STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016902	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY OAKS ASSISTED LIVING	750 CAROLAN DR ALBANY, WI 53502

(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 06/03/2025, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation and standard survey at Albany Oaks Assisted Living, a CBRF located in Albany, WI. As a result of the investigation and survey, 1 deficiency of Chapter DHS 83 was issued. This is a repeat deficiency. See Statement of Deficiency (SOD) N1X511, dated 10/25/2023. Complaint was substantiated Census: 13	N 000		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) of 1 of 3 residents reviewed was followed. Resident 1's record indicated s/he had a pressure alarm as a fall prevention. Interview indicated that the pressure alarm was not in working order on 04/27/2025 during a fall for Resident 1. This is a repeat deficiency. See Statement of Deficiency (SOD) N1X511, dated 10/25/2023. Findings include: On 06/03/2025 at 9:00 a.m., Surveyor arrived at the facility to complete a complaint investigation. The complaint alleged concerns regarding the facility not following the ISP that resulted in a resident injury.	N 388		

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

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N 388	Continued From page 1 On 06/03/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 08/05/2024. Resident 1's ISP, dated 06/03/2025, indicated s/he was a high fall risk. The ISP stated that a pressure alarm was to be placed on the residents chair every morning when resident gets up, and place on bed before resident goes to bed to prevent falls. On 06/03/2025 at approximately 10:15 a.m., Surveyor reviewed the incident report dated 04/27/2025. Staff reported an unwitnessed fall at 07:15 a.m. Staff stated that they heard Resident 1 yelling for help. Staff found Resident 1 in front of his/her bed and was in a large amount of pain. Resident 1 was taken to the hospital. Records indicated that Resident 1 was diagnosed with a broken hip from the fall on 04/27/2025. On 06/03/2025 at approximately 11:30 a.m., Surveyor interviewed Executive Director A. Executive Director A stated that Resident 1 had the pressure alarm since 01/02/2025. Executive Director A said that the staff were placing the alarm on the bed and on the chair. Executive Director A stated that the alarm was working as far as s/he knew. Executive Director A stated that s/he believed the wires got bent when staff were placing the pressure alarm on the chair from the bed because they were folding it over. Executive Director A stated s/he bought 2 new alarms on 05/02/2025 after Resident 1 had a fall on 04/27/2025. On 06/03/2025 at approximately 12:20 p.m., Surveyor interviewed Caregiver B. Caregiver B stated s/he was not on shift when Resident 1 fell. Caregiver B stated that s/he always switched the	N 388		

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N 388	Continued From page 2 pressure alarm from the bed to the chair. Caregiver B stated that the alarm box had stopped working a couple days before Resident 1 fell. Caregiver B stated that Executive Director A was on vacation but did order the pressure alarm when s/he returned to the facility. On 06/03/2025 at approximately 1:00 p.m., Surveyor shared concern with staff following the ISP with Executive Director A. Executive Director A acknowledged concern with the pressure alarm not working during the fall that resulted in Resident 1's injury. Executive Director A stated that the facility has 2 pressure alarms now and they are working well since Resident 1 had returned to the facility.	N 388		