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 _____	R 04/22/2025

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 03/21/2025, with information gathered through 04/22/2025, Surveyor conducted a verificaton visit and 6 complaint investigations at The Courtyard At Fitchburg Assisted Living. Sixeen deficiencies were identified. Three of 16 deficiencies were repeat deficiencies (see Statement of Deficiency (SOD) WYGZ11). Six of 6 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 43	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not investigate and report an allegation of neglect for 1 of 1 resident. Resident 6, who is a standby assist with showering, was left unattended when Med Technician (MT) U left him/her to inform MT R, who was assisting Resident 12 on the first floor with toileting, that s/he was leaving because s/he did not want to work on floor 2. Findings include: Neglect, as defined in Wisconsin Statue 46.90(1)(f), is the failure of a Resident Care Aide to try to secure or maintain adequate care, services or supervision for an individual, including food, clothing, shelter, or physical or mental health care. Neglect can be an act, omission, or course of conduct and creates significant risk or danger to the individual's physical or mental health. On 03/20/2025, the Department received a concern that staff members are always fighting amongst themselves, in front of the residents. On 03/22/2025, at approximately 1:00 PM, Surveyor interviewed MT R and MT S. Surveyor asked if residents were affected by staff members fighting. MT R stated there was a situation where MT U left Resident 6 unattended in the shower because s/he was upset about being assigned to the second floor. MT R explained that s/he was assisting Resident 12 with toileting and MT U "storms into the restroom, going off about how [s/he] isn't putting up with this, [s/he] is not working where [s/he] was assigned. I am trying	N 158		

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N 158	Continued From page 2	N 158		

to calm [him/her] down and asked [him/her] to leave [Resident 12's] bathroom. Then [s/he] just left, so we were also down a caregiver then." MT R stated s/he finished up with Resident 12 and went to Resident 6's aid. MT R showed Surveyor a text message from Administrator A after s/he was informed MT U was leaving the facility, which documented:
"02/17/2025 06:37 AM - I'm sending a message so it gets to everyone - since no one wanted to get on the cart and [MT U] is now leaving, it'll be two up and two down. I am finishing my shower that I had to get out of because of all the calls and getting ready for work."
MT R stated s/he reported the concern to Nurse G and Administrator A. S/he was asked to fill out a statement and discussed the concern in detail with Nurse G and Administrator A. MT R stated, "[MT U] neglected Resident 6 and we are so lucky that [s/he] didn't fall."

On 04/02/2025, at approximately 12:30 PM, Surveyor observed Resident 6, who displayed unsteadiness when s/he ambulated, and interviewed Family Member (FM) T. Surveyor asked FM T if the family had been informed of a situation where Resident 6 was left unattended during a shower due to a staffing concern. FM T stated s/he had not heard of that situation but stated it would be concerning as Resident 6 requires full assistance during showers.

On 04/08/2025, Surveyor reviewed Resident 6's record which was provided by Regional Vice President of Operations (RVPO) B.

Resident 6 moved into the facility, 12/30/2024, with diagnoses including Parkinson's disease, essential tremor, and neurocognitive disorder.

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N 158	Continued From page 3	N 158		

Resident 6's "Care Plan," dated 02/13/2025, documented:
"Bathing: Requires physical assistance with showering weekly. Care staff to physically assist [Resident 6] with showering."

On 04/15/2025, at approximately 5:00 PM, Surveyor interviewed Resident 6's Power of Attorney (POA) V. Surveyor asked if the provider had discussed with them a concern regarding Resident 6 that involved potential neglect of him/her by a staff member. POA V stated s/he had not been informed.

On 04/16/2025, the Surveyor reviewed the department file and did not locate a written report of the allegation of neglect. Surveyor reviewed the Office of Caregiver Quality files and did not locate a written report regarding MT U leaving a resident unattended.

On 04/16/2025, Surveyor requested the internal investigation into this concern from RVPO B and Executive Director F.

On 04/17/2025 at 3:06 PM, RVPO B emailed Surveyor and stated, "Investigation on [MT U] leaving a resident - there are no documents to support this. [MT U] no longer works at the community as [s/he] no called no showed on 03/22/2025."

Surveyor noted Administrator A's last day of employment was 03/21/2025 and Nurse G left employment prior to that.

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed his/her investigation into the concern. RVPO B stated an investigation into the concern

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N 158	Continued From page 4 could not be located.	N 158		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department within 3 working days after law enforcement personnel were called to the facility because of an incident that jeopardized the health, safety, or welfare of residents or employees. On 02/08/2025, police responded to the facility due to an incident involving the de-escalation of 2 staff members who had become physically aggressive towards each other. Findings include: On 03/20/2025, the Department received a concern alleging law enforcement had responded to an altercation between staff members that occurred within resident view. On 03/21/2025, Surveyor requested 2025 law	N 164		

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N 164	Continued From page 5 enforcement records for the facility's address. On 03/24/2025, Surveyor reviewed the law enforcement record which documented: "On 02/08/2025, at approximately 3:56 PM, I was assigned to a pending call ... The caller stated that there was an attempted "jumping" that occurred around 1:50 to 2:20 PM between coworkers. Other works jumped in to avoid escalation. ... At around 1:50 p.m., [Med Technician HH] had come to the Courtyard Assisted Living and stated that [s/he] would like to visit a patient on hospice before they passed. What should be noted prior to this, is that both [Med Technician JJ] and [Med Technician HH] stated that they quit a few days prior to [Nurse G], the manager. [Nurse G] said that this was strange but not completely out of the ordinary. The one thing that [Nurse G] noted was that this was during shift changeover, which is why [Nurse G] believed that fighting was premeditated. [Med Technician HH] noticed [Med Technician II] who was checking into work and began following [him/her] through the building, yelling at [him/her], asking [him/her] when [s/he] got off work, in order to fight [him/her]. There is a video that shows [Med Technician HH] going into the room with [Med Technician II] as [s/he's] attempting to clock in. During this video, [Med Technician II] tells [him/her] multiple times, "If you want to fight, I'll be off at ten." During this interaction, you can hear [Med Technician HH] call someone and say that [Med Technician II] will be off at ten, but [s/he] "Can't wait until ten to handle this." At this point, a large argument between [Med Technician II], [Med Technician HH], [Med Technician JJ] (who came with [Med Technician HH]). Along with this, two unknown [name of color] [fe/males], who [Nurse G] believes to be [Med Technician HH]'s [sisters/brothers], attempted to enter the building	N 164		

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N 164	Continued From page 6 through the main doors. [Nurse G] believed that this was an attempt to, "Jump [Med Technician II]." [Nurse G] was able to push on the doors to keep both of the [boys/girls] out and then tell [Med Technician HH] to leave the premises immediately. [Med Technician HH] did comply with this. ..." On 03/24/2025, Surveyor reviewed the Department files to determine if a written report had been submitted and was unable to locate a report. On 04/14/2025, at approximately 1:00 PM, Surveyor interviewed Executive Director F. Executive Director F stated s/he was new to the company and understood that this incident should have been reported to the department. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed his/her investigation into the concern. RVPO B and Executive Director F took notes.	N 164		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days when 2 of 2 residents sustained an	N 165		

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N 165	Continued From page 7 injury or accident resulting in hospital admission. Resident 12 and Resident 13 sustained falls resulting in hospitalization. Findings include: Example 1: Resident 1 On 04/18/2025, Surveyor reviewed Resident 12's record provided by Regional Vice President of Operations (RVPO) B. Resident 12 moved into the facility, 07/22/2024, with diagnoses including Parkinson's disease, migraines with aura, and heart disease. Resident 12's "Incident Report," dated 11/18/2024, documented: "Staff heard someone calling for help. Staff searched for room, It was [Resident 12] staff entered and found [him/her] laying on the floor. Complained of left leg and hip hurting. ... Transported to hospital." Resident 12's "Observations," dated 07/01/2024 - 12/31/2024, documented: "11/14/2024 - [Resident 12] arrived back to facility yesterday after being in rehab post hip fracture/hip replacement surgery." On 04/18/2025, Surveyor reviewed Resident 12's hospice documentation provided by his/her hospice provider, which stated: "01/21/2025 - Related conditions: ... history of recent right hip fracture (October 2024, Right hip Fracture s/p ORIF of R hip fx (person who has a right hip fracture who has undergone open reduction and internal fixation) and history of left hip fracture (November 2024, s/p (status post)	N 165		

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N 165	Continued From page 8 surgery) ..." On 04/18/2025, Surveyor reviewed the Department file and noted that written reports had not been submitted to the Department regarding Resident 12's falls, which resulted in hospitalization in 10/2024 and 11/2024. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed his/her investigation into the concern. RVPO B and Executive Director F took notes. Example 2: Resident 13 On 04/02/2025, Wednesday, at approximately 1:20 PM, Surveyor observed emergency medical technicians (EMTs) transport Resident 13 out of the building. Surveyor overheard staff state Resident 13 had sustained a fall. On 04/06/2025, Surveyor reviewed Resident 13's record provided by Regional Vice President of Operations B. Resident 13 moved into the facility, 08/08/2024, with diagnoses including anxiety, chronic pain and tremors. Resident 13's "Observations" documented: "04/02/2025 1:30 PM, written by Wellness Director W - [Resident 13] fell in [his/her] room while trying to get out of the chair and move with [his/her] walker in [his/her] room. [S/he] became dizzy and fell backwards. [Resident 13] denied hitting [his/her] head but c/o (complained of) pain to [his/her] right hip and left knee. There were notable bruising on [his/her] lower left shin. EMS (emergency medical service) was called and [s/he] was taken to [hospital]."	N 165		

