. Take (1) tablet orally once daily at bedtime."
03/19 through 03/21 - No Pass due to med not available
03/25 through 03/29 - No Pass due to med not available
"Melatonin 3 MG tablet - Take (1) tablet orally once daily at bedtime."
03/19 through 03/21 - No Pass due to med not available
03/25 through 03/29 - No Pass due to med not available
"Ozempic 2MG (8MG/3ML) 2MG - Inject 2MG subcutaneously on Thursday."
Documented as administered on 03/21 and 03/28.
Surveyor noted the MAR documented it was given on Thursday versus Friday.

On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and COO I. Administrator A stated the medication had been placed in the wrong med refrigerator and staff were unable to locate it, so the medication was administered on Friday instead of the scheduled Thursday.

Example 4: Resident 13

On 03/13/2024, at approximately 4:00 PM, Surveyors reviewed the providers med carts and observed Resident 13's blister card of PRN Olanzapine which documented, "Take (1) tablet (2.5 MG) orally once daily as needed for agitation."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 11	N 352		

On 03/22/2024, Surveyor reviewed Resident 13's record.

Resident 13 was admitted to the facility, 01/16/2024, with diagnosis including Alzheimer's.

Resident 13's January 2024 MAR documented:
"Olanzapine 2.5 MG tablet - Take (1) tablet orally once daily. Start Date: 01/27/2024."
Surveyor noted this medication was listed under the PRN section. Medication was not documented as administered.
"Olanzapine 2.5 MG tablet - Take (1) tablet orally once daily as needed for agitation. Start Date: 01/16/2024. End Date: 01/27/2024."

Resident 13's February 2024 MAR documented:
"Olanzapine 2.5 MG tablet - Take (1) tablet orally once daily. Start Date: 01/27/2024."
Medication was documented as administered once, 02/08/2024.
Surveyor noted this medication was also listed under the PRN section.

Resident 13's March 2024 MAR, dated 03/01/2024 to 03/13/2024, documented:
"Olanzapine 2.5 MG tablet - Take (1) tablet orally once daily. Start Date: 01/27/2024."
Medication was documented as administered.
Surveyor noted this medication was also listed under the PRN section.

On 03/22/2024 at 1:22 PM, Surveyor emailed Administrator A and COO I regarding the concerns identified with Resident 13's medication. COO I responded, "This is the first we are hearing of these issues with medications not entered correctly. Based on what I am seeing, it looks like when pharmacy is entering the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 352	Continued From page 12 orders, they are not updating the scheduling of the medications. When we go to accept the order in the queue, the medication order is changing however the timing is not. I will have to reach out to pharmacy to see why this is happening."	N 352		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were able to lock his/her bedroom door when they wanted when they exited their room. Findings include: On 03/29/2024, at approximately 11:30 AM, Surveyor interviewed Resident 12's Power of Attorney (POA) J. POA J expressed concerns about residents having the ability to come and go from their rooms. POA J stated, "On 03/25/2024, while I was visiting, [Resident 12's] door was locked. [S/He] said it was closed and locked when they [Resident 11 and Resident 12] returned from lunch. [S/He] said [s/he] pressed [his/her] call button about a half hour ago and no one had come yet to see what [s/he] needed. [Resident 12] wanted [his/her] hearing aid, so sometime after 2:00, I went to the desk and	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 355	Continued From page 13	N 355		

asked someone to unlock [his/her] door. One of the aides came back with me and unlocked it. [S/he] thought there was a problem with the lock/handle and said not to close the door, [s/he'd] have maintenance look at it. Later, I went to [Resident 12's] room to get my purse and coat. The door was shut and locked again. We had left it open earlier. I went and got an aide from the dining room. [S/he] came back with me right away and unlocked it. I told [her/him] one of the other aides thought it was broken. [S/he] made sure it was unlocked, went outside, shut the door. She was able to open it from the outside. Then I was visiting with [Resident 12] on 03/29/2024, the door still keeps locking if closed, so [s/he] has to ask for someone to unlock it when [s/he] wants to go in [his/her] room. Not sure who is closing the door. I put [Resident 12's] cane in between the frame and door to keep it open." Surveyor asked POA J if Resident 12 was given the option to hold a key for his/her bedroom, so s/he could open the door independently. POA J stated keys were not discussed and did not know residents could hold a key to their room.

On 04/01/2024, Surveyor reviewed Resident 12's record.

Resident 12 moved into the facility on 03/18/2024.

Resident 12's "Pre-Admission Assessment," dated 02/15/2024, documented:
"Exit Seeking Behavior - N/A (not applicable)."
"Capacity for Self-Determination - Able to make good decisions independently."
"Cognition - Good."

Resident 12's "Admission Care Plan" documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 355	Continued From page 14 "Capacity for self-care: Independent." "Pendant Wireless Call System: A wireless nurse call system is available based on desire/ability as a means for residents to summon staff outside of the ISP (individual service plan)." The care plan does not address Resident 12's ability/desire to hold a key to his/her bedroom. On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and Chief Operations Officer (COO) I. Surveyors asked if residents had access to keys for their room, so they did not have to rely on staff to open their doors. COO I and Administrator A stated we are a memory care center and the resident, or the resident representative have never asked for a key. Surveyors asked if Resident 12 had to rely on staff to open his/her door, because it was locking when s/he left his/her room. COO I stated, "[Resident 12] must be locking it when [s/he] leaves [his/her] room." Administrator A stated s/he would discuss the option with POA J.	N 355		
N 364	83.33(3) Assistance with grievance procedures The CBRF shall assist residents with grievance procedures as required under this section. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident received assistance when it was reported that Resident 7's EZ stand sling was missing. Findings include: On 03/13/2024, at approximately 2:00 PM, Surveyor interviewed Resident 7's Power of	N 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 364	Continued From page 15	N 364		

