STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/28/2026, the bureau of assisted living southern regional office conducted 2 complaint investigations at Hattie's Glen Waunakee a CBRF located in Waunakee, WI. As a result of this survey, 1 violation of DHS chapter 83 was issued. One of 2 complaints were substantiated. Census: 26	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was provided treatment adequate to his/her needs. From 02/18/2026 to 04/08/2026, staff documented observations of the following behaviors in Resident 1's chart, sexually inappropriate statements towards staff, verbal threats of violence towards staff, grabbing staff wrists, hallucinations of bugs on the walls, and throwing glass cups. On 04/22/2026, Staff documented Resident 1 experienced a significant change in condition. Resident 1 was asking people how to leave the facility. Resident 1 became agitated and triggered	N 353		

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

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N 353	Continued From page 1	N 353		

multiple door alarms and fire alarms while attempting to leave the building. Resident 1 threw a book holder and fire extinguisher while staff attempted to intervene.

On 04/27/2026 at 4:26 PM, Resident 1 attempted to elope from the second floor through an alarmed doorway to the south stairwell and fell down 4 steps. Staff discovered Resident 1 in the stairwell with his/her wheelchair on top of him/her at 5:06 PM. Resident 1 was sent to a local emergency room and diagnosed with an L2 vertebral fracture.

FINDINGS INCLUDE:

On 05/05/2026, the Department received a complaint regarding program services.

On 05/28/2026, Surveyor arrived at the facility for a complaint investigation.

RECORD REVIEW:

On 05/28/2026, Surveyor reviewed facility's self-report to the Department. The incident documented occurred on 04/17/2026. Executive Director A documented the following, "At Around (sic.) 4:30pm, [Resident 1] was on the west side of the building and opened up the Egress doors and rolled [his/her] chair down the first 4 stairs. A family on the west side of the building were first to respond to [Resident 1] then notified staff. Staff immediately called 911 Hospice and POA .Resident (sic.) was transported to Hospital(sic.) for evaluation... Resident has a urinary tract infection and fracture to [his/her] back L2 which is non operable. [S/He] does have a brace to wear. [Resident 1] will return admitted to [Name Of

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N 353	Continued From page 2 Hospice Provider] and hospital will control [his/her] pain. Staff at hospital able to get [him/her] to bear weight. [Resident 1] will return to Hospice services....Door Alarms replaced and moved up higher so residents cannot reach , More (sic.) frequent rounds,staff (sic.) educated on wandering residents, incident reporting, and who to contact, ordered more walkie talkies. Terminated 2 staff. Ordered mesh stop signs for all exit doors..." On 05/28/2026, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 01/19/2026. Resident 1 was admitted on Hospice services which were provided by a local Hospice skilled nursing agency. Resident 1's primary diagnosis was major neurocognitive disorder and chronic kidney disease. Resident 1 had an activated power of attorney. Under the subsection titled, "Falling Risk," the following was documented, "Resident is a fall risk per assessment fall 2/27 intervention educate on calling staff for assistance fall 3/1 intervention staff will round more frequently at noc to prevent self transfer to bathroomFloor (sic.) on 4/27 [s/he] is bedbound and has a fall mat with a low bed ..." On 05/282/2026, Surveyor reviewed Resident 1's observations notes. The following entries were documented: 1.) On 02/18/2026 at 6:02 AM, Caregiver E documented Resident 1 displayed sexually inappropriate behaviors towards staff. 2.) On 02/27/2026 at 5:13 AM, Caregiver E documented that Resident 1 was anxious and stating s/he saw bugs on the wall. Caregiver E documented Resident 1 appeared to calm down after s/he gave Resident 1 a mountain dew and a slim jim.	N 353		

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N 353	Continued From page 3 3.) On 03/12/2026 at 1:55 AM, Caregiver D documented, " ...staff informed writer that resident was throwing glass cups and had traveled down the hallway with two in [his/her[hands. Writer went down the hallways to talk to resident and resident motioned throwing the glass but didn't let go. When staff asked to take the glass resident said, "where do you want it" Right between your eyes?" ..." 4.) On 03/14/2026, Staff documented that Resident 1 refused personal cares by grabbing staff by the wrists. 5.) On 04/08/2026 at 2:10 PM, Caregiver F documented, " ...Resident was talking to staff, then out of nowhere resident made a verbal comment "I'm going to rip your head off [explicative]" then lead says "that's not okay" resident then said it to lead and then made another comment saying "You think you're a queen bee or something you're not" Then we thought we were going to get resident back into room resident came to med room and point at lead and said " I'm going to kill you" lead then shuts room. Resident then starts banging on the door ..." 6.) On 04/22/2026 at 9:28 PM, Caregiver G documented, "Resident 1 exhibited significantly escalated and atypical behaviors today. The cause of the behavior is currently unknown. During the incident, [Resident 1] asked [Initials] for directions to exit the building and proceeded to trigger multiple door and fire alarms. [S/He] displayed aggressive behavior towards both residents and staff, including throwing objects. [S/He] struck [Initials] with a book holder and threw fire extinguisher against the wall. While engaging in these behaviors, [Resident 1] sustained a cut to [his/her] right index finger ..." 7.) On 04/30/2026 at 12:12 PM, Executive Director A documented, " Resident returned back	N 353		