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N 165	Continued From page 9 On 04/13/2025, at approximately 1:00 PM, Surveyor interviewed Executive Director F. Executive Director F stated Resident 13 had not discharged back to the facility. Executive Director F reviewed Resident 13's record in the electronic computer system and stated an update regarding Resident 13's status had not been documented. On 04/13/2025, Surveyor reviewed the Department file and noted that a written report had not been submitted to the Department regarding Resident 13's fall, which resulted in hospitalization. On 04/16/2025 at 12:10 PM, Surveyor emailed Regional Vice President of Operations B and Executive Director F and asked for clarification regarding Resident 13's fall and if the provider had submitted a written report to the department regarding the fall. On 04/17/2025 at 3:06 PM, Regional Vice President of Operations B emailed Surveyor and stated Resident 13's fall had not been reported to the department. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed his/her investigation into the concern. RVPO B and Executive Director F took notes.	N 165		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF.	N 196		

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N 196	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the provider complied with all laws governing the CBRF (community-based residential facility). Findings include: The provider received a probationary license on 06/27/2024, as a class CNA (nonambulatory) CBRF able to serve up to 72 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 03/21/2024, with information gathered through 04/22/2024, Surveyors conducted a verification visit and 6 complaint investigations at The Courtyard at Fitchburg Assisted Living. Sixteen deficiencies, including this one, were identified: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0164 83.12(4)(b) Reporting When Law Enforcement is Called N0165 83.12(4)(c) Reporting Incidents With Serious Injury N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0309 83.29(1)(c) 30 Day 83.29(1)(c) Written Notice of Changes N0352 83.32(3)(h) Rights of Resident: Receive Medication - This is a repeat deficiency. N0388 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 83.35(3)(d) Service Plans Updated Annually or On Changes	N 196		

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N 196	Continued From page 11 N0396 83.36(1) Adequate Staff to Meet Resident Needs N0408 83.37(1)(i) PRN Psychotropic Medication - This is a repeat deficiency. N0410 83.37(1)(k) Medication Error or Adverse Reaction N0415 83.37(2)(d) Documentation of Medication Administration - This is a repeat deficiency. N0432 83.38(1)(h) Medication Administration N0449 83.41(2)(b) Nutrition: Meals Y3234 50.09(1)(e) Treatment Review of facility records documented a previous survey event identifying noncompliance, as follows: SOD WYGZ11 - dated 01/28/2025 On 01/27/2025, with information gathered through 01/28/2025, Surveyors conducted a standard survey at Courtyard at Fitchburg Assisted Living. The survey identified five deficiencies. N0352 83.32(3)(h) Rights of Resident: Receive Medication N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments N0408 83.37(1)(i) PRN Psychotropic Medication N0415 83.37(2)(d) Documentation of Medication Administration N0431 DHS 83.38(1)(g) Health Monitoring On 02/05/2025, the provider received a "Notice and Order" letter documenting: SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that	N 196		

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N 196	Continued From page 12 Courtyard at Fitchburg Assisted Living: PROBATIONARY LICENSE: 1. Based on the results of the Department's investigation, and pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., the licensee will correct all violations identified in Statement of Deficiency WYGZ11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License. IF the licensee has not achieved substantial compliance with all laws and administrative rules governing the facility and its Operations BND IF the violations identified in Statement of Deficiency WYGZ11 remain substantially uncorrected, the PROBATIONARY LICENSE for The Courtyard at Fitchburg Assisted Living may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE for The Courtyard at Fitchburg Assisted Living, 5669 Wilshire Drive, Fitchburg, WI 53711. This NOTICE is provided in accordance with: - Wis. Stat. § 50.03(4m)(b), whereby, if the applicant for licensure as a community-based residential facility has not been previously licensed under this subchapter or if the community-based residential facility is not in Operations Bt the time application is made, the department shall issue a probationary license. Prior to the expiration of a probationary license, the department shall evaluate the community-based residential facility. In evaluating the community-based residential facility, the department may conduct an inspection of the community-based residential facility. If, after the department evaluates the community-based residential facility, the department finds that the community-based residential facility meets the	N 196		

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 _____	R 04/22/2025

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

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N 196	Continued From page 13 applicable requirements for licensure, the department shall issue a regular license under sub. (4)(a)1.b. If the department finds that the community-based residential facility does not meet the requirements for licensure, the department may not issue a regular license under sub. (4)(a)1.b. - Wis. Admin. Code § DHS 83.08(2), whereby the Department shall deny a probationary license or regular license to any applicant who does not substantially comply with any provision of Wis. Admin. Code ch. DHS 83 or Wis. Stat. ch. 50. On 04/18/2025 at 3:10 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) B and Executive Director F. Surveyor discussed his/her investigation into the concerns identified. RVPO B stated s/he understood, and processes were being reviewed and implemented.	N 196		
N 309	83.29(1)(c) 30 day written notice of changes Services and charges. Written notice of any change in services or in charges. The CBRF shall give the resident or the resident ' s legal representative a 30-day written notice of any change in services available or in charges for services that will be in effect for more than 30 days. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident (Resident 5) or his/her legal representatives were given a 30-day written notice of a change in charge for services that would be in effect for more than 30 days.	N 309		

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N 309	Continued From page 14 Findings include: On 03/18/2025, the Department received a concern that resident's level of care fees were being increased without notification. On 04/16/2025, at approximately 8:30 AM, Surveyor interviewed Resident 5's Power of Attorney (POA) Z. POA Z stated Resident 5 had been reassessed from a Care Level I to a Care Level II and then s/he had received a notice stating that care level of fees were going up at the beginning of the year, 01/2025. POA Z stated s/he was not notified of what changes in care level caused the increase or what change of condition Resident 5 experienced to cause a change in care level. On 04/16/2025, Surveyor reviewed Resident 5's record provided by Regional Vice President of Operations (RVPO) B. Resident 5 moved into the facility 03/29/2024. Resident 5's provider invoices documented: Fees based on number of days in a month. 04/01/2024 - Care Level I - $1,470 - $49.00/day 05/01/2024 - Care Level I - $1,519 06/01/2024 - Care Level I - $1,470 07/01/2024 - Care Level I - $1,519 08/01/2024 - Care Level I - $1,519 09/01/2024 - Care Level I - $1,470 10/01/2024 - Care Level I - $1,519 Credit of ($539.00). Care Level II - $759.00 11/01/2024 - Care Level II - $2,070 - $69.00/day 12/01/2024 - Care Level II - $2,139 01/01/2025 - Care Level II - $2,139 02/01/2025 - Care Level II - $1,932 03/01/2025 - Care Level II - $2,139	N 309		

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N 309	Continued From page 15 Resident 5's record contained a letter labeled, "Lease Increase Effective 01/01/2025," which documented: "Your monthly care service fee will increase to $51.00" Resident 5's care service fell increased to $69 a day starting 11/01/2024. On 04/16/2025 at 9:49 AM, Surveyor emailed Regional Vice President of Operations (RVPO) B requesting the notification that Resident 5's POA Z received regarding the increase in care level fees. On 04/17/2025 at 3:06 PM, RVPO B emailed Surveyor and stated s/he was unsure when POA Z was notified of the change. POA Z signed the care plan in August which documented that Resident 5 was a Care Level II. RVPO B confirmed the Care Level II pricing started in 11/2024. On 04/18/2025, Surveyor reviewed Resident 5's "Care Plans," which documented: 05/10/2024 - Care Level 1 - $49.00 - Signed by Administrator A and POA Z 08/16/2024 - No Care Level identified 08/29/2024 - No Care Level identified - Signed by Administrator A and POA Z On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed his/her investigation into the concern. RVPO B stated the 'cost of living' letter probably was drafted prior to the level of care cost increase. Surveyor was not provided any documentation that was provided to Resident 5 and his/her resident representative that explained	N 309		

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N 309	Continued From page 16 when his/her care level fee increase was going to go into effect nor documentation that outlined what cares resulted in an increase of level of care.	N 309		
{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 observation, record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 3 of 4 residents. This is a repeat deficiency. See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025. Resident 1's Isosorbide Mononitrate (prevent angina [chest pain]) was not available for med administration. Resident 12's Cyclosporine (Restasis - eye drops) and Dorzolamide-Timolol (eye drop) were not available for med administration. Resident 14's Potassium Chloride (medication to treat levels of potassium) and Eliquis (blood thinner) were not available for med administration. Findings include:	{N 352}		

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{N 352}	Continued From page 17 On 03/20/2025, the Department received a concern regarding the availability of medications. On 04/15/2025, the Department received a concern alleging residents were not receiving their medications in a timely manner. Example 1: Resident 1 On 04/21/2025, Surveyor reviewed Resident 1's record provided by Regional Vice President of Operations (RVPO) B. Resident 1 moved into the facility, 10/09/2024, with diagnoses including acute myocardial infarction and atherosclerotic heart disease. Resident 1's March and April MARs, dated 03/26/2025 to 04/21/2025, documented: "Isosorbide Mononitrate ER (extended release) 60 MG (milligram) - Take 1 tablet by mouth in the morning. Start Date: 10/09/2024." 03/29 - Other Problems - Must Call Nurse On Call - nurse notified 03/30 - Other Problems - Must Call Nurse On Call - nurse notified 04/02 - Other Problems - Must Call Nurse On Call - no refill 04/03 - Other Problems - Must Call Nurse On Call - no refill 04/05 - Other Problems - Must Call Nurse On Call - no refill Documented as administered on 04/04. Example 2: Resident 12 On 03/26/2025, Surveyor reviewed Resident 12's record provided by RVPO B.	{N 352}		

