STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 03/26/2024 with additional information gathered through 04/08/2024, Surveyors conducted six (6) complaint investigations at Helping Hearts in Luxemburg. On 04/04/2024, Surveyor conducted another onsite visit to the facility to investigate an additional complaint. As a result, 6 of 6 complaints were substantiated and 11 deficiencies were identified. Census: 18	N 000		
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 record review and interview, the provider did not ensure residents received medications as prescribed for Resident 4. Findings Include: On 02/19/2024, the Department received 2 complaints alleging concerns with residents not receiving medications as prescribed. On 04/02/2024 at 3:50PM, Surveyor reviewed Resident 4's physician's orders and February and March 2024 medication administration record (MAR). According to the February 2024 MAR, Resident 4	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 1 was prescribed citalopram 20mg - take one tab daily with a start date of 01/11/2024 and end date of 03/10/2024. Further review revealed the citalopram was not present on the March 2024 MAR. Surveyor could not find evidence of administration of citalopram for 03/01/2024 through 03/10/2024, or a physician's order discontinuing it sooner. On 04/04/2024 at approximately 3:00PM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A reported there were several issues obtaining Resident 4's physician's orders and medications upon his/her admission. Assistant Administrator A explained Resident 4 see's a physician at Oneida Community Health Center and experienced communication issues regarding the clarification of physician's orders. Assistant Administrator A confirmed Resident 4's physician's orders and medications have all been clarified. Cross Reference N0415 DHS 83.37(2)(d)) Documentation of Medication Administration Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 352		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or	N 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 358	Continued From page 2 disabilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure they provided a safe environment free of environmental hazards. Findings Include: On 04/03/2024, the Department received a complaint alleging unsafe conditions were present. On 04/04/2024, at 10:31AM, Surveyor toured the kitchen area with Licensed Practical Nurse E (LPN-E). Surveyor observed the cabinet under the kitchen sink and noted the following: -Heavy debris that appeared to be from an overflow. -Black splotchy areas that resembled mold on the walls and floors of the cabinet. -One d-CON No View, No Touch Covered Mouse Trap. -Small black pellets resembling mouse droppings. -Cabinet hinges were heavily coated in white crusty substance. On 04/04/2024 at 10:35AM, Surveyor toured the basement with LPN-E. Surveyor noted the following: -Just past the water heater and to the left, the corner of the ceiling was beginning to separate. -The separated portion of the ceiling was saturated in water and was brown in color. -Water was leaking down the wall on the left side of the separated ceiling piece. -Three paper towel rolls containing a substantial amount of black splotchy material on and inside the rolls.	N 358		

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	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

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HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 358	Continued From page 3 The Centers for Disease Control and Prevention stated the following regarding mold: "Molds are very common in buildings and homes. Mold will grow in places with a lot of moisture, such as around leaks in roofs, windows, or pipes, or where there has been flooding. Mold grows well on paper products, cardboard, ceiling tiles, and wood products. Mold can also grow in dust, paints, wallpaper, insulation, drywall, carpet, fabric, and upholstery .... Some people are sensitive to molds. For these people, exposure to molds can lead to symptoms such as stuffy nose, wheezing, and red or itchy eyes, or skin. Some people, such as those with allergies to molds or with asthma, may have more intense reactions ..." Information obtained on 04/04/2024 at 4:30PM from https://www.cdc.gov/mold/faqs.htm. On 04/04/2024, Surveyor interviewed Executive Director B. (ED-B). ED-B acknowledged the findings of the sink area. ED-B stated the contaminated paper towels will be removed immediately. Regarding the ceiling concern, ED-B reported there is an issue with some landscaping outside that holds water in that area. ED-B confirmed they are aware of the issue, and it is, "on the radar." Cross Reference N0490 DHS 83.44(2)(b) Toilet and Bathing Areas Cross Reference N0501 DHS 83.45(5) Garbage & Refuse Cross Reference N0502 DHS Comfortable and Safe Temperatures	N 358		
N 385	83.35(2) Temporary Service Plan.	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 385	Continued From page 4 Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written temporary service plan was prepared, upon admission, to meet the immediate needs for Resident 4. Findings include: The facility is licensed to care for 20 residents in the following client groups: terminally ill, irreversible dementia/Alzheimer's, advanced age and physically disabled. On 04/02/2024 at approximately 3:30PM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A confirmed Resident 4 was admitted on 01/10/2024. On 04/02/2024 at 4:15PM, Surveyor reviewed Resident 4's ISP dated 01/15/2024. The ISP was created five days after Resident 4 was admitted. On 04/04/2024 at approximately 3:00PM, Surveyors interviewed Executive Director B (ED-B). ED-B stated when a resident is admitted an initial ISP is developed based on the pre-assessment within the first 3 days. Resident 4's ISP was completed five days after admission. ED-B reported the temporary ISP was completed within 3 days, which contradicted the requirement of, upon admission.	N 385		

