STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020580	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG ASSISTED LIVING (THE	5669 WILSHIRE DR FITCHBURG, WI 53711

(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 11/06/2025, Surveyors conducted a complaint investigation at Courtyard at Fitchburg Assisted Living, a CBRF in Fitchburg. Two deficiencies were identified. One deficiency was a repeat deficiency - See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025, SOD WYGZ12, dated 04/22/2025 and SOD WYGZ13, dated 06/26/2025. The complaint was substantiated. Census: 38	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 Resident 2 received all medications as prescribed. Resident 2 received Spironolactone 50 mg and Furosemide 40 mg after they had been discontinued. This is a repeat deficiency - See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025, SOD WYGZ12, dated 04/22/2025 and SOD	N 352		

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

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N 352	Continued From page 1 WYGZ13, dated 06/26/2025. Findings include: On 11/06/2025 at 10:45 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 07/19/2024 with diagnoses including hypertension and stage 3 chronic kidney disease. Resident 2's physician orders included Spironolactone 50 mg (Start Date: 07/31/2025) - Take 1 tablet by mouth in the morning and Furosemide 40 mg (Start Date: 06/02/2025) - Take 1 tablet by mouth in the morning. Resident 2's observation notes indicated s/he had recently been admitted to the hospital from 10/28/2025 to 11/03/2025. Surveyor reviewed Resident 2's hospital discharge summary paperwork, dated 11/03/2025, which had been faxed to the facility on 11/03/2025 at 12:34 p.m. Resident 2 had been admitted to the hospital with acute metabolic encephalopathy (altered brain function due to metabolic disturbances) and hyponatremia (low sodium). Resident 2's discharge medication list indicated his/her spironolactone 50 mg and furosemide 40 mg should be stopped. Resident 2's Observation Notes, dated 09/01/2025 to 11/06/2025 included the following entries: -11/02/2025 at 1:45 p.m. (Wellness Director H): " ...writer spoke to [doctor] ...only changes to medications is [sic] they are currently holding [Resident 2]'s Lasix; informed [doctor] we would need orders faxed to [pharmacy] and to us to make sure we administer orders as prescribed ..." -11/03/2025 at 1:00 p.m. (Vice President (VP) of Clinical Operations C): " ...Resident to return	N 352		

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N 352	Continued From page 2 between 1300 (1:00 p.m.) and 1330 (1:30 p.m.). All new/updated orders being sent to [pharmacy] and faxed to community." On 11/06/2025 at 12:00 p.m., Surveyor reviewed Resident 2's medication administration record (MAR) dated 11/01/2025 to 11/06/2025 and noted the following: -Spironolactone 50 mg at 8:00 a.m.: Documented as administered on 11/04/2025, 11/05/2025, and 11/06/2025. -Furosemide 40 mg at 8:00 a.m.: Documented as administered on 11/04/2025, 11/05/2025, and 11/06/2025. On 11/06/2025 at 12:10 p.m., Surveyor shared concerns about Resident 2's medication administration with Executive Director A, Regional Wellness Director B, and VP of Clinical Operations C. VP of Clinical Operations C indicated medication orders were sent to the pharmacy for review. The pharmacy entered the orders and they show up in the facility's electronic health system. VP of Clinical Operations C indicated the order to discontinue Resident 2's spironolactone and furosemide came through from the pharmacy at 4:05 p.m. on 11/05/2025 and the medication cards were pulled from the cart. Regional Wellness Director B indicated the medications had been signed out that morning because the caregiver administering medications had not realized those medications were not in the cart and thought s/he had given them to Resident 2. Regional Wellness Director B indicated education would be given. Surveyor asked why the facility had to wait for the pharmacy to discontinue the orders when the facility had received the	N 352		

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N 352	Continued From page 3 discharge paperwork from the hospital indicating that the medications should be stopped. VP of Clinical Operations C indicated s/he would have to ask Wellness Director H when the discharge summary was received. Surveyor pointed out the fax time of 12:34 p.m. on 11/03/2025 on the discharge summary.	N 352		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision 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 adequate supervision to meet the needs of Resident 1 was provided. Resident 1 left the facility unsupervised and sustained injuries to his/her face. Findings include: On 11/06/2025, Surveyors conducted a complaint investigation alleging the provider did not provide adequate supervision or monitoring.	N 426		

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N 426	Continued From page 4 On 11/06/2025 at approximately 10:20 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 04/16/2024 and discharged on 10/20/2025. Resident 1's diagnoses included dementia. Resident 1 had an activated Health Care Power of Attorney (HCPOA). Resident 1's individual service plan (ISP), dated 05/29/2025, documented the following: - Supervision: 24-hour supervision checked. - Capacity for self-care: Needs some assistance checked. - Capacity for self-direction: Needs assistance checked. - Orientation/Decision Making: Oriented to Person. HCPOA is activated. Frequently experiences confusion and forgetfulness. Frequent safety checks throughout each shift. Resident 1's progress notes documented the following: - 10/09/2025 8:00 a.m.: [HCPOA G] called and stated that Resident 1 had called his/her [relation] 18 times between 3 a.m. and 6 a.m., resident had also called [HCPOA G] 8x yesterday asking for his/her checkbook. Resident is showing an increase in confusion. Informed [HCPOA G] that [provider] has not had any complaints, care staff had not mentioned any changes, but resident would be placed on 72 hour short-term monitoring to get provider's "eyes" on resident and monitor for confusion. - 10/09/2025 11:00 a.m.: "EMS brought resident back to facility after pedestrian called 911 after they witnessed [s/he] fell, Resident had large gulf	N 426		