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{N 352}	Continued From page 18 Resident 12 moved into the facility, 07/22/2024, with diagnoses including Parkinson's disease, migraines with aura, and heart disease. Resident 12's April 2025 MARs, dated 04/01/2025 to 04/16/2025, documented: "Cyclosporine - Instill 1 drop in both eyes at 1:00 PM. Start Date: 12/30/2024." 04/03 - Other Problems - Must Call Nurse On Call 04/04 - Other Problems - Must Call Nurse On Call 04/07 - Other Problems - Must Call Nurse On Call - No refill 04/09 - Not Yet Available - Must Call Nurse On Call - On Order 04/12 - Not Yet Available - Must Call Nurse On Call 04/13 - Other Problems - Must Call Nurse On Call 04/14 - Not Yet Available - Must Call Nurse On Call 04/15 - Med Not Available on Cart 04/16 - Not Yet Available - Must Call Nurse On Call "Dorzolamide-Timolol 2-0.5% - Instill 1 drop in both eyes at 1:00 PM. Start Date: 02/27/2025." 04/03 - Other Problems - Must Call Nurse On Call 04/04 - Other Problems - Must Call Nurse On Call 04/09 - Not Yet Available - Must Call Nurse On Call - On Order 04/12 - Not Yet Available - Must Call Nurse On Call 04/13 - Other Problems - Must Call Nurse On Call 04/14 - Not Yet Available - Must Call Nurse On Call 04/15 - Med Not Available on Cart 04/16 - Not Yet Available - Must Call Nurse On Call On 04/14/2025, at approximately 12:05 PM, Surveyor interviewed Med Technician M.	{N 352}		

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{N 352}	Continued From page 19 Surveyor asked for clarification on why MARs are documented as "Contact Nurse ...". Med Technician M stated that meant the medication was not available. Surveyor and Med Technician M observed Resident 12's medications in the med cart. Surveyor asked if Resident 12 had any eye drops available. Med Technician M opened the med cart drawer and showed Surveyor that Resident 12 did not have any eye drops available. Med Technician M stated, "I do not know when the eye drops are going to arrive, I know [Wellness Director W] is in the process of ordering the medications." Surveyor asked what the med pass code 'Other Problems - Must Call Nurse On Call' meant. Med Technician M stated that meant the medication was not available. Example 3: Resident 14 On 04/21/2025, Surveyor reviewed Resident 14's record provided by RVPO B. Resident 14 moved into the facility, 08/01/2024, with diagnoses including autoimmune hemolytic anemia (body's immune system destroys red blood cells), hypothyroidism (underactive thyroid), hypercholesterolemia (high cholesterol), and polyneuropathy (nerve damage). Resident 14's March and April MARs, dated 03/23/2025 to 04/21/2025, documented: Potassium Chloride 20 MEQ (milliequivalent) - Take 2 tablets by mouth in the morning. Scheduled at 8:00 AM. Start Date: 01/31/2025. 03/23/2025 8:37 PM - Other Problems-Must Call Nurse On Call 03/24/2025 7:38 AM - Other Problems-Must Call Nurse On Call - Nurse Notified 03/28/2025 7:14 AM - Other Problems-Must Call Nurse On Call - Nurse Notified	{N 352}		

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{N 352}	Continued From page 20 03/31/2025 9:00 AM - Other Problems-Must Call Nurse On Call - Nurse Notified 04/01/2025 8:21 AM - Other Problems-Must Call Nurse On Call - Nurse Notified (Regional Nurse C) 04/02/2025 7:03 AM - Other Problems-Must Call Nurse On Call 04/03/2025 8:41 AM - Other Problems-Must Call Nurse On Call 04/04/2025 9:11 AM - Other Problems-Must Call Nurse On Call MARs documented administration on 03/25, 03/26, 03/27, 03/29, 03/30 Eliquis 5 MG - Take 1 tablet by mouth 2 time a day. Scheduled at 8:00 AM and 8:00 PM. Start Date: 03/23/2025 03/24/2025 10:15 PM - Other Problems-Must Call Nurse On Call - No strip for bedtime. 03/26/2025 7:45 PM - Other Problems-Must Call Nurse On Call - No strip for bedtime. 03/27/2025 8:15 PM - Med Not Available on Cart - 2.5 MG tab in Cart 03/29/2025 7:16 PM - Med Not Available on Cart 03/30/2025 9:02 PM - Med Not Available on Cart 04/01/2025 7:50 PM - Med Not Available on Cart 04/02/2025 9:11 PM - Med Not Available on Cart 04/03/2025 9:08 PM - Med Not Available on Cart 04/04/2025 9:29 PM - Med Not Available on Cart 04/07/2025 9:23 PM - Med Not Available on Cart The MARs documented administration on 03/25, 03/28, 03/31, 04/05, 04/06. Resident 14's March and April 2025 "Observations," dated 03/23/2024 to 04/21/2025, documented: 03/31/2025 - Fax sent to PCP (primary care physician) for refills 04/01/2025 - Pharmacy and writer sent out for	{N 352}		

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{N 352}	Continued From page 21 refills for Potassium with no response. Will continue to try to get refills. Based on documentation, the provider did not follow up on the unavailable medication until 03/31/2025. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated a consultant had been hired to assist with auditing of medication administration and medication availability. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration	{N 352}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not follow the resident's Individual Service Plan (ISP) as written for 4 of 5 residents reviewed. Resident 6 did not receive his/her showers and shaving as outlined in his/her ISP. Resident 7's, Resident 12's and Resident 13's rooms did not receive identified housekeeping services. Resident 12 sustained numerous unwitnessed falls, including falls outside while ambulating without his/her walker. Findings include: The facility is licensed as a Class CNA	N 388		

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N 388	Continued From page 22 (non-ambulatory) assisted living facility that can provide care and services to 72 residents within the client groups: terminally ill, irreversible dementia/Alzheimer's, advanced aged, and physically disabled. On 03/18/2025, the Department received a concern alleging family members were completing housekeeping tasks due to condition of resident rooms. On 03/19/2025, the Department received a concern that residents who are a fall risk are not being monitored and fall risk interventions are not being put into place. On 03/20/2025, the Department received two concerns alleging housekeeping services were not provided. On 03/29/2025, the Department received a concern alleging family members were completing housekeeping tasks due to condition of resident rooms. Findings include: Example 1: Resident 6 On 04/02/2025, at approximately 12:30 PM, Surveyor interviewed Resident 6's Family Member T. Family Member T stated Resident 6 would tell him/her that s/he had not gotten his/her scheduled shower, and s/he has been in the same clothes days in a row, or s/he is not shaven. Family Member T stated, "[S/he] was so independent, and this disease has taken so much from [him/her] and having to rely on others is difficult and I think frustrating for [him/her] and then when [s/he] doesn't receive the cares that were agreed upon." Family Member T stated that family and friends come in often to ensure Resident 6 is receiving his/her cares.	N 388		

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N 388	Continued From page 23 On 04/06/2025, Surveyor reviewed Resident 6's record provided by Regional Vice President of Operations (RVPO) B. Resident 6 moved into the facility 12/30/2024. Resident 6's "Care Plan," dated 02/13/2025, documented: "Dressing: Requires physical assist with dressing and grooming. [S/he] likes to be up around 7AM and to bed around 8PM." "Bathing: Requires physical assistance with showering weekly. Care staff to physically assist [Resident 6] with showering M, W, F (Monday, Wednesday, Friday) at 7AM. [S/he] needs physical assistance with shaving with [his/her] electric razor on [his/her] shower days." On Monday, 04/14/2025, at approximately 12:15 PM, Surveyor interviewed Resident 6's Friend N. Friend N explained that s/he has often assisted with Resident 6's basic cares such as showers and shaving, because Resident 6 will be in the same clothes as the day before or one can see that s/he has not been shaved. Surveyor noted Resident 6 was not shaved. On 04/15/2025, at approximately 4:50 PM, Surveyor observed Resident 6, who did not have a shaved appearance. On 04/16/2025 at 9:20 AM, Surveyor received an email from Resident 6's Power of Attorney (POA) V with an attached picture of Resident 6 from breakfast that morning. Resident 6 was wearing the same clothes s/he had been wearing when Surveyor observed him/her at the evening meal on 04/15/2025.	N 388		

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N 388	Continued From page 24 On Wednesday, 04/16/2025 at 9:33 AM, POA V emailed Surveyor a video audio, timestamped 04/16/2025 9:27 AM. Surveyor listened to the video audio which was a conversation between POA V and Resident 6. POA V was asking Resident 6 if s/he had received his/her shower that morning, since s/he was in the same clothes s/he was wearing yesterday. Resident 6 stated, "No." On 04/16/2025, Surveyor reviewed email communication the family has had with the provider which documented: "01/01/2025 at 8:21 AM - POA V emailed Nurse G: [Dad/Mom] is scheduled to be helped up, and given a shower, dressed, etc. MWF at 7 am. I arrived at 9 am and nobody had come to do that. I called the call button and nobody was aware that it was even scheduled." "01/10/2025 at 2:01 PM - Friend N emailed POA V: Staff need reminding to shave [him/her] on bath days. I did it today." "02/24/2025 at 11:15 AM - Friend N emailed Nurse G: Visited [Resident 6] Saturday, [s/he] clearly had not been shaved on Friday. I shaved [him/her]." On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor asked if there was documentation to show when Resident 6 received his/her showers and shaving. RVPO B stated staff only charted by exception. RVPO B stated that new shower schedules had been developed to ensure staff know which residents are scheduled for a specific day and what time. RVPO B stated additional charting would be completed so that cares could be audited to ensure completion. Example 2: Resident 7	N 388		

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(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 388	Continued From page 25 On 04/02/2025, at approximately 12:10 PM, Surveyor toured Resident 7's room. The room had a urine like scent emanating throughout. Surveyor observed a blue chuck pad on Resident 7's recliner that displayed a large yellowish stain on it that smelled like urine. On 04/02/2025, at approximately 1:00 PM, Surveyor observed a housekeeping staff member cleaning Resident 7's room. On 04/02/2025, at approximately 1:15 PM, Surveyor observed Resident 7's room and observed that the soiled chuck pad was still on the recliner. On 04/08/2025, Surveyor reviewed Resident 7's record provided by RVPO B. Resident 7 moved into the facility 07/29/2024. Resident 7's "Care Plan," dated 10/22/2024, documented: "Housekeeping Skills: Will have [his/her] room cleaned by housekeeping once weekly and PRN (as needed)." On 04/14/2025, at approximately 11:30 AM, Surveyor and Executive Director F observed Resident 7's room. The room had a urine like scent emanating throughout. Surveyor and Executive Director F observed a white chuck pad, with blue trim, in Resident 7's recliner chair, which was sliding off the chair, that displayed a large yellowish stain on it that smelled like urine and was damp to touch. Executive Director F stated s/he would request housekeeping to do a deep clean of the room.	N 388		

