STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018316	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERSTONE MEMORY CARE INC	5100 SCHMIDT LANE GRAND CHUTE, WI 54913

(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 07/14/2025, Surveyor conducted a complaint investigation at Silverstone Memory Care Inc. The complaint was substantiated. One deficiency was identified. Census: 41	N 000		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the	N 328		

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

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N 328	Continued From page 1	N 328		

provider did not provide a 30-day written notice of involuntary discharge to a resident's legal representative.

Resident 1 exhibited threatening behaviors to him/herself and others, as well as eloped from the facility with staff present. Resident 1 was taken to the emergency room at the hospital and was not accepted back to the facility upon attempted discharge. Resident 1 remained at the hospital from 07/01/2025 through 07/10/2025 until s/he was discharged to a dementia stabilization unit. No notice of discharge was provided to Resident 1.

Findings include:

On 07/03/2025, the department received complaint information alleging a resident was not accepted back to the facility from the hospital.

On 07/14/2025, Surveyor conducted a complaint investigation.
At approximately 9:30 AM, Surveyor inquired with Director A whether s/he had any recent residents who were involuntarily discharged. Director A stated yes, Resident 1 was sent to the hospital on 07/01/2025, and was expected to discharge to a stabilization facility.

Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 06/26/2025 with diagnoses of unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cerebral aneurysm, and other specified disorders of bone density and structure. Resident 1 was able to make his/her needs known and had an activated Power of Attorney for Health Care.

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N 328	Continued From page 2	N 328		

Surveyor reviewed Resident 1's pre-admission assessment completed by Director A. Resident 1 was not identified as an elopement or wandering risk at the time of assessment. Resident 1 was known to walk his/her dog in his/her neighborhood at home daily. S/he was assessed as not having any behavior patterns that were harmful to self or others.

Surveyor reviewed Resident 1's incident report from 07/01/2025 at 2:11 PM with "Incident Classification Behavior - Danger to Self" listed. Surveyor noted Resident 1 physically and verbally aggressed towards staff and was exit seeking. Resident 1 successfully eloped from the building and had ran into traffic. Staff had followed and made multiple attempts to redirect and bring him/her back to the facility. Surveyor noted the report listed "Per PCP [primary care physician] took to ER [emergency room] for evaluation in hopes to send to get stabilized."

Surveyor reviewed Resident 1's observation notes and noted Resident 1 had exit seeking behavior and verbal aggression towards staff every day s/he was at the facility (06/26/2025-07/01/2025). Resident 1 voiced a desire to leave and made multiple attempts, and successful attempts to leave the building.

At approximately 10:00 AM, Surveyor interviewed Director A and Administrator B. Director A indicated Resident 1 had resided at the facility for approximately a week and his/her behaviors were not present or apparent upon his/her pre-admission assessment. Administrator B stated s/he had contacted Nurse Practitioner D who directed them to send Resident 1 to the hospital due to Resident 1 verbally threatening to kill staff and kill him/herself, as well as making

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N 328	Continued From page 3 attempts to run into traffic. Administrator B stated, "I needed [Resident 1] to be safe." Administrator B stated the hospital called on 07/02/2025 ready to discharge Resident 1 back to the facility since s/he was not accepted at a mental health facility. Administrator B said Resident 1 was not stable and could not take Resident 1 back until s/he was. Resident 1 was placed on a Chapter 55 hold in hopes to secure placement at a mental health facility. At approximately 10:42 AM, Surveyor interviewed Care Manager C who stated Resident 1 was making suicidal statements related to having a gun, but did not make others threats of suicidal ideation. Care Manager C stated Resident 1 was not identified as being unsafe to return home, back to the facility. Since Resident 1 had an activated Power of Attorney for Healthcare, s/he was not accepted to a mental health inpatient facility. Care Manager C stated Resident 1 required 1:1 in the hospital due to the elopement risk, but was able to be redirected. At approximately 10:55 AM, Surveyor interviewed Director A and Administrator B who acknowledged Resident 1 did not receive a 30-day written notice of involuntary discharge prior to discharging him/her and not accepting him/her back to the facility.	N 328		