Attorney (POA) F. POA F stated, "I believe it was October when [Resident 7] was issued a new sling. The sling goes under [his/her] 'seat' as [s/he] has no strength in [his/her] legs or shoulders. Anyways, it was brand new, put [his/her] name on it and staff never used it. Said they didn't know how to use it. So, [Physical Therapist (PT) G] took the sling and went out front where staff were sitting and showed them how to use the sling. We never saw it again. When I questioned it, staff said they had a spare they could use. Every time I visit, 'their' sling is rolled up in a ball thrown in this corner, nobody knows where [his/her] new sling is. I don't ask anymore." Surveyor observed the providers sling rolled up and lying on the floor next to the television.

On 03/13/2024, at approximately 2:30 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was not aware of the concern but stated s/he was new to the facility. Administrator A stated s/he would ask staff to look for it.

On 03/16/2024 at 10:04 AM, Surveyor emailed Chief Operations Officer (COO) I and stated there were concerns with Resident 7's missing EZ stand sling. COO I stated s/he was not aware of a missing sling but would investigate.

On 03/21/2024 at 10:13 AM, COO I emailed Surveyor and stated Resident 7's sling was found in a linen closet. The sling would be laundered and placed back into Resident 7's room.

On 03/22/2024, at approximately 9:05 AM, Surveyor was contacted by a representative for Resident 7's physical therapy which stated it had been documented that Resident 7's sling had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 364	Continued From page 16 been missing in his/her notes since 02/13/2024. Surveyor requested Resident 7's physical therapy documentation. On 03/22/2024, at approximately 9:40 AM, Surveyor interviewed Resident 7's managed care organization Registered Nurse (RN) H. RN H stated, "[Resident 7] has an EZ stand, and I know PT (physical therapy) had trained staff on sling. I was not aware that the sling was misplaced, that was a brand-new sling!" On 03/23/2024, at approximately 2:30 PM, Surveyor interviewed Administrator A and COO I. Surveyor explained that Resident 7's sling had been missing since at least 02/13/2024, based on interviews, and the sling was not located until Surveyors investigated. COO I stated s/he understood. On 03/25/2024, Surveyor reviewed Resident 7's physical therapy documentation which stated: "02/13/2024 [PT G]: PT has implemented transfer training and home exercise program. ALF (adult living facility) educated in correct use of EZ stand with appropriate sling. Patient's sling is not in [his/her] room, but facility has a spare they can use until they are able to find his." On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and COO I. COO I stated the physical therapist did not follow proper grievance procedure when the sling went missing. COO I stated when state made them aware of the missing sling, they began an investigation and located the sling.	N 364		
N 383	83.35(1)(c) Listed areas for assessments.	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 383	Continued From page 17 Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the resident assessment, at a minimum, included all the areas applicable to the resident risks, including, the use of adaptive equipment.	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 383	Continued From page 18 Findings include: This facility can provide cares for up to 40 residents in the client groups: irreversible dementia, Alzheimer's, advanced aged, terminally ill, and physically disabled. On 03/23/2023, at approximately 2:30 PM, Surveyor observed the following 2 residents utilizing bedrails in their rooms: -Resident 1, had 1 quarter bedrail in the up position. -Resident 10, had 1 quarter bedrail in the up position. Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings: "Individualized Patient Assessment Any decision regarding bed rail use or removal from use should be made within the framework of an individual patient assessment. If a bed rail has been determined to be necessary, steps should be taken to reduce the known risks associated with its use. Sleeping environment assessment This assessment includes elements or conditions that may affect the patient's ability to sleep and may be considered in evaluating areas to address in a patient's care plan. Treatment Programs/Care Plans -Address diagnoses, symptoms, conditions, and/or behavioral symptoms for which the use of a bed rail is being considered. -Identify nursing/medical and environmental interventions (e.g., for a patient with a life-long habit of staying up at night, provide nighttime	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 383	Continued From page 19	N 383		

activity).
-If clinical and environmental interventions have proven to be unsuccessful in meeting the patient's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment should be in the patient's medical chart.
-The team should review the treatment program and determine its effects on the patient through an ongoing cycle of evaluation that includes assessment of outcomes and adverse effects.
-When planning care for the patient for whom a low bed is selected, consideration should be given to potential effects on the patient such as restraining desired voluntary movement or creating an unwanted psychological effect by being placed close to the floor. The individualized care plan and risk benefit considerations should address these issues and the plan modified accordingly." (Source: Restraints- Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings., 2003, https://www.dhs.wisconsin.gov/regulations/assisted-living/standards.htm (retrieval date- March 25, 2024).)

On 03/18/2024, Surveyor reviewed Resident 1's and Resident 10's record.

Example 1: Resident 1

Resident 1 moved into the facility, 02/14/2022, with diagnosis including depression.

Resident 1's "Change in Condition: Care Plan," dated 01/10/2023, documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 383	Continued From page 20	N 383		

Bed Mobility - Full Assist: Is not able to reposition [him/herself] in bed. Staff will assist with repositioning every two hours while awake.

Resident 1's "Annual Assessment," dated 01/01/2024, documented:
Bed Mobility - Full Assist: Is not able to reposition [him/herself] in bed. Staff will assist with repositioning every two hours while awake.