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N 388	Continued From page 26 On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated there was a breakdown in communication between staff on who was responsible for what tasks. RVPO B stated this concern has been addressed as new management is reviewing our processes and family members are expressing concerns. On 04/21/2025, at approximately 11:00 AM, Surveyor interviewed FM MM. FM MM explained that s/he had visited Resident 7 on 04/18/2025, in the morning, and his/her room smelled strongly of incontinence. FM MM stated, "It took my breath away, because the odor was so bad. My [dad/mom] was not in the room, because [s/he] was at breakfast." FM MM stated this was an ongoing concern that s/he had communicated with Nurse G on different occasions. FM MM provided Surveyor with the following communication: 12/14/2024 - Text to Nurse G: We got here last night late. [Resident 7] had what I thought was fuzz all over [his/her] bathroom floor. [S/he] told me it was TP (toilet paper) from water that came out from the shower. I asked this morning when I got here for someone to clean it up. No one has come yet. I asked again now. I ended up cleaning it up with urine gone spray. In cleaning it up it was [feces]. It was all over the floor and some in the shower. It is stuck in the grip strips on the floor. The smell is mostly gone now. Example 3: Resident 12 On 03/20/2025 at 9:00 AM, Surveyor interviewed Resident 12's Power of Attorney (POA) H. POA H expressed concerns regarding the number of unwitnessed falls Resident 12 had experienced.	N 388		

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POA H stated, "I received a call on 03/16/2025 from a family member stating they had found [Resident 12] outside, with no coat, no walker and that [s/he] had fallen. I tried calling the facility and there is no answer. Then I receive a call from [Concierge I] stated, 'It is a good thing I saw [him/her] outside because [s/he] fell. This was around 4:30 PM."

On 03/21/2025, at approximately 11:45 AM, Surveyor observed Resident 12 ambulate, with a 2 wheeled walker, to the dining room table for the noon meal. Resident 12 ambulated slowly and appeared unsteady when seating him/herself into a chair.

On 03/21/2025, at approximately 12:00 PM, Surveyor toured the facility. Surveyor observed Resident 12's room and detected a urine like scent emanating from his/her room. Surveyor entered the room and observed his/her bathroom. The toilet and the toilet riser had streaks of what appeared to be feces like substance on them. There were what appeared to be torn pieces of toilet paper on the floor. The garbage can contained a soiled cloth towel, a soiled undergarment and soiled paper toweling.

On 03/21/2025, at approximately 4:30 PM, Surveyor interviewed Administrator A. Surveyor showed the pictures s/he had taken of Resident 12's room. Administrator A stated the concern would be discussed with housekeeping.

On 03/22/2025, at approximately 12:00 PM, Surveyor toured the facility. Surveyor observed Resident 12's room and detected a urine like aroma emanating from his/her room. Surveyor entered the room and observed his/her bathroom. The toilet and the toilet riser had streaks of what

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appeared to be feces like substance on them. There were what appeared to be torn pieces of toilet paper on the floor.

On 03/22/2025, at approximately 12:05 PM, Surveyor interviewed Concierge Q. Surveyor asked if s/he was familiar with the fall Resident 12 had experienced when s/he was outside. Concierge Q stated s/he was not working on that day, but the concierge's are responsible to ensure resident's sign out when they leave the building. Concierge Q and Surveyor reviewed the "Visitor Sign In Log" which did not document that Resident 12 had left the building. Concierge Q stated that if s/he saw a resident leave the building without signing the form, s/he would sign the form for them.

On 03/22/2025, at approximately 12:15 PM, Surveyor interviewed Resident 12. Surveyor asked if s/he had been sustaining falls recently. Resident 12 stated, "Does it matter."

On 03/25/2025, Surveyor reviewed Resident 12's record which was provided by Regional Vice President of Operations (RVPO) B.

Resident 12 admitted to the facility, 07/22/2024, with Parkinson's disease.

Resident 12's 2025 "Incident Reports" documented:
04/10/2025 - [Resident 12] turned on [his/her] pager while staff was on [his/her] way down to bring [him/her] breakfast, Staff walked in and [Resident 12] was on the floor, on [his/her] back with [his/her] bed propped up on [his/her] arm. ...
04/09/2025 - [Resident 12] was yelling and staff when [sic: went] into room, they found [him/her] on the floor with [his/her] head on the cabinet and

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N 388	Continued From page 29 [his/her] feet by [his/her] table. ... 04/07/2025 - [Resident 12] was exit seeking so staff stayed with [him/her] by the front door, [s/he] then went out the side door planning on going home. [Resident 12] had an unwitnessed fall outside on the grassy area that was seen by a family member leaving, the family member called for staff to assist. 3 staff members went outside. [S/he] had fallen and they were helping to get [him/her] standing up. 04/04/2025 - [Resident 12] fell this afternoon when trying to stand up from [his/her] wheelchair. A caregiver was with [him/her] at the time. ... [S/he] tried to stand up and fell backwards to the floor. 03/31/2025 - [Hospice] came to check on [Resident 12] from previous fall and found [him/her] on the floor next to [his/her] walker laying in urine. 03/31/2025 - Care staff heard [Resident 12] yelling for help. They went to [Resident 12's] room and found [him/her] on the floor next to [his/her] bed. [S/he] slipped off this bed and didn't have [his/her] walker nearby to get up. [S/he] left the call pendent in the living room of [his/her] room. 03/29/2025 - [Resident 12] had a fall around 8:30 on Saturday, [S/he] was yelling help when staff arrived in [his/her] room. [Resident 12] was on the floor by [his/her] bed. 03/16/2025 - Resident was outside walking when staff seen [him/her] fall. Resident tripped over [his/her] foot and fell onto the ground outside. 03/16/2025 - Resident called with [his/her] call button when staff made it to [his/her] room [s/he] was sitting on the floor on [his/her] butt. 03/12/2025 - Resident was sitting in [his/her] chair in [his/her] living room and says that [s/he] slipped out of it. [S/he] was yelling for help and activities alerted staff. ... wearing shoes. Call	N 388		

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pendant around neck. Lights on in room. Walker off to the side in front of [him/her].

Resident 12's 2025 "Observations" documented:
03/15/2025 - Resident had a fall.
01/24/2025 - Resident had a fall today
01/23/2025 - This morning resident had a fall in their living room, resident has cut on right cheek and behind right ear.

Resident 12's ISP, dated 02/17/2025, documented:
"Housekeeping Skills: Utilizes standard housekeeping services. Maintain clean apartment. Housekeeping to be done weekly and PRN (as needed). Please check bathrooms daily."
"Physical Disabilities - Falls: [Resident 12] has had several falls in the last year. [S/he] has broken both hips and had them both replaced. Frequent falls. Care staff to remind [Resident 12] to use [his/her] call pendant for assistance. [S/he] tries to be independent with mobility, but [s/he] should be a stand-by-assist for safety. Please encourage [him/her] to walk with assistance."
"Physical Disabilities - Ambulation: Requires a standby assist with ambulation for safety."

The Care Plan did not document additional interventions that had been implemented regarding Resident 12's fall risk.
Resident 12's record did not contain any fall assessments.

On 03/31/2025, at approximately 4:10 PM, Surveyor interviewed Resident 12's Power of Attorney (POA) H. POA H explained that s/he understood Resident 12 was sustaining numerous falls and usually would refuse medical

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attention. POA H stated, "I have spoken to [Administrator A] and [Nurse G] about my concerns, and it does not appear that any additional fall interventions are put into place. They just say staff remind [him/her] to use [his/her] call light. That doesn't seem to be working!"

On 04/11/2025, at approximately 1:00 PM, Surveyor interviewed Executive Director F. Executive Director F stated that Resident 12 was a stand-by assist with ambulation and should not have been outside unsupervised. Resident 12 could not be relied on to utilize his/her call pendent. Executive Director F stated that s/he was new to the company but based on the information provided, if a concierge saw Resident 12 outside without his/her walker and a staff member, s/he should have contacted staff immediately. Executive Director F stated the concierges are familiar with the residents and their needs.

On 04/15/2025, Surveyor reviewed Resident 12's hospice documentation provided by his/her hospice provider, which documented:
"01/17/2025 [neurology department] Medical Doctor X: Since our last visit, [s/he] sustained a hip fracture and was discharged to rehab. Shortly thereafter was readmitted with a femur fracture. Both fractures were managed operatively ...Goals are comfort focused. [S/he] would prefer to manage symptoms at home and void hospital admissions. ... I would not be surprised if [s/he] died in the next six months from complications of a fall. I also note a 30 lb (pound) weight loss in the last 3 months."
"01/30/2025 - 1 fall last week, without serious injury. [S/he] does have a scab on the R (right) side of [his/her] head from this."