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	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 385	Continued From page 5 Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 385		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure individual service plans (ISP) for each resident (1) identified the resident's needs and desired outcomes, (2) identified the program services, frequency, and approaches, (3) established measurable goals with specific time limits for attainment and (4) specified methods for delivering needed care and who is responsible for delivering the care for Resident 1, Resident 4 and Resident 5. Findings Include:	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 386	Continued From page 6 On 04/01/2024 at 7:13PM, Surveyor reviewed ISPs for Resident 1, dated 03/01/2024, Resident 4, dated 01/15/2024, and Resident 5, dated 11/07/2023. The ISPs were completed on a document titled, "Sun Valley Homes LLC: Comprehensive ISP Assessment." The assessment had five sections including: activities of daily living, escalated behavior patterns, mental health, social participation, and independent living. Each section had a table that included used to identify certain cares needs. For example, activities of daily living included: eating, choking, special diet, oral care, dressing, grooming bathing, toileting, personal hygiene, walking/ambulation. The table was set up for the person completing the form to place an "x" or check mark next to the level of assistance needed, such as "independent, monitor and que, full assist, etc." Further review of the ISP's revealed there was no further information regarding desired outcomes, frequency, approaches, measurable goals with time limits for attainment or methods who is responsible for delivering the care. On 04/01/2024 at approximately 3:30PM, Surveyor interviewed Assistant Administrator A regarding the format and information included in the ISPs. Assistant Administrator A confirmed this is the form used to document the ISP. On 04/01/2024, at 7:13PM, Surveyor reviewed Resident 4's ISP dated 01/15/2024 and noted the ISP had columns for initial, 6-month review and yearly review. Resident 4's ISP had an "x" under "initial," with the date of 01/15/2024, indicating this was the temporary or initial ISP. There was no further documentation on the ISP to indicate	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 386	Continued From page 7 this was reviewed 30 days after admission for development of the comprehensive ISP. On 04/04/2024 at approximately 3:00PM, Surveyors interviewed Executive Director B (ED-B). ED-B reported in the future they plan to implement the use of the electronic record system, ECP. ED-B explained the ECP program will include all of the necessary information for the ISP. Cross Reference N0385 DHS 83.35(2) Temporary Service Plan Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure individual service plans (ISP) were signed by the resident or resident's	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 389	Continued From page 8 legal representative for Resident 1, Resident 3, Resident 4, Resident 5, Resident 6 and Resident 7. Findings Include: On 04/01/2024 at 7:13PM, Surveyor reviewed ISP's for Resident 1, Resident 4 and Resident 5. The ISP's had signature lines at the bottom but were not signed by the resident and/or their legal representative. -Resident 1 dated 03/01/2024 - Signed only by Assistant Administrator A. -Resident 4 dated 01/15/2024 - No signatures. -Resident 5 dated 11/07/2023 - Signed only by Assistant Administrator A. On 04/02/2024 at 4:02PM, Surveyor reviewed Resident 3's ISP was completed on 08/20/2022 and included Resident 3's signature. The ISP was updated on 05/08/2023 and indicated Resident 3's power of attorney was activated on 05/08/2023 due to experiencing a stroke on 05/07/2023. Upon Resident 3's return, the ISP was updated again on 06/12/2023 to add interventions for ambulation, toileting, bathing, and grooming. There was no signature from Resident 1's activated power of attorney for the updates on 05/08/2023 or 06/12/2023 to acknowledge their involvement, understanding and agreement with the ISP. On 04/02/2024 at 4:13PM, Surveyor reviewed Resident 6's dated 10/21/2022. The ISP was updated on 04/20/2023 to include changes regarding grooming. There was no signature from Resident 6's guardian after the ISP was updated on 04/20/2023 to acknowledge their involvement, understanding and agreement with the ISP.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 389	Continued From page 9 On 04/02/2024 at 4:19PM, Surveyor reviewed Resident 7's ISP dated 10/21/2022. The ISP was updated on 04/21/2023 to include changes regarding grooming. There was no signature from Resident 7's guardian after the ISP was updated on 04/20/2023 to acknowledge their involvement, understanding and agreement with the ISP. On 04/04/2024, at approximately 3:00PM, Executive Director B (ED-B). ED-B explained most of the time ISP meetings are held on the phone or by remote technology such as Zoom. The ISP is then emailed to the participants that need to sign and sent back. ED-B explained in the future they will be using the electronic system "ECP," which will allow for digital signatures. Cross Reference N0385 DHS 83.35(2) Temporary Service Plan Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan	N 389		
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 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.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at the time of medication administration, the person administering the medication or treatment documented administration of the medications and/or treatments for Resident 4, Resident 5 and Resident 8. Additionally, after administration of a PRN, the resident's response was not documented for Resident 4. Findings include: On 02/19/2024, the Department received two complaints related to medication administration. On 03/26/2024, Surveyors conducted an onsite visit to the facility. Surveyors requested Resident 4, Resident 5 and Resident 8's Medication Administration Record (MAR) for January 2024 through March 2024. On 04/01/2024, Surveyors received February and March 2024 MARs, but did not receive January 2024. On 04/04/2024, Surveyors received January 2024 MARs for Resident 4, Resident 5 and Resident 8. RESIDENT 4: On 04/02/2024 at 3:50PM, Surveyor reviewed Resident 4's February and March 2024 MAR and noted several areas that were not initialed by the person administering the medication. The medication and missing initials were noted on the following dates: Aripiprazole 15mg - take 15mg by mouth every	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 11	N 415		