Example 2: Resident 10

Resident 10 moved into the facility, 11/22/2023, with diagnoses including malignant neoplasm of cerebral meninges (tumors that develop from the membrane that covers the brain and spinal cord - brain tumor), cerebral edema (brain swelling), and Type 2 diabetes.

Resident 10's "30 Day Assessment," dated 12/21/2023, documented:
Bed Mobility - Independent: Resident is able to move freely in bed, rolling from side to side, independently adjust position in bed.

Resident 10's "Observations" documented:
"03/11/2024 - Staff to reposition every 2 hours ..."
"03/04/2024 - Monitor for any seizure like activity."
"02/26/2024 - Encourage repositioning every 2 hours."
"02/15/2024 - Patient has been leaning to the side, if [s/he] is leaning even with broad chair reclined and it is unsafe for patient then patient will have to remain in bed for safety."
"02/12/2024 - Patient was put in broad chair today, [s/he] did not realize that [s/he] was in [his/her] new chair. [S/he] is pleasantly confused today."
"01/29/2024 - concerns with behaviors and agitation."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 383	Continued From page 21 "01/26/2024 - Resident is very confused today and doesn't know what [s/he] wants." Resident 10's bedrail assessment was not updated as s/he displayed a decline in cognition. On 03/23/2024, at approximately 2:30 PM, Surveyor interviewed Administrator A and Chief Operations Officer (COO) I. COO I stated Resident 1 and Resident 10 had the bedrails upon admission and would follow up with hospice to determine if a bedrail assessment had been completed. On 03/25/2024 at 8:43 AM, COO I emailed Surveyor and stated, "I wanted to circle back regarding the bed rail assessments you had requested we provide. After careful thought and review of the regulations, this is not required to be completed however we do review every resident's bed mobility in their pre-admission assessment, COC (change of condition) assessment and yearly assessment. This is also included in their care plan. On 03/25/2024 at 9:08 AM, Surveyor emailed COO I and stated that due to a bedrail being considered a potential restraint, an assessment needed to be completed. COO I stated, "Okay, I can provide you the assessments we complete that do discuss bed mobility. Everyone that currently has a side rail has had them for quite a while and it was never mentioned in any of our other state surveys."	N 383		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written.	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 388	Continued From page 22	N 388		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not follow 2 of 2 resident Individual Service Plan (ISP) as written.

Resident 7 was documented on his/her ISP that s/he was to be encouraged fluids throughout the day for urinary tract infection (UTI) prevention. Resident 7's water cup was not placed within reach for him/her to utilize. Resident 7 is a fall risk and would have to self-transfer to reach the water cup.

Resident 11 was documented in his/her ISP to remain hydrated, but s/he did not have a water cup available to him/her in his/her room.

This is a repeat deficiency. See Statement of Deficiency (SOD) GNOK11, dated 02/17/2022.

Findings include:

The provider is licensed to care for up to 40 residents in the client groups terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's.

Example 1: Resident 7

On 03/13/2024, at approximately 1:50 PM, Surveyor observed Resident 7 and his/her Power of Attorney (POA) F, in Resident 7's bedroom. Upon entrance, Surveyor observed Resident 7 sitting in his/her recliner chair, next to the window and his/her water cup sitting on a table, close to the television. Resident 7 would have to self-transfer to reach the water cup. Surveyor asked Resident 7's Power of Attorney (POA) F if this was a normal occurrence. POA F stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 388	Continued From page 23	N 388		

"Yes, when staff assist him/her to move to his/her recliner chair, they do not make sure s/he has everything that s/he needs; and when staff come in to check on him/her, they do not ask about his/her water. I usually move it towards him/her when I get here."

On 03/13/2024, at approximately 2:30 PM, Surveyor interviewed Administrator A. Surveyor explained the observation in Resident 7's room. Administrator A stated s/he would discuss this concern with staff members as that was unacceptable. Administrator A stated, "[Resident 7] is unsteady on [his/her] feet and is unable to ambulate independently. We would not want [him/her] having to get up to get [his/her] water."

On 03/18/2024, Surveyor reviewed Resident 7's record.

Resident 7 was admitted to the facility, 11/10/2021, with diagnoses included dementia, anxiety, and chronic obstructive pulmonary disease (COPD).

Resident 7's "Care Plan," undated, documented:
"Hydration/Nutrition Pass: A care team member will offer a snack in the afternoon as well as early evening which will include a beverage to assist with hydration."
"UTI Prevention: Encourage fluids throughout the day."
"Transfer: Requires assistance of 1 staff with sit-to-stand lift at all times due to increased weakness."
"Behavior/Anxiety: Trying to get [him/herself] up"

Resident 7's "Annual Assessment," dated 01/14/2024, documented:
"Hydration/Nutrition Pass: A care team member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 388	Continued From page 24	N 388		

will offer a snack in the afternoon as well as early evening which will include a beverage to assist with hydration."
"Transfer: Requires assistance of 1 staff with sit-to-stand lift at all times due to increased weakness."
"Behavior/Anxiety: Trying to get [him/herself] up"
"Fall Risk 2 - Moderate Risk: There is a sign in [his/her] room reminding [him/her] to push pendant for assistance. 07/01/2023 fell trying to get a pillow off floor. Bed to be in lowest position possible to prevent injury from falls. continue purposeful rounds. 09/16/2023 attempted to transfer [him/herself]. Has reminder to use pendant, on purposeful rounds. eventually sent out for eval, treatment implemented during week for UTI treatment. 09/28/2023 fell during transfer with staff. Two assist for all transfers, if weak/unable to stand staff must use easy stand."

Example 2: Resident 11

On 03/26/2024, the Department received a concern that residents were not provided water cups to maintain hydration while in his/her room.