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N 388	Continued From page 32 "03/18/2025 - Worsening cognition with increased confusion ... falls frequently as [s/he] won't use [his/her] call button, walker or wheelchair. At this point [s/he's] becoming a serious threat to [him/herself]." "03/19/2025 - Contusion to left side of forehead ... ambulates with a walker and should be up with SBA (stand-by assist)." "03/22/2025 - Pt ambulating with impaired gait, precariously transferring from standing to seated on chair." "03/30/2025 - [POA H] reports the patient did have a fall Saturday am and sustained no injury and did not hit [his/her] head. [POA H] reports after lunch on Saturday, around 1330 (1:30 PM), the patient had another fall. ... at 1830 (6:30 PM) Saturday 03/29. The patient had another fall where [s/he] sustained no injury and did not hit [his/her] head." "04/03/2025 - Fall - Pt fell backward from standing and hit head hard on the ground." "04/04/2025 - CG (caregiver) states that [s/he] had just settled pt in the living room watching TV and went to check on a different pt, a few minutes later pt was found by a different CG lying on [his/her] back on the floor. The CGs speculate that pt was attempting to self-transfer and fell, maybe d/t (due to) wheelchair not being locked. CGs state that [s/he] also had a fall with head injury last night but has been at baseline since then ..." "04/07/2025 - Spoke with [Med Technician Y]. [Med Technician Y] reports that this is pts 4th fall since last Thursday. Voices concerns that pt is having increased falls and may require more assistance for safety. ... This evening pt let [him/herself] outside for unknown period of time, was notified [s/he] was outside. Pt was found sitting on lawn. EMS called for lift assist."	N 388		

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N 388	Continued From page 33 On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed the concern of Resident 12 ambulating throughout the building and outside without his/her walker or standby assist. . Surveyor discussed the concern of Resident 12's record not containing fall assessments which then should have been reflected in his/her individual service plan (care plan). RVPO B and Executive Director F proceeded to take notes. Example 4: Resident 13 On 03/22/2025, at approximately 1:30 PM, Surveyor interviewed Resident 13. Surveyor noted the room appeared unkempt due to slippers, mail, used Kleenexes, clothing items, oxygen tubing, pill bottles, books, pens, and miscellaneous other items laying on his/her floor, around his/her recliner. Surveyor observed a sign in Resident 13's bathroom that stated, "Your laundry and housekeeping will be done Monday Mornings!" On 04/02/2025, Wednesday, at approximately 1:20 PM, Surveyor observed emergency medical technicians (EMTs) transport Resident 13 out of the building. Surveyor overheard staff state Resident 13 had sustained a fall. Surveyor walked to Resident 13's room and observed slippers, mail, used Kleenexes, clothing items, oxygen tubing, pill bottles, books, pens, and miscellaneous other items laying on his/her floor, around his/her recliner. Surveyor observed a sign in Resident 13's bathroom that stated, "Your laundry and housekeeping will be done Monday Mornings!" Surveyor recalled the room looked like when s/he interviewed Resident 13 on 03/21/2025.	N 388		

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N 388	Continued From page 34 On 04/08/2025, Surveyor reviewed Resident 13's record provided by RVPO B. Resident 13 moved into the facility, 08/08/2024, with diagnoses including depression, anxiety, autistic disorder and chronic pain. Resident 13's "Care Plan," dated 10/27/2024, documented: "Housekeeping Skills: [Resident 13] will have [his/her] housekeeping done weekly and PRN per housekeeping schedule." "Physical Disabilities - Ambulation: Uses walker for ambulation." On 04/14/2025, at approximately 12:00 PM, Surveyor observed Resident 13's room. Resident 13 had not returned from the hospital and his/her room did not appear to have been cleaned since 04/02/2025. Surveyor observed a sign in Resident 13's bathroom that stated, "Your laundry and Housekeeping will be done Monday Mornings!" On 04/14/2025, at approximately 1:00 PM, Surveyor interviewed Executive Director F. Surveyor showed Executive Director F pictures s/he had taken of Resident 13's room. Executive Director F stated s/he would discuss the concern with housekeeping.	N 388		
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	N 389		

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N 389	Continued From page 35 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 observation, record review and interview, the Individual Service Plan (ISP) for 2 of 5 residents were not updated when there was a change in resident needs and abilities. Resident 5's ISP was not updated to include interventions/guidelines regarding his/her refusals of showers, linen changes, and completion of laundry. Resident 13's ISP was not updated to include guidelines regarding his/her oxygen levels. Findings include: On 03/18/2025 and 03/19/2025, the Department received concerns that residents who refuse cares are not being redirected. Example 1: Resident 5 On 03/21/2025, at approximately 11:20 AM, Surveyor interviewed Resident 5. Surveyor asked if Resident 5 received assistance with his/her showers and laundry. Resident 5 stated, "I don't need assistance." On 04/10/2025, Surveyor reviewed Resident 5's record provided by RVPO B.	N 389		

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N 389	Continued From page 36 Resident 5 moved into the facility, 04/16/2024, with diagnosis including dementia. Resident 5's "Observations," dated 01/01/2025 through 03/25/2025, documented: 01/04/2025 - Resident refused shower and laundry on 01/03. Writer reapproached today, shower and laundry completed. 01/10/2025 - Resident refused shower, stating that [s/he] didn't feel like doing it this evening, stated [s/he] will do it tomorrow. Resident also refused sheets and laundry, [s/he] had said that [his/her] sheets had never been slept on and [s/he] had almost no laundry to wash. 03/19/2025 - Resident refused to have [his/her] sheets changed, stated "it looks like no one slept in here." Writer called residents [son/daughter] due to resident not allowing writer to change sheets, resident then let writer change [his/her] sheets. Surveyor noted there were 9 entries total for this timeframe. Resident 5's "Care Plan," dated 08/29/2024, documented: "Dressing - Reminders, instructions, supervision, or assistance with dressing or undressing, etc. Ensure [Resident 5] is changing [his/her] clothes daily." "Bathing - [Resident 5] requires a stand-by assist for showers. Please ensure [Resident 5] is showering at least once per week. Reports refusals to RN (registered nurse)." "Laundry Services - Please ensure [Resident 5's] laundry is being done at least once per week. Report refusals to RN." On 04/14/2025, at approximately 1:00 PM, Surveyor interviewed Executive Director F.	N 389		

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N 389	Continued From page 37 Executive Director F stated s/he was new to the company and had been reviewing the process of when staff document observations or tasks completed. Executive Director F stated his/her expectation is that staff will document when a task is completed or why a task was not completed. Executive Director F explained that based on family concerns that have been discussed with him/her, staff have not been documenting when a resident is refusing a care. Executive Director F stated Resident 5 is known to refuse assistance with his/her cares. On 04/16/2025, at approximately 8:30 AM, Surveyor interviewed Resident 5's Power of Attorney (POA) Z. POA Z stated there were concerns with how often Resident 5 is receiving showers and his/her sheets on his/her bed are being washed. POA Z stated, "I know at one point it had been 6 weeks since [his/her] sheets had been changed, based on the placement of [his/her] extra sheets in the closet and the condition of the sheets on [his/her] bed. I talk with staff, and they tell me [s/he] won't let them change [his/her] sheets or s/he doesn't want to change his/her clothes, or s/he doesn't want to take a shower. I question how they are redirecting him/her." On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed the concerns that Resident 5 was not receiving his/her showers, completion of linen changes, and/or laundry completed due to his/her refusals which was not identified in his/her care plan. RVPO B stated that s/he had met with Resident 5's POA Z and a new care plan was being developed which would identify his/her behaviors of refusing cares.	N 389		

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N 389	Continued From page 38 Example 2: Resident 13 On 03/22/2025, at approximately 1:30 PM, Surveyor interviewed Resident 13. Resident 13 expressed concerns if the provider had a backup generator, since s/he was on oxygen. Surveyor observed Resident 13 wearing his/her nasal cannula for oxygen and his/her oxygen concentrator. On 04/08/2025, Surveyor reviewed Resident 13's record provided by Regional Vice President of Operations (RVPO) B. Resident 13 moved into the facility, 08/08/2024, with diagnoses including malignant neoplasm of endometrium, depression, and anxiety disorder. Resident 13's "Care Plan," dated 10/27/2024, documented: "General Health: Not Applicable" "Physical Disabilities - Falls: Uses Oxygen independently. Care staff to report any problems with [Resident 13's] oxygen to nursing." On 04/14/2025, at approximately 1:30 PM, Surveyor interviewed Executive Director F. Surveyor asked if the provider had a physician order regarding Resident 13's oxygen, since oxygen guidelines were not available in his/her ISP. Executive Director F reviewed Resident 13's record and determined a physician order was not on file.	N 389		
{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	{N 408}		

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{N 408}	Continued From page 39 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. 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 that 2 of 2 resident's prescribed PRN (as needed) psychotropic medications were documented with a rationale and the effectiveness in his/her record when administered. This is a repeat deficiency. See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025. Resident 8 was administered his/her PRN Lorazepam without a documented rationale or effectiveness. Resident 12 was administered his/her PRN Lorazepam and PRN Quetiapine Fumarate without a documented rationale or effectiveness. Findings include:	{N 408}		

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{N 408}	Continued From page 40 Example 1: Resident 8 On 04/18/2025, Surveyor reviewed Resident 8's record provided by RVPO B. Resident 8 moved into the facility, 08/06/2024, with diagnoses including dementia and major depressive disorder. Resident 8's April Medication Administration Record (MAR), dated 04/01/2025 to 04/16/2025, documented: "Lorazepam 0.5 MG - Take 1 tablet by mouth every 6 hours as needed (anxiety). Start Date: 10/23/2024)." Documented as administered: 04/15 7:12 PM - No rationale listed, No effectiveness listed. Example 2: Resident 12 On 04/18/2025, Surveyor reviewed Resident 12's record provided by Regional Vice President of Operations (RVPO) B. Resident 12 moved into the facility, 07/22/2024, with diagnosis including Parkinson's disease. Resident 12's April MAR, dated 04/01/2025 to 04/16/2025, documented: "Lorazepam 0.5 MG (milligram) - Take 1 tablet by mouth every 4 hours as needed (anxiety/shortness of breath). Start Date: 03/25/2025." Documented as administered: 04/02 9:04 AM - No rationale listed, No effectiveness listed. "Quetiapine Fumarate 25 MG - Take ½ tablet by mouth every 6 hours as needed (agitation). Start Date: 03/25/2025." Documented as administered: 04/02 5:29 PM -	{N 408}		

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{N 408}	Continued From page 41 No rationale listed, No effectiveness listed. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated a consultant had been hired to assist with auditing of medication administration.	{N 408}		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify 1 of 1 resident's (Resident 14) prescribing practitioner, nurse, or pharmacist when s/he did not receive his/her prescribed medication (Eliquis [blood thinner]) for 2 or more consecutive days. Findings include: On 04/21/2025, Surveyor reviewed Resident 14's record provided by RVPO B.	N 410		