morning:
8:00AM - 02/01, 02/02, 02/08, 02/09, 02/12, 02/29, 03/01, 03/03, 03/04, 03/12 and 03/24.

Buspirone HCL 10mg - take one tab by mouth three times daily:
8:00AM - 02/01, 02/02, 02/08, 02/09, 02/11, 02/12, 02/29, 03/01, 03/03, 03/04, 03/09 and 03/12.
2:00PM - 02/01, 02/07, 02/08, 02/11, 02/29, 03/01, 03/03, 03/04, 03/12, 03/13, 03/14 and 03/27.
8:00PM - 02/06, 02/07, 02/11, 02/22, 02/29, 03/01, 03/02, 03/04, 03/05, 03/06, 03/07, 03/08, 03/09, 03/10, 03/11, 03/12, 03/13 and 03/14.

Citalopram 20mg - take one tab by mouth daily:
8:00AM - 02/01, 02/02, 02/08, 02/09, 02/11, 02/12 and 02/29.

Fluoxetine HCL 10mg - take one cap with 20mg cap to = 30mg daily in the morning:
8:00AM - 02/01, 02/02, 02/08, 02/09, 02/11, 02/12, 02/29, 03/01, 03/03, 03/04, 03/09, 03/12 and 03/24.

Fluoxetine HCL 20mg - take one cap with 10mg cap to = 30mg daily in the morning:
8:00AM - 02/01, 02/02, 02/08, 02/09, 02/11, 02/12, 02/29, 03/01, 03/03, 03/04 and 03/12.

Melatonin 3mg - take 2 tabs daily at bedtime:
8:00PM - 02/06, 02/07, 02/11, 02/22, 02/29, 03/01, 03/02, 03/04, 03/05, 03/06, 03/07, 03/08, 03/09, 03/10, 03/11, 03/12, 03/13 and 03/14.

Additionally, Resident 4's February 2024 MAR reflected s/he was administered hydroxyzine HCL 25mg on 03/25/2024 at 10:30PM for anxiety. There was no documentation of Resident 4's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 12	N 415		

response to the medication.