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N 353	Continued From page 4	N 353		

to the facility at 11:30am with L2 fracture. [s/he] will be currently wearing a TLSO brace until further notice. Resident will remain under hospice cares. [s/he] has skin tears to Right elbow, Right forearm and Right hand have bruises all over. Staff will need to monitor and do checks frequently ..."
8.) On 05/05/2026 at 12:50 PM, Caregiver E documented Resident 1 was longer responding to external stimuli and was entering end of life stage.

On 05/28/2026, Surveyor reviewed Resident 1's change of condition assessment signed by Executive Director A and Nurse C on 05/04/2026. Under the subsection titled, "Behavior Patterns," was documented that Resident 1 was, "Aggressive/Combative ...resident uses repeated sexual profanity during interactions especially when frustrated or when cares are provided [Resident 1] has difficulty expressing needs due to cognitive impairment and environmental stressors. Intervention: Staff to respond calmly and avoid escalating language .Offer choices to support autonomy and reduce frustration identify and reduce triggers where possible Provide (sic.) reassurance and validation of emotions ..." Under the subsection titled, "Falling Risk," the following was documented, "Resident is a fall risk per assessment fall 2/27 intervention educate on calling staff for assistance fall 3/1 intervention staff will round more frequently at noc to prevent self transfer to bathroomFloor (sic.) on 4/27 [s/he] is bedbound and has a fall mat with a low bed ..."

On 05/28/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 05/04/2026. According to the ISP, Resident 1 required full assistance from staff for ambulation, transfers, bathing, dressing, grooming and

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N 353	Continued From page 5	N 353		

toileting. Resident 1 required a wheelchair for mobility. Resident 1's behavioral plan instructed staff to encourage him/her to participate in treatment and activities. Resident 1's ISP wasn't signed by him/her or his/her APOA (Family Member B). Resident 1's ISP didn't document his/her psychotropic medications, or directives on when to administer them. Resident 1's ISP didn't document Resident 1 as a fall risk who was bedbound, required a floor mat, and might attempt to self-transfer due to cognitive impairment.

On 05/28/2026, Surveyor reviewed Resident 1's April 2026 medication administration record (MAR). Resident 1 was prescribed the following psychotropic medications:
1.) Bupropion HCl 150 mg XL tablet, scheduled once daily in the morning to treat anxiety.
2.) Lorazepam 0.5 mg tablet, scheduled once daily at bedtime for anxiety, sleep, or agitation.
3.) Sertraline 100 mg tablet, scheduled once daily to treat anxiety.
4.) Lorazepam 0.5mg tablet, as needed (PRN) up to 3 times daily for anxiety.

INTERVIEWS:

On 05/28/2026 at 10:00 AM, Surveyor reviewed facility investigation for the 04/27/2026 incident with Executive Director A. Surveyor reviewed the "Detailed Event Report," which documented the "South 2nd Floor Stairwell Door," alarm as sounding from 4:26 PM to 5:06 PM. Executive Director A acknowledged Resident 1 was in the stairwell unsupervised for the 40-minute window documented hurt. The facility investigation concluded there were 2 instances from 4:26 PM to 5:06 PM that a staff member had turned off the stairwell alarm without assessing the cause for

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N 353	Continued From page 6 the alarm. Executive Director A stated Caregiver G and Caregiver H did not follow the facility policy during this incident and their employment was terminated. Executive Director A also reported s/he now does a daily audit of door alarm with the "Detailed Event Report" and follows-up with staff to monitor resident wait times for care. On 05/28/2026 at 11:30 AM, Surveyor discussed the above concerns with Executive Director A and Nurse C. Executive Director A and Nurse C acknowledged that Resident 1 had major cognitive disorder, communication deficit, a fall risk and required full staff assistance for ambulation/transfers. Executive Director A and Nurse C acknowledged that Resident 1 displayed increased aggression and elopement risk from February 2026 until April 2026, and a behavioral plan to address his/her changes in condition was not implemented. Executive Director A and Nurse C acknowledged that Resident 1's ISP was last updated on 05/04/2026 and didn't document information on Resident 1's scheduled psychotropic medication, PRN psychotropic medication, verbal threats towards staff, grabbing staff wrists, sexually inappropriate behavior towards staff, throwing glad cups at staff, triggering door alarms, triggering fire alarms, exit-seeking, fall risk with interventions, and hallucinations of bugs on the walls.	N 353		