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N 410	Continued From page 42 Resident 14 moved into the facility, 08/01/2024, with diagnoses including autoimmune hemolytic anemia (body's immune system destroys red blood cells), hypothyroidism (underactive thyroid), hypercholesterolemia (high cholesterol), and polyneuropathy (nerve damage). Resident 14's March and April MARs, dated 03/23/2025 to 04/21/2025, documented: Eliquis 5 MG - Take 1 tablet by mouth 2 time a day. Scheduled at 8:00 AM and 8:00 PM. Start Date: 03/23/2025 03/24/2025 10:15 PM - Other Problems-Must Call Nurse On Call - No strip for bedtime. 03/26/2025 7:45 PM - Other Problems-Must Call Nurse On Call - No strip for bedtime. 03/27/2025 8:15 PM - Med Not Available on Cart - 2.5 MG tab in Cart 03/29/2025 7:16 PM - Med Not Available on Cart 03/30/2025 9:02 PM - Med Not Available on Cart 04/01/2025 7:50 PM - Med Not Available on Cart 04/02/2025 9:11 PM - Med Not Available on Cart 04/03/2025 9:08 PM - Med Not Available on Cart 04/04/2025 9:29 PM - Med Not Available on Cart 04/07/2025 9:23 PM - Med Not Available on Cart The MARs documented administration on 03/25, 03/28, 03/31, 04/05, 04/06. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated a consultant had been hired to assist with auditing of medication administration and medication availability. On 04/21/2025 at 12:51 PM, Surveyor emailed RVPO B and requested the documentation showing that Resident 14's physician or a nurse had been notified that s/he had not received	N 410		

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N 410	Continued From page 43 his/her Eliquis from 03/24/2025 through 04/07/2025. On 04/21/2025 at 4:07 PM, RVPO B emailed Surveyor Resident 14's March and April 2025 "Observations," dated 03/23/2024 to 04/21/2025, which documented: 03/31/2025 - Fax sent to PCP (primary care physician) for refills 04/01/2025 - Pharmacy and writer sent out for refills for Potassium with no response. Will continue to try to get refills. 04/02/2025 - Call placed to [physician] requesting a new updated and signed medication list from PCP. There is a discrepancy with the Eliquis dosing of what was sent to the pharmacy and the order in the MAR. Calling to get clarification. At this time the Eliquis dosing is ½ of what is needed, 2.5 MG instead of 5 MG. The Eliquis was first documented as unavailable 03/24/2025 and the observation notes did not document that a nurse or physician had been notified until 03/31/2025. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Resident: Receive Medication	N 410		
{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	{N 415}		

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{N 415}	Continued From page 44 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 proper documentation on the Medication Administration Record (MAR) for 3 of 4 residents reviewed. This is as repeat deficiency. See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025. Resident 1's MAR contained blanks were medication administration should have been documented. Resident 9's MAR contained blanks where medication administration should have been documented. Resident 12's Latanoprost (eye drops) were documented as administered when the medication was not available. Resident 12's Dorzolamide-Timolol (eye drops) were documented as refused when the medication was not available. Findings include: Example 1: Resident 1 On 04/212025, Surveyor reviewed Resident 1's record provided by Regional Vice President of Operations (RVPO) B. Resident 1 moved into the facility, 10/14/2024, with diagnoses including	{N 415}		

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{N 415}	Continued From page 45 Resident 1's April Medication Administration Record (MAR), dated 04/01/2025 to 04/21/2025, documented: -Metoclopramide HCL (hydrochloride) 5 MG (milligram) - Take 1 tablet by mouth 3 times a day before meals. Scheduled at 7:00 AM, 11:00 AM, 4:00 PM. Start Date: 10/09/2024. MAR did not document 4:00 PM administration on 04/03, 04/07, 04/09. -Hydrocortisone 10 MG - Take 1 ½ tablets by mouth in the morning and in the evening. Scheduled at 8:00 AM and 4:00 PM. Start Date: 10/09/2024. MAR did not document 4:00 PM administration on 04/03, 04/07, 04/09. -Metformin HCL 500 MG - Take 2 tablets by mouth 2 times a day in the morning and evening. Scheduled at 8:00 AM and 4:00 PM. Start Date: 10/09/2024 MAR did not document 4:00 PM administration on 04/03, 04/07, 04/09. -Clonazepam 0.5 MG - Take 1 tablet by mouth in the evening. Scheduled at 4:00 PM. Start Date: 01/06/2025. MAR did not document 4:00 PM administration on 04/03, 04/07, 04/09. -Humalog Kwikpen 100 Unit/ML (milliliter) - Inject 4 Units under skin prior to each meal. Add correction scale: see sliding scale. Scheduled at 8:00 AM, 12:00 PM, 4:00 PM. Start Date: 02/23/2025. -Acetaminophen 325 MG - 1 tablet given every 6 hours for pain management. Scheduled at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM. Start Date: 04/11/2025. MAR did not document 12:00 AM administration on 04/12, 04/15, 04/18, 04/21. MAR did not document 6:00 PM administration on 04/17, 04/18	{N 415}		

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{N 415}	Continued From page 46 Example 2: Resident 9 On 04/10/2025, Surveyor reviewed Resident 9's record provided by RVPO B. Resident 9 moved into the facility, 07/31/2024, with diagnoses including Type 2 diabetes, hyperlipidemia (high cholesterol) and hypertension (high blood pressure). Resident 9's April MAR, dated 04/01/2025 to 04/10/2025, documented: -Calcium Citrate - Vitamin D3 315 MG - Take 1 tablet by mouth 2 times a day. Scheduled at 8:00 AM and 8:00 PM. Start Date: 01/02/2025. MAR did not document 8:00 PM administration on 04/03 and 04/07. -Flaxseed Oil 1000 MG - Take 1 capsule by mouth 2 times a day. Scheduled at 8:00 AM and 8:00 PM. Start Date: 01/02/2025. MAR did not document 8:00 PM administration on 04/03 and 04/07. -Lovastatin (cholesterol medication) 10 MG - Take 2 tablets by mouth at bedtime. Scheduled at 8:00 PM. Start Date: 01/01/2025. MAR did not document 8:00 PM administration on 04/03 and 04/07. -Melatonin (sleep aid) 3 MG - Take 1 tablet by mouth at bedtime. Scheduled at 8:00 PM. Start Date: 02/21/2025. MAR did not document 8:00 PM administration on 04/03 and 04/07. -Lantus Solostar (insulin) 100 Unit/ML (milliliter) - Inject 25 Units subcutaneously at bedtime. Scheduled at 8:00 PM. Start Date: 01/01/2025. MAR did not document 8:00 PM administration on 04/03 and 04/07. Example 3: Resident 12	{N 415}		

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{N 415}	Continued From page 47 On 04/14/2025, at approximately 12:05 PM, Surveyor and Med Technician M observed Resident 12's medications. Surveyor asked if Resident 12 had any eye drops available. Med Technician M opened the med cart drawer and showed Surveyor that Resident 12 did not have any eye drops available. Med Technician M stated, "I do not know when the eye drops are going to arrive, I know [Wellness Director W] is in the process of ordering the medications." Surveyor asked what the med pass code 'Other Problems - Must Call Nurse On Call' meant. Med Technician M stated that meant the medication was not available. On 04/18/2025, Surveyor reviewed Resident 12's record. Resident 12's April MAR, dated 04/01/2025 to 04/16/2025, documented: -Latanoprost 0.005% - Instill 1 drop in both eyes at bedtime. Start Date: 01/15/2025. The MAR documented that the medication had been administered 04/11 to 04/16/2025. -Dorzolamide-Timolol 2-0.5% - Instill 1 drop in both eyes at 1:00 PM. Start Date: 02/27/2025. 04/03 - Other Problems - Must Call Nurse On Call 04/05 - Refused by Patient 04/06 - Left Blank 04/07 - Refused by Patient 04/08 - Left Blank 04/10 - Left Blank 04/11 - Left Blank 04/12 - Not Yet Available - Must Call Nurse On Call On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated a consultant had been hired to assist with auditing of medication administration and	{N 415}		

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{N 415}	Continued From page 48 medication availability. RVPO B explained that med technicians who continued to make errors after re-education would be removed from the med cart. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Resident: Receive Medication	{N 415}		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration 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 1 of 1 resident reviewed received appropriate medication administration. Resident 14's Cephalexin (antibiotic) was delivered 03/07/2025 at 8:56 PM and was not released in the electronic computer system so that s/he could receive his/her first dose for his/her diagnosed urinary tract infection (UTI). Findings include: On 03/20/2025, the Department received a concern regarding the availability of medications	N 432		

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N 432	Continued From page 49	N 432		

when they are received on the weekends.

On 03/21/2025, at approximately 4:15 PM, Surveyor interviewed Administrator A. Administrator A stated that any med technician should be able to release a med order in the electronic computer system. Once the medication is released in the system, the start date is filled in on the MAR.

On 03/22/2025, at approximately 1:00 PM, Surveyor interviewed Med Technician R and Med Technician S. Surveyor asked if med technicians were able and/or required to release med orders if there was a medication in the med cart that was not listed on the MAR when doing med pass. Med Technician R and Med Technician S explained that med technicians can release med orders. Med Technician S explained, "This can happen especially when a resident is sent out for a medical evaluation and return to the facility with a new or changed med order. If the medication arrives and we are putting it in the med cart, we should 'release' the medication and determine if the resident needs their first dose then or if it has a different start date." Surveyor asked if antibiotics would be considered a medication that the med order would be 'released' in the system when the medication arrived, so that the resident could immediately receive their first dose. Med Technician R and Med Technician S both agreed that antibiotics were a medication that should not be delayed in the administration of their first dose. Med Technician R stated, "If a med technician questioned if the resident should receive the antibiotic, they could always call the on-call nurse."