On 04/04/2024 at approximately 4:15PM, Surveyor reviewed Resident 4's January 2024 MAR and noted the following:

Resident 4 was administered hydroxyzine 25mg every 8 hours as needed on the following dates:
-01/21, 01/24,.01 28 and 01/29
-Twice on 01/22, 01/25, 01/26, and 01/27.

Further review of the MAR revealed no documentation of Resident 4's response to the medication.

Resident 4 was administered lorazepam 0.5mg 3 times daily as needed on the following dates:
-01/14, 01/15 and 01/17
-Twice on 01/11, 01/12, 01/13 and 01/16.

Further review of the MAR revealed no documentation of Resident 4's response to the medication.

RESIDENT 5:

On 04/02/2024 at 9:00AM, Surveyor reviewed Resident 5's February 2024 MAR and noted dates that were not initialed by the person administering the medication. The medication and missing initials were noted on the following dates:

Quetapine Tab 25 mg - take one-half tablet by mouth every morning - may take ½ tablet two times a day PRN.
8:00AM: 02/01/24, 02/02/24 and 02/04/24.

On 04/05/2024 at 7:30AM, Surveyor reviewed Resident 5's January 2024 MAR. Review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 13 January MAR revealed several dates not initialed by the person administering the medications for the following dates: Quetapine Tab 50 mg - take one-half tablet by mouth at 5 PM and take one and one-half tablet nightly at bedtime. 5:00 PM: 01/28/24 and 01/31/24. Rytary Cap 36.25/145 mg - take 1 capsule by mouth at 8:00AM, 11:00AM, 2:00PM, 5:00PM, 8:00PM. 11:00AM: 01/23/24, 01/28/24 and 01/31/24. 2:00PM: 01/27/24 and 01/31/24. 5:00PM: 01/14/24, 01/27/24, 01/28/24 and 01/31/24. RESIDENT 8: On 04/03/2024 at 4:18PM, Surveyor reviewed Resident 8's February and March 2024 MAR. Review of the MAR revealed several dates not initialed by the person administering the medications for the following: Tulicity INJ 0.75/.0.5ML - inject subcutaneously once a week: February: 02/20/24 March: There were no initials for the month of March 2024. On 04/04/2024 at approximately 3:00PM, Surveyors interviewed Assistant Administrator A. Assistant Administrator A reported acknowledged the findings and stated initialing the MAR has been discussed in staff meetings. Additionally, Assistant Administrator A reported s/he has removed certain caregivers from medication administration duties. Executive Director B explained in the future they plan to use the	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 415	Continued From page 14 electronic record system, ECP. Once ECP is in use, it will prompt the medication passer to enter the response to the as needed medications. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 415		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 431	Continued From page 15	N 431		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure health monitoring was completed for Resident 3 and Resident 8.

Findings Include:

On 02/27/2024 and 03/26/2024, the Department received complaints alleging the provider was not monitoring residents' health.

On 04/02/2024 at 4:02PM, Surveyor reviewed Resident 3's individual service plan was updated on 05/08/2024. The ISP identified Resident 3 experienced an intercranial hemorrhage on 05/07/2023.

On 03/26/2024 at 12:47PM, Surveyor interviewed Assistant Administrator A regarding how Resident 3's blood pressures are monitored. Assistant Administrator A reported the caregivers take the blood pressure and document it in the daily charting.

On 04/01/2024 at 5:30PM, Surveyor reviewed Resident 3's physician's orders. Surveyor noted an order dated 09/26/2023 that stated Resident 3's blood pressure should be checked weekly, and the physician should be updated if it is over 160/90.

On 04/01/2024 at 5:41PM, Surveyor reviewed Resident 3's Vital Signs Flow Sheet for January