On 03/38/2024, Surveyor reviewed Resident 11's record.

Resident 11 moved into the facility, 03/18/2024, with diagnosis including dementia.

Resident 11's "Pre-Admission Assessment," dated 02/15/2024, documented:
"Hx (history) dehydration, dehydration leads to falls."
"Fall Risk: Fall in last 3 months: Dehydration, Fx (fracture) 5 L (left) ribs"

Resident 11's "Care Plan" documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 388	Continued From page 25	N 388		

"Hydration/Nutrition Pass: Give snack and beverage. 10:30 AM, 4:00 PM, 7:00 PM. Remain hydrated."

On 03/28/2024, at approximately 10:50 AM, Surveyor interviewed Resident 11's Power of Attorney (POA) J. POA J stated s/he had been in contact with Administrator A regarding his/her concerns on how often Resident 11 was receiving water throughout the day. POA J stated staff provided Resident 11 with water to take his/her medications but did not leave a cup/mug of water for her/him to utilize throughout the day. POA J forwarded Surveyor the email s/he had sent Administrator A that identified this concern.

On 03/29/2024, at approximately 11:30 AM, Surveyor interviewed Resident 11's POA J. POA J stated Resident 11 still did not have a water cup in his/her room for staff to fill. POA J stated s/he had been told by Administrator A that large cups with lids/straws were to be distributed to residents. The staff were to make sure they were checked a couple of times a day to see if residents were drinking enough. They were to remind residents to drink water and refill them as needed. Resident 11 still had not received one as of 03/25/2024. POA J stated s/he had not been able to visit recently as s/he had been ill. Resident 12, Resident 11's spouse, had been providing Resident 11 with cups of water. Resident 12 had a Brita filtered water pitcher s/he kept in his/her refrigerator, as well as other drinks they can have.

On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A. Administrator A stated s/he would follow up on the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 408	Continued From page 26	N 408		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure that 1 of 2 resident's prescribed PRN (as needed) psychotropic medications were documented on the Individualized Service Plan (ISP). The ISP did not include a rationale for use, nor a detailed description of the behaviors, which indicate the need for administration. The provider did not ensure that the PRN psychotropic medications were monitored at least monthly for inappropriate use. Resident 14's PRN Clonazepam was not	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 408	Continued From page 27	N 408		

documented in his/her ISP and was not monitored.

Findings include:

On 03/13/2024, at approximately 4:00 PM, Surveyors and Administrator A reviewed the providers med carts and observed Resident 14's blister card of PRN Clonazepam which documented, "Take (1/2) to (1) tablet orally twice daily as needed for anxiety." Administrator A stated s/he would be contacting Resident 14's physician for further clarification as to when the resident should receive ½ tablet versus 1 tablet.

On 04/01/2024, Surveyor reviewed Resident 14's record.

Resident 14 was admitted to the facility 09/14/2023 with diagnoses including anxiety and dementia.

Resident 14's January, February, and March 2024 Medication Administration Record (MAR) documented:
"Clonazepam 0.5 MG tablet - Take (1/2) to (1) tablet orally twice daily as needed for anxiety. Start Date: 09/15/2023."
Administered 03/04/2024 at 7:55AM. No Rationale listed. No Effect listed.

Resident 14's "Observations," dated 01/01/2024 to 03/31/2024, documented 3 entries. The entry on 01/14/2024 stated, "I faxed [Resident 14's] DR (doctor) today regarding the possibility of getting [him/her] a depression medication. [Physical Therapy] brought it up to staff that [s/he] feels [s/he] is a bit depressed."

Resident 14's "Care Plan," undated, documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 408	Continued From page 28 "Medication Management: Receives assistance from staff to administer medication. Resident will continue to receive medication as ordered through next review." "Behavior Anxiety: Behavior: [Resident 14] does get tearful and anxious due to [him/her] not remembering things. [S/he] knows that [s/he] is forgetting things. [His/Her] [spouse] passed away in April 2023. [S/he] may not be able to verbalize what's bothering [him/her], but will be apparent by [his/her] facial expressions or say, "I don't know what I'm supposed to be doing," or "I'm waiting for the kids." [S/he] may have an unmet need. [S/he] may also have delusions or paranoia when introduced to new surroundings or stressors. Interventions: Staff to provide reassurance, redirection, provide one on one time with [Resident 14] when [s/he] is notably anxious or upset, [s/he] enjoys watching birds and is very social so inviting [him/her] to group activities ongoing daily is encouraged. Getting [him/her] physically active may also help redirect [him/her]. Staff to evaluate pain if anxiety not relieved by redirection." The care plan did not identify that resident is on PRN Clonazepam. On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and Chief Operations Officer (COO) I. COO I stated, "We have never been informed of this requirement during any previous surveys."	N 408		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 415	Continued From page 29	N 415		

administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure proper documentation on the Medication Administration Record (MAR) for 4 of 4 residents reviewed.

Resident 3's MAR contained blank marks where staff initials should have been recorded to document medication administration.
Resident 5's MAR did not correlate with remaining 'as needed' (PRN) Oxycodone tablets.
Resident 6's MAR contained blank marks where staff initials should have been recorded to document medication administration.
Resident 13's MAR did not correlate with remaining PRN Olanzapine (psychotropic medication) tablets.

