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 _____	01/28/2025

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 From 01/27/2025 to 01/28/2025, Surveyors conducted a standard survey at Courtyard at Fitchburg Assisted Living, a CBRF in Fitchburg. Five deficiencies were identified. Census: 43	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 1 of 3 residents reviewed received their medications as prescribed. Resident 1 did not receive his/her Humalog insulin as prescribed 28 times from 12/03/2024 to 01/27/2025. Findings include: On 01/27/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/14/2024 with diagnosis including diabetes. Resident 1's physician orders included Humalog 100 unit/ml (Start Date: 10/14/2024) 4 times daily with sliding scale at meals of <150=0 units, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, 400 or higher=Call Physician and sliding scale at	N 352		

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

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 bedtime of <200=0 units, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=4 units, >400=Call Physician. Resident 1's Medication Administration Record (MAR), dated 12/03/2024 to 01/27/2024, documented the following occurrences of Resident 1 receiving a dose that did not follow the physician's sliding scale order: - 12/03/2024 9:51 p.m. Blood Sugar 387 - 5 units of insulin administered. *Per order, 4 units of insulin should have been administered. - 12/04/2024 8:40 p.m. Blood Sugar 304 - 4 units of insulin administered. *Per order, 3 units of insulin should have been administered. - 12/12/2024 9:23 p.m. Blood Sugar 188 - 1 unit of insulin administered. *Per order, 0 units of insulin should have been administered. - 12/13/2024 8:27 p.m. Blood Sugar 373 - 5 units of insulin administered. *Per order, 4 units of insulin should have been administered. - 12/14/2024 7:51 a.m. Blood Sugar 325 - 3 units of insulin administered. *Per order, 4 units of insulin should have been administered. - 12/16/2024 9:00 p.m. Blood Sugar 273 - 3 units of insulin administered. *Per order, 2 units of insulin should have been administered. - 12/19/2024 8:56 p.m. Blood Sugar 257 - 3 units of insulin administered. *Per order, 2 units of insulin should have been administered. - 12/24/2024 6:06 p.m. Blood Sugar 268 - 4 units of insulin administered. *Per order, 3 units of insulin should have been	N 352		

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N 352	Continued From page 2	N 352		

administered.
- 12/25/2024 8:57 p.m. Blood Sugar 237 - 2 units of insulin administered.
*Per order, 1 units of insulin should have been administered.
- 12/26/2024 7:14 p.m. Blood Sugar 329 - 4 units of insulin administered.
*Per order, 3 units of insulin should have been administered.
- 12/29/2024 8:15 p.m. Blood Sugar 358 - 5 units of insulin administered.
*Per order, 4 units of insulin should have been administered.
- 12/31/2024 9:43 p.m. Blood Sugar 225 - 2 units of insulin administered.
*Per order, 1 unit of insulin should have been administered.
- 01/01/2025 8:25 p.m. Blood Sugar 192 - 1 unit of insulin administered.
* Per order, 0 units of insulin should have been administered.
- 01/02/2025 9:20 p.m. Blood Sugar 308 - 4 units of insulin administered.
*Per order, 3 units of insulin should have been administered.
- 01/04/2025 9:38 p.m. Blood Sugar 237 - 2 units of insulin administered.
*Per order, 1 unit of insulin should have been administered.
- 01/05/2025 8:19 p.m. Blood Sugar 322 - 4 units of insulin administered.
*Per order, 3 units of insulin should have been administered.
- 01/06/2025 8:13 p.m. Blood Sugar 340 - 4 units of insulin administered.
*Per order, 3 units of insulin should have been administered.
- 01/07/2025 8:17 p.m. Blood Sugar 400 - 5 units of insulin administered.
*Per order, 4 units of insulin should have been

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N 352	Continued From page 3 administered. - 01/08/2025 5:31 p.m. Blood Sugar 400 - 4 units of insulin administered. *Per order, 5 units of insulin should have been administered. - 01/10/2025 5:26 p.m. Blood Sugar 420 - 7 units of insulin administered. *Per order, physician should have been called. Record did not include documentation of physician correspondence. - 01/10/2025 8:10 p.m. Blood Sugar 348 - 4 units of insulin administered. *Per order, 3 units of insulin should have been administered. - 01/11/2025 7:49 p.m. Blood Sugar 271 - 3 units of insulin administered. *Per order, 2 units of insulin should have been administered. - 01/17/2025 9:18 p.m. Blood Sugar 195 - 1 unit of insulin administered. *Per order, 0 units of insulin should have been administered. - 01/18/2025 8:44 p.m. Blood Sugar 173 - 1 unit of insulin administered. *Per order, 0 units of insulin should have been administered. - 01/21/2025 9:23 p.m. Blood Sugar 217 - 2 units of insulin administered. *Per order, 1 unit of insulin should have been administered. - 01/23/2025 8:20 p.m. Blood Sugar 269 - 3 units of insulin administered. *Per order, 2 units of insulin should have been administered. - 01/24/2025 9:24 p.m. Blood Sugar 266 - 3 units of insulin administered. *Per order, 2 units of insulin should have been administered. - 01/25/2025 7:36 p.m. Blood Sugar 371 - 5 units of insulin administered.	N 352		