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 431	Continued From page 16 2024 through March 2024. Review revealed blood pressures were only taken on 01/05/2024 and 02/26/2024. The Vital Sign Flow Sheet listed the following dates, but had no data for blood pressures: 01/10/2024, 01/18/2024, 01/22/2024, 01/31/2024, 02/07/2024, 02/15/2024, 02/21/2024, 03/05/2024, 03/13/2024 and 03/20/2024. On 04/03/2024 at 12:21PM, Surveyor interviewed Healthcare Power of Attorney D (HCPOA-D). HCPOA-D reported s/he was activated as the healthcare power of attorney for Resident 3 when s/he had a stroke in May 2023. HCPOA-D stated s/he recently asked to see a copy of Resident 3's blood pressures, but the provider was not able to provide he information. The same day of the request, HCPOA-D was visiting Resident 3. The caregiver attempted to take Resident 3's blood pressure, but the device being used was broken. HCPOA-D expressed concern the blood pressures are not being monitored as ordered by the physician. There was limited evidence presented to show evidence of Resident 3's blood pressures were being taken and monitored weekly. Due to no evidence of weekly blood pressure checks, it is unclear how the provider would know when to notify the physician of a blood pressure over 160/90. RESIDENT 8 On 03/26/2024 at 3:10PM, Surveyor interviewed Family Member C. Family Member C reported s/he is concerned the provider is not notifying the physician when Resident 8 has a low blood sugar reading. Family Member C reported Resident 8's blood sugar was low yesterday.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 431	Continued From page 17 On 04/02/2024 at 1:35PM, Surveyor Interviewed Family Member C again. Family Member C advised Resident 8 checks his/her blood sugar independently. Resident 8 writes it down in a pocketbook but does not share it with caregivers and they do not ask to see them. Family Member C confirmed the provider administers the insulin injection. On 03/26/2024 at 4:15PM, Surveyor interviewed Assistant Administrator A regarding how Resident 8's blood sugars are monitored. Assistant Administrator A stated they do not have any diabetic parameters for Resident 8's blood sugars. Assistant Administrator A advised they would treat with orange juice or glucose tablets it if was below 70. Assistant Administrator A explained when family members take residents to their appointments, they do not always update him/her on orders. On 04/01/2024 at 5:52PM, Surveyor reviewed Resident 8's physician's orders. Surveyor noted an order dated, 08/30/2023 that stated, "Blood Glucose Accu-Chek once daily." On 04/01/2024 at approximately 6:00PM, Surveyor reviewed Resident 8's February and March 2024 MAR. The MARs stated, "ACCU-CHEK TES GUIDE USE ONCE A DAY FOR DIABETES." There was handwritten note over the boxes caregivers would initial that stated, "does [his/herself]. Further review of the MARs revealed Resident 8 is administered a Trulicity injection - 0.75/0.5ML weekly by the provider's staff. On 04/02/2024 at approximately 10:30AM, Surveyor reviewed the Telephone Contact Summary from Resident 8's physician. Surveyor	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 431	Continued From page 18 noted the following contacts: 03/29/2024 at 2:50PM: "Patient [family member] calling to let you know that the patient had low blood sugars for the last 2 days. [s/he] states that [s/he] woke up on 3/28/24 and [his/her] blood sugar was 61 and quickly went doen [sic] to 58 at breakfast. [S/he] was given 2 glucose tablets and it came up. [Family Member C] states that [his/her] blood sugar was low again today and [s/he] was not given any tablets, but juice. [S/he] is concerned that the facility has not been notifying provider and wants to make [him/her] aware. [S/he] is wondering if this can be looked into [sic]. Please advise." 03/29/2024 at 2:58PM by the Advanced Practice Nurse Practitioner (APNP): "Would recommend that the facility update us if [s/he] is having blood sugars less than 60 and/or symptomatic ... Stop glimepiride." Review of the March 2024 MAR revealed Resident 8 was administered glimepiride 1mg on 03/30/2024 after the order to stop the medication. According to the Mayo Clinic, "Glimepiride is used to treat high blood sugar levels caused by type 2 diabetes ..." Information obtained on 04/03/2024 at 10:49AM from: https://www.mayoclinic.org/drugs-supplements/glimepiride-oral-route/side-effects/drg-20072155?p=1#:~:text=Glimepiride%20is%20used%20to%20treat,where%20it%20can%20work%20properly. On 04/04/2024 at approximately 3:00PM, Surveyor interviewed Assistant Administrator A and Executive Director B. Executive Director B confirmed if Resident 8 needs the provider to administer medications, they should also be	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 431	Continued From page 19 responsible for obtaining blood sugars. Assistant Administrator A reported Family Member C conveyed Resident 8 wants the blood sugar taken at the exact same time every day. Resident 8 fears if the provider obtains the blood sugars, it will not happen at the exact time. Assistant Administrator A stated s/he would meet with Resident 8 and the family to discuss the need for the provider to obtain the blood sugars. Resident 8 was checking his/her blood sugars independently. Family Member C expressed concerns the provider does not correspond with Resident 8 to obtain the blood sugar readings. Assistant Administrator A verified if Resident 8's blood sugar if below 70 they would treat; however, this would require the provider to have knowledge of Resident 8's blood sugar checks. Additionally, on 03/29/2024, the APNP discontinued the medication glimepiride due to the low blood sugars reported by Family C, but it was administered on 03/30/2024 and 04/01/2024 through 04/04/2024. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication Cross Reference N0415 DHS 83.37(2)(d)) Documentation of Medication Administration	N 431		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu.	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 450	Continued From page 20 This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure deviations from the planned menu were documented. Findings Include: On 02/19/2024 and 02/27/2024, the Department received complaints alleging concerns with meals and menus. On 03/26/2024 at approximately 8:50AM, Surveyor interviewed Resident 2. Resident 2 expressed frustration about the lunch meal that was served a day prior (03/25/2024). Resident 2 explained they were served half-warm white fish and rice that was not cooked thoroughly. On 03/26/20204 at 9:04AM, Surveyor interviewed Resident 3. Resident 3 expressed s/he gets frustrated because what is served for lunch and supper are never what is listed on the menu. On 03/26/2024 at approximately 10:10AM, Surveyor interviewed Assistant Administrator A regarding the menu. Assistant Administrator A explained to Surveyors the overnight shift is responsible for prepping the meals. The kitchen staff has a list for the week. The overnight shift has been failing to prep the meals, which leaves caregivers struggling to figure out an alternative to prepare. Administrator A reported residents were very upset about having fish instead the meal that was listed on the menu. Assistant Administrator A explained they were supposed to have ground beef and gravy, but the ground beef was left out for over 24 hours and was unusable. A	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 450	Continued From page 21	N 450		