Findings include:

On 03/13/2024, at approximately 4:00 PM, Surveyors observed the medication carts with Administrator A and observed the following:

Example 1: Resident 3

On 03/14/2024, Surveyor reviewed Resident 3's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 415	Continued From page 30 Resident 3's March 2024 MAR did not document the following medication administrations: 03/02 to 03/04 8:00 PM - Atorvastatin, cranberry, Eliquis, Levetiracetam, Metoprolol Tartrate, acetaminophen, Gabapentin, Oxycodone, Nystatin, Clotrimazole and Triamcinolone. 03/02 to 03/04, 03/08 5:00 PM - Metformin 03/06, 03/08, 03/11 2:00 PM - acetaminophen and Gabapentin On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and Chief Operations Officer (COO) I. COO I and Administrator A stated, "We have been putting new processing in place to review staff med administration processes." Example 2: Resident 5 Surveyors observed a blister pack of Resident 5's prescribed Oxycodone, with 3 remaining tablets, which documented: "Take (1) to (2) tablets orally every six hours as needed for pain." Surveyors also found a PRN blister card of acetaminophen 500 MG prescribed for pain. Administrator A stated s/he would be contacting Resident 5's physician for further clarification as to when the resident should receive 1 tablet versus 2 of Oxycodone and when staff should administer acetaminophen vs Oxycodone. Administrator A stated the 01/29/2024 date handwritten on the blister card represented when the blister card was put into the medication cart. On 03/14/2024, Surveyor reviewed Resident 5's record. Resident 5's January MAR, dated 01/29/2024 to	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 415	Continued From page 31	N 415		

01/31/2024, documented:
"Oxycodone Hcl 5 MG (milligram) tablet. Take (1) to (2) tablets orally every six hours as needed for pain. Start Date: 01/29/2024." This was listed twice on the MAR.
Administered:
01/29 at 7:36 PM. Reason: Hand Pain. Level of pain not recorded. Relief not recorded. Number of tablets administered not recorded.
01/30 at 11:14 AM. Reason: Leg Pain. Level of pain not recorded. Relief recorded as significant relief. Number of tablets administered not recorded.
01/31 at 4:37 PM. Reason: Hand Pain. Level of pain 0. Relief not recorded. Number of tablets administered not recorded.
01/31 at 11:39 PM. Reason: Arm Pain. Level of pain not recorded. Relief recorded as complete relief. Number of tablets administered not recorded.

Resident 5's February MAR documented:
"Oxycodone Hcl 5 MG tablet. Take (1) to (2) tablets orally every six hours as needed for pain."
Administered:
02/08 11:31 PM. Reason: Pain. Level of pain not recorded. Relief recorded as complete relief. Number of tablets administered not recorded.
02/13 2:33 PM. Reason: Pain. Level of pain: 5. Relief recorded as complete relief. Number of tablets administered not recorded.
02/15 10:26 PM. Reason: Pain. Level of pain not recorded. Relief not recorded. Number of tablets administered not recorded.
02/16 3:55 PM. Reason: Leg Pain. Level of pain 9. Relief recorded as no relief. Number of tablets administered not recorded.
02/19 11:53 AM. Reason: Back Pain. Level of pain not recorded. Relief recorded as some relief. Number of tablets administered not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 415	Continued From page 32	N 415		

recorded.
02/22 2:04 PM. Reason: Extreme Hand Pain. Level of pain 6. Relief recorded as complete relief. Number of tablets administered not recorded.
02/25 5:03 PM. Reason: Pain. Level of pain not recorded. Relief not recorded. Number of tablets administered not recorded.
02/27 9:15 PM. Reason: Leg Pain. Level of pain 10. Relief not recorded. Number of tablets administered not recorded.
02/28 6:56 PM. Reason. Leg Pain. Level of pain 10. Relief recorded as some relief. Number of tablets administered not recorded.

Resident 5's March MAR, dated 03/01/2024 to 03/13/2024, documented:
"Oxycodone Hcl 5 MG tablet. Take (1) to (2) tablets orally every six hours as needed for pain."
Administered:
03/03 7:40 AM Reason: Extreme Hand Pain. Level of pain not recorded. Relief not recorded. Number of tablets administered not recorded.
03/06 9:12 AM Reason: Extreme Hand Pain. Level of pain not recorded. Relief not recorded. Number of tablets administered not recorded.
03/07 10:30 AM Reason: Extreme Hand Pain. Level of pain not recorded. Relief not recorded. Number of tablets administered not recorded.
03/07 8:12 PM Reason: Extreme Hand Pain. Level of pain not recorded. Relief not recorded. Number of tablets administered not recorded.
03/09 1:16 PM Reason: Extreme Hand Pain. Level of pain not recorded. Relief recorded as some relief. Number of tablets administered not recorded.
03/11 2:02 PM Reason: Extreme Hand Pain. Level of pain 10. Relief recorded as minimal relief. Number of tablets administered not recorded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 415	Continued From page 33	N 415		

03/13 6:16 AM Reason: Extreme Hand Pain. Level of pain not recorded. Relief recorded as some relief. Number of tablets administered not recorded.

Surveyor counted 20 documented administrations. The Oxycodone blister pack originally had 30 tablets; there were 3 tablets remaining.

On 03/22/2024, at approximately 2:30 PM, Surveyor interviewed Administrator A and Chief Operations Officer (COO) I. COO I stated they would be reaching out to the pharmacy to determine how medication orders appear on the MARs. Administrator A stated additional training would be provided to staff on proper medication documentation.

Example 3: Resident 6

On 03/14/2024, Surveyor reviewed Resident 6's record.

Resident 6's March 2024 MAR did not document the following medication administrations:
03/01 to 03/04 8:00 PM - Allopurinol, Quetiapine, Tamsulosin, Carvedilol, Gabapentin

On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and Chief Operations Officer (COO) I. COO I and Administrator A stated, "We have been putting new processing in place to review staff med administration processes."