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N 426	Continued From page 5 ball size swelling under right eye, dried blood on nose/mouth, resident denied any pain, resident reported [s/he] was going to walk to [his/her relation]'s house to visit [him/her], writer called [HCPOA] ... Per the 'sign out' sheet at the front desk, [Resident 1] signed out at 0940 and destination was [bank]. An incident report, dated 10/09/2025 at 10:00 a.m., documented Resident 1 was brought back to the facility via ambulance after s/he was observed on the ground after tripping over the sidewalk. The report documented Resident 1's right eye had moderate bruising and swelling and dried blood on the nose. Resident 1 was transferred to the emergency room for evaluation. The After Visit Summary, dated 10/09/2025, indicated Resident 1 was seen for facial lacerations with no treatment. On 11/06/2025 at 10:40 a.m., Surveyor reviewed pictures of Resident 1 following his/her fall. The pictures show Resident 1 with a bruise under his/her right eye, blood on his/her upper right cheek, blood on his/her nose and blood on his/her chin. On 11/06/2025 at 10:55 a.m., Surveyor reviewed the provider's sign out book, dated 08/07/2025 to 11/06/2025. Surveyor identified 1 sign out from Resident 1 on 10/09/2025 at 9:40 a.m. to the bank and 1 sign out from Resident 1 on 10/15/2025 for an appointment. The 10/15/2025 sign out appeared to be in different writing. On 11/06/2025 at 11:00 a.m., Surveyor interviewed Receptionist D. Receptionist D stated most residents residing in the facility were "free to go" or come and go from the facility as they wished.	N 426		

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Receptionist D stated there were a few residents that s/he didn't feel were appropriate to leave the facility on their own and if those residents attempted to leave s/he would either go for a walk with them or contact other staff. Receptionist D stated there was no formal list to follow regarding what residents needed supervision to leave and which residents didn't require supervision to leave. Receptionist D stated it would not have been common for Resident 1 to leave the facility on his/her own and that s/he always walked with him/her if s/he wanted to go for a walk.

On 11/06/2025 at 11:15 a.m., Surveyor interviewed Wellness Director H, Executive Director A, Regional Wellness Director B and VP of Clinical Operations C. Wellness Director H confirmed s/he spoke to HCPOA G on 10/09/2025 at 8:00 a.m. and placed Resident 1 on "72-hour short term monitoring" due to confusion noted by HCPOA G. Wellness Director H explained this meant staff were to document any abnormalities observed with Resident 1 each shift for the next 72 hours. VP of Clinical Operations C informed Surveyor it was not abnormal for residents, including Resident 1, to walk independently on and off the facility campus. Surveyor shared observation of 2 sign outs in the sign out log and asked if they had sign out records further back from 08/07/2025. VP of Clinical Operations C stated s/he wouldn't know where prior sign outs were.

On 11/06/2025 at 11:40 a.m., Surveyor interviewed Life Enrichment Director E. Life Enrichment Director E stated Resident 1 did not walk outside the facility by him/herself. Life Enrichment Director E stated Resident 1 preferred to be in his/her room and wasn't very social. Life Enrichment E stated

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N 426	Continued From page 7 the facility did not have a formal list of individuals that could leave the facility unsupervised, but agreed with Receptionist D's thoughts on who could and couldn't leave unsupervised. On 11/06/2025 at 11:45 a.m., Surveyor interviewed Receptionist F, who worked on 10/09/2025. Receptionist F stated s/he was covering for Receptionist D and s/he recalled Resident 1 state that s/he was going for a walk. Receptionist D stated s/he had never been told residents couldn't leave the facility on their own, but after Resident 1 returned to the facility s/he heard chatter than Resident 1 stumbled in the hallways and shouldn't have left alone. On 11/06/2025 at 12:10 p.m., Surveyors reviewed concern with Executive Director A, Regional Wellness Director B and VP of Clinical Operations C that the provider did not provide adequate supervision to meet Resident 1's needs, resulting in a fall and facial fractures. VP of Clinical Operations C stated residents in the facility were allowed to come and go as they pleased. Surveyor reviewed ISP that stated Resident 1 required 24-hour supervision and experienced confusion. VP of Clinical Operations C stated the 24-hour supervision was in regard to care needs and that if a resident required 24-hour supervision they would be appropriate for a nursing home where they can't have their door open.	N 426		