substitution had to be made due to the ground beef being thrown out. Assistant Administrator A informed Surveyors on 03/17/2024, St. Patrick's day, they were supposed to have corn beef and cabbage for lunch. The overnight shift did not prepare this, so pizza was purchased instead.

On 03/26/2024 at approximately 11:00AM, Assistant Administrator A confirmed deviations are documented on the menu.

On 03/26/2024 at approximately 3:15PM, Surveyor reviewed the March 2024 menu posted in the hallway. The menu was blank from 03/01/2024 to 03/19/2024. On 03/28/2024 at 2:08 PM, Surveyor received a second March 2024 menu for 03/17/2024 - 03/31/2024. Surveyor noted two days where deviations were not documented.

This second menu received identified the lunch meal on 03/17/2024 was listed as Sloppy Joe's on Wheat Bread, French Fries, Broccoli, and Sherbert." The interview with Assistant Administrator A on 03/26/2024 at approximately 10:10AM, contradicted the menu as Surveyors were informed the intention was to serve corn beef and cabbage. There was no deviation documented on the menu.

Both March 2024 menus for 03/25/2024 listed lunch as, "Ground Beef and Gray Over Mashed Potatoes, Broccoli. The interview with Assistant Administrator A on 03/26/2024 at approximately 10:10AM confirmed fish was served instead, but there was no documented deviation on the menu.