Example 4: Resident 13

Surveyors observed a blister pack of prescribed Olanzapine, with 19 remaining tablets, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 415	Continued From page 34 documented: "Take 1 tablet orally once daily as needed for agitation." Richard PRN Olanzapine - MARs document 6 doses - blister cards showed different. Richard PRN Olanzapine - Prescription 01/16 to 01/27 - administered 4 times - blister card shows different. Prescription changed to Once daily (scheduled) - 01/27 - left as a PRN - administered as a PRN on 02/08. March MAR - still technically listed under PRN medications - blister card still does not line up with documented administration. On 03/22/2024, at approximately 2:30 PM, Surveyor interviewed Administrator A and Chief Operations Officer (COO) I. COO I stated they would be reaching out to the pharmacy to determine how medication orders appear on the MARs. Administrator A stated additional training would be provided to staff on proper medication documentation.	N 415		
N 417	83.37(3)(a) Medication storage: original containers. Original containers. The CBRF shall keep medications in the original containers and not transfer medications to another container, unless the CBRF complies with all of the following: 1. Transfer of medications from the original container to another container shall be done by a practitioner, registered nurse, or pharmacist. Transfer of medication to another container may be delegated to other personnel by a practitioner, registered nurse or pharmacist. 2. If a medication is administered by CBRF employees	N 417		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 417	Continued From page 35	N 417		

and the medication is transferred from the original container by a registered nurse, or practitioner or other personnel who were delegated the task, the CBRF shall have a legible label on the new container that includes, at a minimum, the resident ' s name, medication name, dose and instructions for use. The CBRF shall maintain the original pharmacy container until the transferred medication is gone.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure medications were kept in the original container for 2 of 2 residents reviewed.

Findings include:

On 03/13/2024, at approximately 4:00 PM, Surveyors observed the medication carts with Administrator A and Business Development E.

Surveyors observed an empty box with a label that read:
"[Resident 4] - Albuterol HFA (Ventolin) (inhaler). Med Order ID: 598277306. Issued 10/15/2023."
Administrator A looked through the med cart and found a Ventolin inhaler and stated it belonged to Resident 4. The inhaler did not have a label on it.

Surveyors observed Resident 8's Fluticasone inhaler with a label that read:
"Inhale 1 puff orally twice daily - may not use after 30 days after removing from foil package."
The inhaler did not have a 'Date Opened' written on it.

Surveyors observed loose medications in the carts that could not be identified as they were located on the bottom of the med drawers, under the blister cards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 417	Continued From page 36 On 03/13/2024, at approximately 4:10 PM, Administrator A stated the medication should have been labeled appropriately and s/he would provide additional training to staff.	N 417		
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 observation, record review and interview, the provider did not ensure residents received timely assistance with personal cares. This is a repeat deficiency. See Statement of Deficiency (SOD) 2U5R12, dated 06/01/2023. Resident 2 did not receive routine assistance with incontinence care. Resident 7 did not receive assistance within 15 minutes of pressing his/her call light.	N 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 425	Continued From page 37	N 425		

Resident 11 did not receive routine assistance with incontinence care.

Findings include:

On 01/20/2024, the Department received a complaint alleging residents did not receive prompt care during episodes of incontinence.

Example 1: Resident 2

On 03/13/2024, at approximately 3:35 PM, Surveyor interviewed Resident 2's Power of Attorney (POA) B and Family Member (FM) K. Surveyor was informed that Resident 2 was new to the facility and was still adjusting. FM K stated, "Unfortunately, [Resident 2] deals with incontinence and [s/he] is usually wet when I arrive. I am usually here at least two days a week and I usually end up changing [him/her] because [s/he] is wet when I arrive. I used to assist with providing [her/him] cares before [s/he] moved in here, so I feel comfortable assisting [him/her] but it is frustrating that [s/he] is sitting in [his/her] incontinence. I have stripped [his/her] bedding also due to incontinence issues." Surveyor leaned down and smelled Resident 2's bedding, which had a strong aroma of what appeared to be incontinence of urine. Surveyor spoke with Resident 2 who cognitively did not understand the concerns that Surveyor had mentioned. POA B stated, "Like anywhere, you have really good staff and then you have some that are not. We have been working with [Administrator A] to address some of these concerns, but [s/he] is only one person. [S/he] is trying." POA B and FM K stated they did not want to create "waves with the staff, they just want [Resident 2] taken care of." Resident 2 does not understand to use his/her call light when s/he needs assistance toileting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 425	Continued From page 38 On 03/14/2024, Surveyor reviewed Resident 2's record. Resident 2 admitted to the facility, 02/06/2024, with diagnosis including dementia without behavioral disturbance. Resident 2's medical documentation documented: "12/22/2023 - Reason for visit: Urinary Incontinence (And bowel incontinence)" "Bladder Training: Care Instructions" Resident 2's "Pre-Admission Assessment," undated, documented: "Elimination: Recognizes need to void. Recognizes need to evacuate. Total Assist." Resident 2's "30 Day Assessment," dated 03/04/2024, documented: "Toileting Program - Full Assist: Hands on assistance and/or cuing as needed to main Q2 (every 2) hour while awake and 2x at NOC (time of sleep) toilet schedule. Assist with un/dressing wash/wiping, and changing incontinence products. Remove soiled products immediately. To remain clean, free of odor and breakdown." Resident 2's current "Care Plan" documented: "Personal Cares AM - Staff to complete peri-cares each morning to reduce risk of skin breakdown due to incontinence issues." "Personal Cares HS - Staff to complete peri-cares at bedtime to reduce risk of skin breakdown due to incontinence issues." "Toileting Program - Hands on assistance and/or cuing as needed to main Q2 hour while awake and 2x at NOC toilet schedule. Assist with un/dressing wash/wiping and changing	N 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 425	Continued From page 39	N 425		

incontinence products. Remove soiled products immediately. To remain clean, free of odor and breakdown."