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N 352	Continued From page 4 *Per order, 4 units of insulin should have been administered. On 01/27/2025 at 12:35 p.m., Surveyors reviewed insulin administration concerns with Administrator A, Regional Vice President B and Regional Nurse C. Regional Nurse C stated the facility nurse should have audited insulin administration. Regional Vice President B stated the provider would ensure insulin administration was audited weekly moving forward.	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the needs, abilities and physical condition were assessed for 1 of 3 residents reviewed when there was a change in needs. Resident 2's physical condition and/or needs were not reassessed after sustaining falls. Findings include:	N 381		

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N 381	Continued From page 5 On 01/27/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 10/14/2024. Resident 2's progress notes, dated 10/27/2024 to 01/27/2025, documented that Resident 2 had sustained falls on 12/03/2024, 12/13/2024 and 12/20/2024. The progress notes did not document an assessment of Resident 2's physical condition after sustaining the fall or an assessment to determine if Resident 2 had a change in needs due to the fall. Resident 2's individual service plan (ISP), dated 10/27/2024, did not identify him/her as a fall risk or include fall intervention/prevention measures. On 01/27/2025 at approximately 12:00 p.m., Surveyor requested incident reports, assessments and/or any follow up documentation regarding Resident 2's 3 falls sustained in December. On 01/27/2025 at approximately 12:30 p.m., Administrator A followed up with Surveyor and stated s/he was unable to locate any follow up documentation related to Resident 2's 3 falls in December. Administrator A stated, "It looks like those were missed."	N 381		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication.	N 408		

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N 408	Continued From page 6 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 2 individual service plans (ISP) reviewed for residents that received a PRN psychotropic medication included the rational for use and a detailed description of the behaviors which indicated the need for administration of the PRN psychotropic medications. Resident 1's ISP did not include his/her use of Olanzapine PRN. Findings include: On 01/27/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/14/2024 with diagnosis including depression and anxiety. Resident 1's physician orders included Olanzapine 2.5 mg (Start Date: 10/24/2024) - Use daily as needed. Resident 1's ISP, dated 11/07/2024, did not include his/her use of Olanzapine PRN. Resident 1's Medication Administration Record (MAR), did not include the rational for use and a detailed description of the behaviors that warranted the administration of the	N 408		

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N 408	Continued From page 7 Olanzapine PRN. On 01/27/2025 at 12:35 p.m., Surveyors reviewed concern that Resident 1's ISP did not include the rational for use and a detailed description of behaviors that warranted the administration of his/her Olanzapine with Administrator A, Regional Vice President B and Regional Nurse C. Regional Vice Present B wrote down Surveyors' concern.	N 408		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the medication administration of 3 of 4 residents was documented. Resident 4 and Resident 1's unit dose of sliding scale insulin was not documented in the medication administration record (MAR). Resident 2's Rivastigmine patch was documented as administered when the medication was not available in the medication cart.	N 415		

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N 415	Continued From page 8 Findings include: Example 1 - Resident 4 On 01/27/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 08/22/2024 with diagnoses including diabetes. On 01/27/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 4's MAR for Insulin Lispro Kwik pen (Humalog 100 Units/ml) (Start Date 12/03/2024)- to inject 15 units subcutaneously 3 times a day in the morning, noon and evening ** If BS 201-250=+4U, 251-300=+6U, 301-350=+8U, 351-400=+10U, Over 400=+12U and call MD. Hold for BS less than 100. Surveyor reviewed Resident 4's MAR, dated 01/01/2025 to 01/27/2025, which did not document the amount of insulin units administered on the following dates: - 01/03/2025 11:19 a.m.: Blood Sugar 265 *Per order, 6 units of insulin should have been administered. - 01/06/2025 11:37 a.m.: Blood Sugar 206 *Per order, 4 units of insulin should have been administered. - 01/08/2025 11:06 a.m.: Blood Sugar 244 *Per order, 4 units of insulin should have been administered. - 01/10/2025 12:49p.m.: Blood Sugar 231 *Per order, 4 units of insulin should have been administered. - 01/13/2025 4:45 p.m.: Blood Sugar 220 *Per order, 4 units of insulin should have been administered. - 01/25/2025 1:09 p.m.: Blood Sugar 209 *Per order, 4 unit of insulin should have been administered.	N 415		