On 04/04/2024 at approximately 3:00PM, Surveyors interviewed Assistant Director A and Executive Director B and they acknowledged the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 450	Continued From page 22 findings. No further information was provided.	N 450		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toilet and bathing areas were clean and in good working order which affected 18 of 18 residents at the facility. Findings include: On 02/27/2024, the Department received a complaint alleging concerns staff do not clean or empty garbages. On 03/26/2024 at 8:30 AM, Surveyors arrived at the facility. On 03/26/2024 at 8:50 AM, Surveyors interviewed Resident 1 and 2 who are a married couple and occupy two rooms, one of which is set up like a living room and the other like a bedroom. Resident 2 reported she was not feeling well last week and vomited in the garbage can in the bathroom. S/he stated the vomit was still in the garbage can from last week and staff have not emptied it or cleaned the bathroom. Resident 2 stated staff do not empty the garbage cans until they are told or they are overflowing with garbage. Resident 2 suggested for Surveyors to check the garbage in both of their bathrooms as they were both full. On 03/26/2024 at approximately 9:05 AM, Surveyors observed both bathrooms belonging to	N 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 490	Continued From page 23 Resident 1 and 2. Surveyors observed the following: 1) Toilets had dried feces and stains inside of the toilet 2) Toilet brush holders showed dust and possibly what appeared to be dried urine 3) Sinks had soap build up both inside and outside the sink 4) Garbage cans were full with used toilet paper that had brown-like stains and a foul smell 5) Splatter on the wall behind the garbage cans On 03/26/2024 at 9:26 AM, Surveyors interviewed Resident 8 who stated staff do not empty his/her bathroom garbage can. Resident 8 reported s/he has nightly incontinence issues and there were soiled briefs left in his/her bathroom garbage for four days. Resident 8 stated since staff do not empty his/her bathroom garbage, s/he takes care of it his/herself and sets it in the hall for staff to dispose of. Resident 8 stated staff will remove the garbage bag that s/he sets in the hallway, but do not remove it from his/her room on a daily basis. On 03/26/2024 at 10:50 AM, Surveyors observed a shared shower room on side 1 of the facility. Surveyors observed the shower room smelled of urine and the toilet had not been cleaned. Surveyors observed dried feces on the rim of the toilet seat and stains on the inside of the toilet. On 03/26/2024 at 11:00 AM, Surveyors interviewed Assistant Administrator A who acknowledged Surveyors findings. S/he stated the staff are supposed to clean and take out the garbage daily. Assistant Administrator A confirmed day shift should clean the bathrooms on side 1, second shift should clean the bathrooms on side 2 and night shift should clean	N 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 490	Continued From page 24 the hall bathrooms. S/he also confirmed staff have a shift duty checklist and s/he provided Surveyors with copies to review. Surveyors observed a daily tasks list for 1st shift which included but is not limited to: "cleaning side 1 bathrooms daily, vacuuming side 1 rooms/hallway 2-3 times per week and taking residents garbage out after toileting." Surveyors also observed a daily tasks list for 2nd shift which included but is not limited to: "emptying resident's garbage after toileting, side 2 bathrooms need to be cleaned daily, vacuuming side 2 rooms/hallway 2-3 times per week." Lastly, Surveyors observed a daily tasks list for 3rd shift which included but is not limited to: "cleaning public bathrooms (front and back) (sweeping, mopping, scrubbing toilets, emptying garbages)." On 04/04/2024 at approximately 3:00PM, Surveyors interviewed Assistant Administrator A and Executive Director B, and they acknowledged Surveyors findings. Cross Reference N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment Cross Reference N0501 DHS 83.45(5) Garbage & Refuse	N 490		
N 501	83.45(5) Garbage & refuse. Garbage and refuse. The CBRF shall dispose of garbage and refuse. Garbage and refuse in inside areas shall be kept in leak-proof, non-absorbent closed containers. Garbage and refuse in outside areas shall be in closed containers. This Rule is not met as evidenced by: Based on observation and staff interview, the	N 501		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

(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 501	Continued From page 25	N 501		

provider did not keep garbage and refuse in outside areas in closed containers to properly contain refuse.

Findings include:

On 02/27/2024, the Department received a complaint alleging concerns the outside dumpster was overflowing with garbage.

On 03/26/2024 at 8:30AM, Surveyors arrived at the facility. One of two dumpsters located outside the facility was observed to have an open lid and contained plastic garbage bags filled with refuse. Surveyors observed the dumpster was overflowing with the lid unable to close. Additionally, garbage bags and other refuge was observed outside, on the ground, and near the dumpsters. The dumpster remained opened and refuge remained on the ground next to the dumpster from 8:30AM until 5:00PM.

On 03/26/2024 at 11:40AM, Surveyors interviewed Assistant Administrator A and discussed concerns related to the outdoor dumpster. Assistant Administrator A verified the dumpster lid was not closed and overflowing with refuge. Assistant Administrator A stated the garbage is supposed to be picked up every week and the recyclables every two weeks. Assistant Administrator A reported s/he has asked Executive Director B for a bigger dumpster and was hopeful they would be getting one soon.