On 03/13/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A. Administrator A stated family should not have to assist their "loved ones" with incontinence care and s/he would be addressing toileting schedules with staff.

Example 2: Call Lights

On 02/01/2024, the Department received a concern alleging that the facility was short staffed that affected resident cares.

On 03/22/2024 at 2:30 PM, Surveyor interviewed Administrator A and Chief Operations Officer (COO) I. Surveyor stated there were concerns about staffing levels and wait times when residents utilize their call pendent. Surveyor asked what the longest amount of time would be a resident should have to wait for assistance. COO I stated that 15 minutes would be ideally the longest time a resident should have to wait for assistance. COO I stated there was room for improvement.

On 03/22/2024, Surveyor randomly selected 6 resident (Resident 1, Resident 2, Resident 3, Resident 5, Resident 7, Resident 10) call light reports from Administrator A and COO I. Surveyor selected a resident that utilized his/her call light on an average basis.

Resident 7's February 2024 call light report documented 175 call light alarms in 29 days. Thirty-four alarms took 20 to 29 minutes to respond to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 425	Continued From page 40	N 425		

Fourteen alarms took 30 to 39 minutes to respond to.
Five alarms took over 40 minutes, with the longest timeframe being 60 minutes.

Resident 7's March 2024 call light report, dated 03/01 to 03/22, documented 89 call light alarms in 22 days.
Nine alarms took 20 to 29 minutes to respond to.
Six alarms took 30 to 39 minutes to respond to.
Three took over 40 minutes, with the longest timeframe being 56 minutes.

On 03/22/2024, at approximately 3:15 PM, Surveyor interviewed Resident 5. Resident 5 stated, "They don't like to help me. I usually call the main desk phone instead of pressing my call light. I just keep calling it so they don't forget about me. When you press a call light, you never know when they will show up."

Example 3: Resident 11

On 03/26/2024, at approximately 5:30 PM, Surveyor interviewed Resident 11's Power of Attorney (POA) J. POA J stated Resident 11 had only lived at the facility since 03/18 and s/he had concerns about the cares that Resident 11 received. POA J stated, "There has been a breakdown in communication in regards to when [Resident 11] is supposed to receive a shower. On Friday (03/22/2024), [Resident 11] loose stools, per text from [Administrator A]. I asked [Administrator A] to be sure someone assists [Resident 11] with wiping after bowel movements as [s/he] doesn't do that well, and I didn't want [him/her] getting a UTI (urinary tract infection). On Saturday (03/23/2024), [Resident 12 (Resident 11's spouse)] called me in the morning, stated that they had a virus and were quarantined

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 425	Continued From page 41	N 425		

to their rooms. The aide woke [Resident 11] up and [his/her] cloths and bed were full of diarrhea. They got [Resident 11] up to use the bathroom and then showered [him/her] and put [him/her] in clean cloths. [Resident 12] was concerned because there was feces on the carpet, bathroom floor and all over the toilet, and it hadn't been cleaned up. I called a little after 7pm to check on them. [Resident 12] said they still hadn't cleaned [Resident 11's] bathroom or carpet. On Sunday (03/24/2024) I visited and went to [Resident 11's] room about 1:20 PM, to put some items away that I had brought with me. There was feces on the carpet, bathroom floor, on the toilet seat and running down the outside of the toilet, pooling around it. The towels used the previous day for her shower were still on the shower bench and soiled cloths sitting in the basket under the sink. The odor was foul. An aide was in the hallway when I came out of [Resident 11's] room. I told them about the mess and asked that it be cleaned up right away, that it's been there since Saturday morning. [S/he] said, 'That's housekeeping's job and I don't think [s/he's] here today.' I took pictures of [Resident 11's] room and texted them to [Administrator A] around 2:50 PM." POA J forwarded the text message to Surveyor which read: [Administrator A], sorry to send this on a Sunday. I'm concerned about the condition of [Resident 11's] room has been left in. Apparently [s/he] was covered in feces yesterday morning. [S/he] was showered and changed, [his/her] sheets changed. However, there is feces on the carpet, bathroom floor and on the toilet, running down the outside of it. The feces has been stepped in and tracked. The bathroom smells and the towels weren't even picked up after [his/her] shower. I asked one of the aides about it around 1:00 today. [S/he] said that's housekeeping's job and [s/he's] not around today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 425	Continued From page 42	N 425		

The aide is sitting at the front desk resting [his/her] head on the desk. I realize it's not [his/her] job to clean, but this is gross. Not to mention, the virus [Resident 11] had is being spread by not being cleaned up and [his/her] room sanitized." Administrator A responded at 4:32 PM and stated, "I will absolutely deal with this first thing tomorrow! I'm reaching out to the PM (second shift) aides to go in and clean the bathroom now. We will have to use the carpet cleaner in any carpet stains which the aides can't access tonight. I'll make sure it's addressed." POA J explained s/he visited Resident 11 on Monday (03/25/2024). I checked Resident 11's room. The carpet had been cleaned but smelled like feces. Small pieces of feces still under the edge of the bed. Room smelled awful. Bathroom was not cleaned, wet towels remained from Saturday shower, as did laundry basket full of soiled clothing. I went to the front desk at about 1:20 PM as [Administrator A] was just heading out the door. I stopped [him/her] and said that no cleaning was done, it smelled awful, and I wanted it done right away. I said that I wouldn't allow my parents to live in unsanitary conditions and would pull them from the facility if services weren't improved. [Administrator A] said ok, then told staff to get the room cleaned right away. Housekeeping arrived to clean [Resident 11's] room at 1:56 PM. I had opened the window to air it out. The bathroom was cleaned, but used towels weren't removed and dirty laundry was still there. Green blanket used to cover [Resident 11] had feces on it. I put the red blanket on [his/her] bed and took the green one home to wash it.