On 03/22/2025, at approximately 1:25 PM, Surveyor interviewed Med Technician P.

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(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 432	Continued From page 50	N 432		

Surveyor asked if s/he had encountered a situation in which a medication was available in the med cart, but the medication did not appear in the MAR. Med Technician P explained that Resident 14 had been sent out due to concerns of having a possible UTI and when Resident 14 returned, staff was informed s/he had a UTI, and an antibiotic had been ordered and was to be delivered. Med Technician P stated, "I did med pass on 03/08/2025, in the morning, and I noticed there was an antibiotic in the cart for [Resident 14], but it did not appear on the MAR. I went in and to the system and 'released' the order, so that it would show up in the MAR and I could document that I administered the medication. I noticed the medication had been delivered the night before and asked the med passer [Med Technician AA] why [s/he] didn't administer the antibiotic. I was informed [s/he] didn't do it because it wasn't on the MAR. I asked [him/her] why [s/he] didn't release the med order, like we are trained. [S/he] told me that wasn't [his/her] responsibility. I felt bad for [Resident 14], UTIs are painful. You want to start your antibiotic as soon as possible."

On 04/14/2025, Surveyor reviewed Resident 14's record provided by Regional Vice President of Operations (RVPO) B.

Resident 14 moved into the facility 08/01/2024.

Resident 14's "Observations" documented: 03/06/2025 - Resident is concerned that [s/he] has a UTI. [S/he] has dark urine. [S/he] called [his/her] doctor.

Resident 14's March 2025 MAR documented: "Cephalexin 500 MG - Take 1 capsule by mouth 4 times a day for 7 days. Start Date: 03/08/2025."

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N 432	Continued From page 51 Resident 14's physician order, dated 03/07/2025 12:25 (12:25 PM), documented: "Cephalexin 500 MG - Take 1 capsule by mouth 4 times a day for 7 days." Resident 14's pharmacy delivery report documented his/her Cephalexin had been delivered on 03/07/2025 at 8:56 PM by Med Technician AA. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated it would be expected of the med technician to call the on-call nurse if they were unsure if the first dose of the antibiotic should be given.	N 432		
N 449	83.41(2)(b) Nutrition: meals Meals. 1. The CBRF shall provide meals that are routinely served family or restaurant style, unless contraindicated in a resident ' s individual service plan or for short-term medical needs. 2. The CBRF shall provide at least 3 meals a day, unless otherwise arranged according to the program statement or the resident ' s individual service plan. A nutritious snack shall be offered in the evening or more often as consistent with the resident ' s dietary needs. 3. If a resident is away from the CBRF during the time a meal is served, the CBRF shall offer food to the resident on the resident ' s return. This Rule is not met as evidenced by: The provider did not ensure a nutritious snack was offered during evening hours or more	N 449		

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N 449	Continued From page 52 consistent with the resident's dietary needs for 43 of 43 residents. Findings include: On 03/19/2025 and 03/20/2025, the Department received concerns alleging staff do not ensure residents receive seconds during meals or provide an evening snack. On 03/21/2025, at approximately 11:00 AM, Surveyor toured the facility and observed the daily menu times which documented: "Breakfast - 8:00 AM, Lunch - 12:00 PM, Dinner - 4:30 PM" On 04/14/2025, at approximately 11:20 AM, Surveyor interviewed Cook J and Cook K. Surveyor asked if they prepared evening snacks for the residents. Cook K stated that snacks were purchased but were not passed out to the residents on a regular basis. Cook J and Cook K stated that if a resident specifically asked for a snack, a snack could be given. On 04/14/2025, at approximately 12:10 PM, Surveyor interviewed Cook L. Surveyor asked if they prepared evening snacks for the residents. Cook L stated this was an area that could be improved upon. On 04/18/2025 at 3:10 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) B and Executive Director F. RVPO B and Executive Director F continued to take notes.	N 449		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident	Y3234		

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Y3234	Continued From page 53 in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Staff act disrespectful towards residents. Findings include: On 03/20/2025, the Department received a concern alleging staff were verbally aggressive towards other staff and residents. On 04/15/2025, the Department received a concern that staff were involving residents in their disagreements with each other and were verbally abusive towards residents. On 03/21/2025, at approximately 1:55 PM,	Y3234		

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Y3234	Continued From page 54 Surveyor interviewed Med Technician GG. Surveyor asked if s/he had witnessed any interactions by staff that was concerning. Med Technician G stated, "There is a breakdown in communication. [Med Technician U] is always swearing at staff, calling them [explicative words]. [Med Technician U] talks rough towards residents. [S/he] doesn't care who hears [him/her]." On 03/21/2025, at approximately 3:20 PM, Surveyor interviewed Resident 3. Resident 3 explained to Surveyor that staff need to be respectful to residents. Resident 3 stated, "They treat you like you don't know anything." On 03/22/2025, at approximately 11:40 AM, Surveyor interviewed Resident 15 and Resident 16. Surveyor asked if they had any concerns regarding staff. Resident 15 stated, "We have some really nice staff, and then there are others." Surveyor asked Resident 15 to elaborate. Resident 15 crossed his/her hands onto his/her lap and looked at Surveyor and stated, "And there are others." On 03/22/2025, at approximately 1:00 PM, Surveyor interviewed Med Technician R and Med Technician S. Surveyor asked if they had witnessed staff be inappropriate towards residents or if residents had voiced concerns regarding staff treatment. Med Technician R and Med Technician S stated various interactions had occurred involving staff-to-staff interactions, along with staff-to-resident interactions that were reported to management. Med Technician S stated, "There are staff here that forget this is the resident's home and we are to be respectful of their home and them. You cannot be yelling up and down the halls. Speaking loudly about a resident who is requiring assistance. There are	Y3234		

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Y3234	Continued From page 55	Y3234		

residents who can be verbally or physically aggressive; it is their disease, do not take it personally."

On 03/22/2025, at approximately 3:30 PM, Surveyor interviewed Resident 17's Power of Attorney (POA) LL. Surveyor asked if s/he had any staffing concerns. Resident 17 stated, "[Med Technician BB] is rude. [S/he] is rude to the other staff, to the residents."

On 04/02/2025, at approximately 1:30 PM, Surveyor interviewed Resident 10. Resident 10 explained that staff do not listen to you. Resident 10 stated, "You can be in the middle of telling them a story and they just turn around and leave. I am still talking."

On 04/15/2025, at approximately 1:00 PM, Surveyor interviewed Resident 8's Family Member (FM) KK. FM KK stated s/he had been contacted by Resident 8, who was upset, due to a staff member yelling at him/her.

On 04/15/2025, at approximately 4:15 PM, Surveyor interviewed Resident 8. Resident 8 explained that on Friday s/he did not receive his/her evening medications, so s/he went to look for the staff to get his/her meds. Resident 8 walked with Surveyor to show him/her the room where s/he found them. The staff were in the 'staff' room. Resident 8 explained that I knocked on the door because s/he could hear them talking inside. Resident 8 stated they answered the door, and s/he requested his/her meds. Resident 8 stated the staff member went and got his/her medications. Resident 8, through tears, said when s/he started to walk away the staff member walked the other direction and was saying really mean things. Surveyor asked if s/he could

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Y3234	Continued From page 56 remember what was said. Resident 8 said they were saying [explicative words]. Resident 8 was visibly upset during this conversation. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated current staff have communicated with the new management regarding staffing concerns. Executive Director F stated Resident 8's concern was being investigated and the staff member in question, Med Technician BB, did not show up for his/her scheduled shift to be interviewed. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect Cross Reference: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement is Called	Y3234		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

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Y3244	Continued From page 57	Y3244		

This Rule is not met as evidenced by:
Based on observations, record review and interview, the provider did not ensure residents received adequate and appropriate cares.

Resident 2, Resident 12, Resident 17, Resident 18, and Resident 19 did not receive timely assistance with care needs.
Residents expressed concerns about receiving scheduled showers.
Resident 6 did not receive assistance with his/her dietary requirements.
Resident 7 did not receive routine assistance with his/her incontinence and showering.
Resident 10 did not receive assistance his/her first night in the facility, resulting in him/her sleeping in his/her chair.
Resident 11 sustained a fall and staff assigned to his/her cares had left the building.
Residents had concerns about the timely completion of their laundry and laundry being misplaced.

Findings include:

The facility is licensed as a Class CNA (non-ambulatory) assisted living facility that can provide care and services to 72 residents within the client groups: terminally ill, irreversible dementia/Alzheimer's, advanced aged, and physically disabled.

Example 1: Call Light Response

On 03/20/2025, the Department received two concerns alleging call light response times were significant, due to a shortage in staffing, and residents did not receive scheduled cares.