On 03/26/2024 at 2:30PM, Surveyors observed a cat below the dumpster eating refuge left on the ground.

On 03/26/2024 at 2:44PM, Surveyors interviewed Executive Director B who stated they previously

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HEARTS ASSISTED LIVING LLC	143 SCHOOL CREEK TRL LUXEMBURG, WI 54217

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N 501	Continued From page 26 contacted the garbage company requesting a larger dumpster and more pick up times, but they have not heard back. On 04/04/2024 at 3:00PM, Surveyors interviewed Executive Director B who stated, "We have pick up one time a week. I just don't know how many more times we can pick it up. I don't know if it was a one-time situation. One time circumstance. We discussed and we feel someone was using our dumpster." Cross Reference N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment Cross Reference N0490 DHS 83.44(2)(b) Toilet and Bathing Areas	N 501		
N 502	83.46(1)(a) Comfortable and safe temperatures A CBRF shall maintain comfortable and safe temperatures. The CBRF shall provide tempered air at all times to eliminate cold air drafts. The heating system shall be capable of maintaining temperatures of 74º F. in areas occupied by residents. This Rule is not met as evidenced by: Based on observations and resident and staff interviews, the provider did not maintain a temperature of 74 degrees Fahrenheit in areas occupied by residents. Findings include: On 03/26/2024 at 8:50AM, Surveyors observed	N 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015336	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 502	Continued From page 27 Resident 1 and Resident 2 in their room, sitting in recliner chairs wearing sweatshirts and covered with blankets. During an interview, Resident 1 and 2 indicated their room is always drafty and cold and stated, "There is never any heat. It's always 68 degrees in here no matter what. We freeze all the time." Resident 1 stated they have complained to management about the lack of heat, but nothing changes. Resident 1 and Resident 2 confirmed they have to leave their door open so they can get warm air from the hallway because it gets so cold in their room. Surveyors noted a draft and how much cooler it was compared to other areas of the building. While Surveyors were interviewing Resident 1 and Resident 2, Surveyor set a thermometer down on a shelf nearby. Surveyors checked the thermometer approximately 15 minutes later and observed the temperature of Resident 1 and 2's room to be 69.9 degrees Fahrenheit. Resident 1 and 2 reported they have two rooms in the facility and use one of the rooms as their living room and the other room as their bedroom. Resident 1 and 2 suggested for Surveyors to check out the temperature in their bedroom as it was even colder. Resident 1 and 2 reported their bedroom was just down the hall on the same side as their living room. Surveyors exited Resident 1 and 2's living room and observed a thermostat in the hallway across from their room. Surveyors observed a temperature on the hallway thermostat of 71 degrees Fahrenheit. On 03/26/2024 at 9:20AM, Surveyors went to Resident 1 and 2's second room which was identified as their bedroom and where they sleep. Surveyors observed a clock hanging on the wall that included a temperature gauge. Surveyors observed the temperature gauge on the clock and it indicated a room temperature of 68	N 502		

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N 502	Continued From page 28 degrees Fahrenheit. Surveyors noted the room was also cooler than the rest of the building. On 03/26/2024 at 11:40AM, Surveyors interviewed Assistant Administrator A and Executive Director B. Assistant Administrator A stated s/he was aware it was colder on "side 1" of the building and confirmed s/he tried to raise the temperature, but it goes back down to 71 degrees. Assistant Administrator A verified the thermostat in the hallway controls the temperature in resident rooms. Executive Director B indicated they will have maintenance look at the thermostat and adjust it. On 04/04/2024 at approximately 11:40AM, Surveyor observed the thermostat was set at 69 degrees. Surveyor entered Resident 1 and Resident 2's shared room. Resident 2 was sitting in a recliner under a blanket. Resident 2 confirmed s/he was cold and the thermostat never holds at the right temperature. On 04/04/2024 at approximately 3:00PM, Surveyors interviewed Assistant Administrator A and Executive Director B. Assistant Administrator A reported s/he thought one of the residents was tampering with the thermostat. Executive Director B stated they will purchase a cover for the thermostat. Cross Reference N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment	N 502		