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N 415	Continued From page 9 On 01/27/2025 at approximately 12:30 p.m., Surveyor shared concern with Administrator A and Regional RN C regarding sliding scale insulin documentation. Surveyor asked who was monitoring the sliding scale documentation. Regional RN C stated that nursing audited medication orders. Regional RN C stated that the drop-down box to document the unit dose given was not checked for Resident 4, so staff were not triggered to document insulin administration in the electronic charting program. Regional RN C said, "the drop-down box is now fixed." Regional VP B stated that the facility would start monitoring sliding scale MAR's weekly and would review with staff in the staff meeting scheduled 01/28/2025. Example 2 - Resident 1: On 01/27/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/14/2024 with diagnosis including diabetes. Resident 1's physician orders included Humalog 100 unit/ml (Start Date: 10/14/2024) 4 times daily with sliding scale at meals of <150=0 units, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, 400 or higher=Call Physician and sliding scale at bedtime of <200=0 units, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=4 units, >400=Call Physician. Resident 1's Medication Administration Record (MAR), dated 12/01/2024 to 01/27/2024, did not document the amount of insulin units administered on the following dates: - 12/01/2025 5:46 p.m.: Blood Sugar 226 *Per order, 2 units of insulin should have been administered.	N 415		

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N 415	Continued From page 10 - 12/01/2025 9:42 p.m.: Blood Sugar 307 *Per order, 3 units of insulin should have been administered. - 12/02/2025 12:23 p.m.: Blood Sugar 204 *Per order, 2 units of insulin should have been administered. - 12/02/2025 4:59 p.m.: Blood Sugar 260 *Per order, 3 units of insulin should have been administered. - 12/02/2025 9:12 p.m.: Blood Sugar 286 *Per order, 2 units of insulin should have been administered. - 12/03/2025 8:20 a.m.: Blood Sugar 170 *Per order, 1 unit of insulin should have been administered. On 01/27/2025 at 12:35 p.m., Surveyors reviewed insulin administration concerns with Administrator A, Regional Vice President B and Regional Nurse C. Regional Vice President B stated the provider would ensure insulin administration was audited weekly moving forward. Example 3 - Resident 2: On 01/27/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 09/26/2024. Resident 2's physician order included Rivastigmine 4.6 mg/24 hour (Start Date: 12/21/2024) - Apply 1 patch topically in the morning. Remove old patch before placing a new patch. Resident 2's Medication Administration Record (MAR), dated 12/21/2024 to 01/27/2024, documented the administration of Resident 2's Rivastigmine 4.6 mg/24 hour on 12/26/2024, 01/06/2025, 01/07/2025 and 01/11/2025. The MAR documented 25 occurrences of the medication being unavailable.	N 415		

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N 415	Continued From page 11 On 01/27/2025 at approximately 12:00 p.m., Surveyors reviewed the provider's medication cart with Administrator A and Caregiver D. The cart did not include Resident 2's Rivastigmine. Caregiver D stated the provider was still waiting on authorization to obtain the medication from pharmacy. On 01/28/2025 at approximately 10:00 a.m., Surveyor interviewed Pharmacy E, who confirmed the provider's pharmacy has yet to provide the facility with Rivastigmine for Resident 2 because the pharmacy had not received prior authorization. Resident 2's record documented 4 administrations of Rivastigmine when the medication was not available for administration.	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	N 431		

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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.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 4 residents reviewed had their health monitored and recorded in their record. Resident 1 and Resident 3's blood sugars were not monitored and/or documented as ordered.

Findings include:

On 01/27/2025, Surveyors reviewed resident records and identified the following health monitoring concerns:

Example 1 - Resident 3:

On 01/27/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 3's facility record. Resident 3 was admitted to the provider's facility on 12/09/2024. Resident 3's physician ordered Insulin Aspart Flexpen 100 unit/ml injector pen (Start Date 12/09/2024) 3 times a day with meals per sliding scale 141-180=4 units, 181-220=6

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 _____	01/28/2025

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 431	Continued From page 13 units, 221-260=8 units, 261-300=10 units, 301-360=12 units, 361-400=14 units. Resident 3's Medication Administration Record (MAR), dated 01/01/2025 to 01/27/2025, indicated staff administered Insulin Aspart Felxpen sliding scale insulin subcutaneously 68 times. Staff did not document the blood sugars 63 of 68 times the insulin was administered. On 01/27/2025 at 12:35 p.m., Surveyors reviewed concern with Administrator A, Regional Vice President B and Regional Nurse C that Resident 3's blood sugar was not always documented. Regional Vice President B stated the provider would ensure insulin administration and blood sugar documentation was audited weekly moving forward. Example 2 - Resident 1: On 01/27/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/14/2024 with diagnosis including diabetes. Resident 1's physician orders included Humalog 100 unit/ml (Start Date: 10/14/2024) 4 times daily with sliding scale at meals of <150=0 units, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, 400 or higher=Call Physician and sliding scale at bedtime of <200=0 units, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=4 units, >400=Call Physician. Resident 1's Medication Administration Record (MAR), dated 12/01/2024 to 01/27/2025, did not document the blood sugar on 12/24/2024 at 7:52 p.m. when s/he was administered 4 units of insulin. On 01/27/2025 at 12:35 p.m., Surveyors reviewed insulin administration concerns with Administrator	N 431		

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 _____	01/28/2025

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 431	Continued From page 14 A, Regional Vice President B and Regional Nurse C. Regional Vice President B stated the provider would ensure insulin administration and blood sugar documentation was audited weekly moving forward.	N 431		