On 04/01/2024, Surveyor reviewed Resident 11's record.

Resident 11 moved into the facility, 03/18/2024,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 425	Continued From page 43 with diagnosis including dementia. Resident 11's "Care Plan" documented: "Personal Cares AM (morning): Resident will receive assistance and oversight of personal cares daily through next review." "Personal Cares HS (hours of sleep): Resident will receive assistance and oversight of personal cares daily through next review." On 04/01/2024, at approximately 3:30 PM, Surveyors interviewed Administrator A and Chief Operations Officer (COO) I. COO I and Administrator A stated, "Staff should never tell a family member that 'it isn't their job.'" COO I stated that staff member was released from employment. Cross Reference: N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable	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 interview and record review, the	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 432	Continued From page 44	N 432		

provider did not ensure medication administration services, including procedures to assure the accurate administering of all medications, were provided to meet the needs of 2 of 2 residents.

Resident 11's and Resident 12's Medication Administration Record (MAR) was not reviewed to ensure required blood sugar checks were being completed.

Resident 12's Power of Attorney (POA) J was responsible for ordering his/her medications since the provider does not order medications from the veteran's administration.

Findings include:

On 03/26/2024, the Department received a complaint alleging residents who are diabetic are not monitored. The complaint alleged that resident representatives are responsible for ordering resident medications.

On 03/26/2024, at approximately 5:30 PM, Surveyor interviewed Resident 11's and Resident 12's Power of Attorney (POA) J. POA J stated Resident 11 and Resident 12 are diabetic and since they moved into the facility, 03/18/2024, their blood sugars (BS) had not been checked. POA J stated s/he was also informed after Resident 12 moved into the facility, that due to him/her receiving medications from the veteran administration (VA), s/he would have to order those medications as the provider is not responsible for those medications. Once the medications are received, the provider would send the medications to the contracted pharmacy to have the medications packaged into blister cards. POA J stated, "Do you know how much they are paying to live at that place, and they can't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 432	Continued From page 45	N 432		

even order the medications, which they state in their literature they can and express no concerns during the initial assessments."

On 04/01/2024, Surveyor reviewed Resident 11's and Resident 12's record.

Resident 11's "Pre-Admission Assessment," dated 02/15/2024, documented:
"Diabetic: Glucose Checks Q (every) day"
Resident 11's March 2024 Medication Administration Record did not document any blood sugar levels.

Resident 12's "Pre-Admission Assessment," dated 02/15/2024, documented:
"Diabetic - written on the top of the first page"
"Diabetic: Glucose Checks Q (every) day"

Resident 11's and 12's March 2024 Medication Administration Record did not document any blood sugar levels.

On 04/01/2024, at approximately 3:00 PM, Surveyors interviewed Administrator A and Chief Operations Officer (COO) I. Administrator A stated Resident 11's and Resident 12's POA was responsible for ordering Resident 12's medications from the VA as the process was difficult and communication was poor with the VA. Surveyor asked for clarification as to who would ultimately be responsible to ensure the medications for Resident 12 were received. Administrator A stated the POA, "could probably get the medications on a cycle to be automatically filled." Administrator A stated the provider had not received a physician order for the daily blood glucose checks for Resident 11 and Resident 12. Surveyor commented that the residents are diabetic, and the pre-admission assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 432	Continued From page 46 defined they were to check their blood sugar levels daily. Administrator A stated at the last medical appointment, the physician stated the blood sugar levels no longer needed to be monitored. Surveyor asked for that documentation. As of 04/02/2024 at 4:00 PM, Surveyors did not receive any additional documentation.	N 432		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure a living environment that was safe, clean, comfortable, and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) 2U5R12, dated 06/01/2023. Findings include: On 03/13/2024 at approximately 2:00 PM, Surveyors toured the facility. The following was observed while on tour of the facility: 1.) Resident 1's room had a strong urine like odor in the bathroom. There was a soiled chux (disposable) pad in the bathroom that had a very strong urine like odor. There was a chux pad on	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 481	Continued From page 47 Resident 1's bed, inside of a basin that had cookies in it, that was covered in nemesis. 2.) Resident 2's room had a very strong urine like odor in the bathroom. There were soiled linens sitting on top of the shower chair in the bathroom. 3.) Resident 3's room had brown soiled washcloths in the bathroom and a very strong urine like odor in the bathroom. The uncovered garbage was full of soiled briefs. On 03/13/2024 at approximately 2:18 PM, Surveyor shared findings with Administrator A. Administrator A stated s/he was aware that there were some changes that needed to be made. Administrator A stated the chux pad in Resident 1's room was from the day prior because Resident 1 was not feeling well and was vomiting. Administrator A took the chux pad and threw it in the garbage. On 03/13/2024 at approximately 3:10 PM, Surveyor interviewed Power of Attorney of Health Care (POAHC) B. POAHC B stated, "The facility always has an odor. Depends routinely sit in the garbage soiled. I brought in OdoBan to help with the strong odors in the room." POAHC B stated s/he visits the facility daily.	N 481		