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Y3244	Continued From page 58 On 03/29/2025, the Department received a concern alleging call light response times are significant. On 03/21/2025, at approximately 1:45 PM, Surveyor interviewed Med Technician AA. Surveyor asked if residents had commented on the length of time it takes for call lights to be responded to. Med Technician AA stated residents had voiced concerns. Med Technician AA stated, "There are shifts where we are understaffed." On 03/21/2025, at approximately 1:55 PM, Surveyor interviewed Med Technician GG. Surveyor asked if residents had commented on the length of time it takes for call lights to be responded to. Med Technician GG stated residents had voiced concerns. Med Technician GG stated, "We can be understaffed at times." On 03/22/2025, at approximately 11:40 AM, Surveyor interviewed Resident 15 and Resident 16. Surveyor asked if they had concerns regarding response times to call pendants. Resident 15 stated the response time varied; it depended on who was scheduled. On 03/22/2025, at approximately 1:00 PM, Surveyor interviewed Med Technician R and Med Technician S. Surveyor asked if residents had commented on the length of time it takes for call lights to be responded to. Med Technician R and Med Technician S explained that the acuity of residents was increasing and with the number of staff scheduled per shift, can cause a delay in response times. On 03/22/2025, at approximately 1:25 PM,	Y3244		

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Y3244	Continued From page 59 Surveyor interviewed Med Technician P. Surveyor asked if residents had commented on the length of time it takes for call lights to be responded to. Med Technician P stated residents had voiced concerns. Med Technician P stated the number of staff members scheduled had been decreased recently. On 03/22/2025, at approximately 3:30 PM, Surveyor interviewed Resident 17's Power of Attorney (POA) LL. Surveyor asked if s/he had concerns regarding the call light response times for Resident 17. POA LL stated Resident 17 had waited a "significant amount" of time when s/he pressed his/her call pendant. On 04/09/2025, at approximately 12:00 PM, Surveyor interviewed Executive Director F. Executive Director F stated that if a staff member is currently assisting another resident, the response time to the new call light should be within 7 minutes. Executive Director F stated that the staff now have pagers that can be heard throughout the building, and they also alert on the med computer. On 03/28/2025, Surveyor reviewed Resident 2's, Resident 12's, Resident 17's, Resident 18's, and Resident 19's call light reports provided by Regional Vice President of Operations (RVPO) B. Surveyor identified call light response times greater than 15 minutes. Resident 2's March call light report, dated 03/01/2025 to 03/24/2025, documented: 03/08 - 6:09 AM - Response time 1 hour 35 minutes 03/10 - 6:03 PM - Response time 23 minutes 03/14 - 7:39 AM - Response time 26 minutes 03/15 - 6:08 AM - Response time 58 minutes	Y3244		

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Y3244	Continued From page 60 03/16 - 8:05 AM - Response time 46 minutes 03/17 - 7:41 AM - Response time 20 minutes 03/18 - 7:42 AM - Response time 71 minutes 03/18 - 9:19 PM - Response time 29 minutes 03/22 - 4:50 AM - Response time 19 minutes 03/23 - 7:49 AM - Response time 29 minutes 03/24 - 8:08 AM - Response time 21 minutes Resident 12's March call light report, dated 03/01/2025 to 03/23/2025, documented: 03/02 - 12:50 AM - Response time 52 minutes 03/07 - 5:50 AM - Response time 32 minutes 03/08 - 9:11 PM - Response time 36 minutes 03/10 - 2:08 AM - Response time 17 minutes 03/13 - 12:03 AM - Response time 17 minutes 03/14 - 5:56 AM - Response time 20 minutes 03/14 - 6:04 PM - Response time 33 minutes 03/14 - 11:01 PM - Response time 67 minutes 03/15 - 2:50 AM - Response time 3 hours 28 minutes 03/15 - 8:33 AM - Response time 1 hour 12 minutes Resident 17's March call light report, dated 03/01/2025 to 03/22/2025, documented: 03/04 - 9:29 AM - Response time 25 minutes 03/04 1:42 PM - Response time 46 minutes 03/05 - 2:47 PM - Response time 21 minutes 03/08 - 7:18 AM - Response time 46 minutes 03/10 - 4:49 PM - Response time 25 minutes 03/11 - 1:14 PM - Response time 22 minutes 03/13 - 7:43 AM - Response time 25 minutes 03/15 - 9:48 AM - Response time 28 minutes 03/16 - 12:53 PM - Response time 53 minutes 03/17 - 11:36 AM - Response time 23 minutes Resident 18's March call light report, dated 03/01/2025 to 03/15/2025, documented: 03/08 - 5:34 PM - Activity Room - Response time 53 minutes	Y3244		

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Y3244	Continued From page 61 03/09 - 11:44 AM - Response time 40 minutes 03/12 - 8:49 PM - Response time 32 minutes 03/13 - 7:41 PM - Response time 20 minutes 03/13 - 8:12 PM - Response time 24 minutes 03/13 - 9:07 PM - Response time 34 minutes 03/14 - 2:49 AM - Response time 29 minutes 03/14 - 6:25 AM - Response time 37 minutes 03/14 - 8:33 PM - Response time 25 minutes 03/15 - 3:40 AM - Response time 32 minutes 03/15 - 4:31 AM - Response time 47 minutes 03/15 - 6:01 AM - Response time 28 minutes 03/15 - 6:35 AM - Response time 36 minutes 03/15 - 8:19 PM - Response time 33 minutes Resident 19's March call light report, dated 03/01/2025 to 03/24/2025, documented: 03/08 2:16 PM - 2nd Floor Dining Room - Response time 17 minutes 03/10 12:51 PM - 2nd Floor Dining Room - Response time 23 minutes 03/11 9:13 AM - 2nd Floor Dining Room - Response time 61 minutes 03/13 9:11 AM - 2nd Floor Dining Room - Response time 53 minutes 03/14 6:45 PM - 2nd Floor Dining Room - Response time 24 minutes 03/15 12:33 PM - 2nd Floor Activity Room - Response time 18 minutes 03/16 5:51 PM - 2nd Floor Activity Room - Response time 29 minutes 03/16 8:27 PM - 2nd Floor Activity Room - Response time 40 minutes 03/17 4:56 PM - 2nd Floor Dining Room - Response time 24 minutes 03/21 10:51 AM - 2nd Floor Activity Room - Response time 20 minutes 03/22 9:44 AM - 2nd Floor Dining Room - Response time 40 minutes 03/24 9:04 AM - 2nd Floor Dining Room - Response time 26 minutes	Y3244		

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Y3244	Continued From page 62 03/24 5:59 PM - 2nd Floor Dining Room - Response time 58 minutes On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed the concern of adequate response times to call lights. RVPO B stated 7 minutes was an adequate amount of time unless it was during the busier times of a shift, like during meals and mornings when residents were getting up. Example 2: Showers On 03/18/2025, the Department received a concern alleging residents are not receiving scheduled showers. On 03/21/2025, at approximately 11:40 AM, Surveyor interviewed Med Technician P. Med Technician P explained that showers are not completed when scheduled and residents can express frustration. Med Technician P explained this was due to staffing shortages or staff not knowing which residents need to be showered. On 03/21/2025, at approximately 12:00 PM, Surveyor interviewed Resident 7's Family Member (FM) DD. Surveyor asked if s/he had concerns with Resident 7's scheduled shower times. FM DD stated s/he did not think Resident 7 received his/her scheduled showers due to him/her smelling of incontinence when s/he visited. On 03/21/2025, at approximately 1:40 PM, Surveyor interviewed Med Technician Y. Surveyor asked if s/he was able to complete the showers that were scheduled on his/her shift. Med Technician Y stated 2 or 3 showers were	Y3244		

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completed per shift, it depended on how many staff were scheduled. Med Technician Y stated, "All the showers might not get completed."

On 03/21/2025, at approximately 1:55 PM, Surveyor interviewed Med Technician GG. Surveyor asked if s/he was able to complete the showers that were scheduled on his/her shift. Med Technician GG stated, "Showers probably did not get completed, because we aren't informed what was done or not done during shift change report."

On 03/22/2025, at approximately 1:00 PM, Surveyor interviewed Med Technician R and Med Technician S. Med Technician R and Med Technician S explained that showers are missed. Residents are requiring more assistance, and more residents were moving in, but the number of staff on schedule was decreasing versus increasing.

On 04/07/2025, at approximately 11:00 AM, Surveyor interviewed Resident 17's Power of Attorney (POA) LL. POA LL explained that on 04/02/2025 s/he gave Resident 17 a shower as staff had not completed that care. POA LL stated, "I do not understand why [s/he] doesn't get [his/her] scheduled showers."

On 04/14/2025, at approximately 11:10 AM, Surveyor interviewed Resident 12. Surveyor asked if s/he remember when s/he had his/her last shower. Resident 12 stated, "I don't know, I probably told them no."

On 04/16/2025, at approximately 8:30 AM, Surveyor interviewed Resident 5's POA Z. POA Z explained that s/he did not feel Resident 5 was receiving his/her scheduled showers and when

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staff are asked when s/he had his/her last shower, they were unable to inform him/her.

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated there had been a breakdown in communication between staff as to who was responsible for providing the resident showers. Executive Director F explained that new shower schedules had been developed to ensure all staff knew what a resident was scheduled for a shower and staff are to document when a shower has been completed.

Example 3: Resident 6

On 03/19/2025, 03/20/2025 and 03/29/2025, the Department received concerns alleging residents did not receive individualized cares.

On 03/22/2025, at approximately 1:00 PM, Surveyor interviewed Med Technician R and Med Technician S. Med Technician R and Med Technician S explained that Resident 6 required sit-by assist with eating as s/he was not able to manipulate the silverware.

On 03/22/2025, at approximately 12:30 PM, Surveyor interviewed Resident 17's Power of Attorney (POA) LL, while they were observing residents at the noon meal. Surveyor asked if s/he had concerns regarding the meals. POA LL stated his/her concern was that there often were not enough staff members present while residents were eating.

On 04/02/2025, at approximately 12:30 PM, Surveyor interviewed Resident 6's Family Member T. Family Member T stated there were concerns with staff providing adequate dietary

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assistance for Resident 6. Family Member T stated, "I visit often and assist [Resident 6] with meals, but it concerns me who helps [him/her] when a family member is not here." Family Member T stated "I have arrived to find to-go containers in his/her room and the food is not touched. I know that nobody came in to assist [him/her]."

On 04/14/2025, at approximately 12:15 PM, Surveyor interviewed Resident 6's Friend N. Friend N stated s/he had concerns when s/he visited Resident 6 on 04/11/2025, during the evening meal. Resident 6 was sitting by him/herself, with his/her food sitting in front of him/her. Resident 6 is unable to maneuver silverware and had to wait for assistance. Friend N stated, "I commented to [Med Technician EE] that [Resident 6] required assistance. Med Technician EE informed Friend N that s/he was the only person working and s/he would assist Resident 6 when s/he had time. Friend N stated, "I assisted [him/her] because [his/her] food was getting cold, and [s/he] was just sitting there staring at [his/her] food." While Surveyor was interviewing Friend N, staff delivered Resident 6's lunch which consisted of chicken cordon bleu, which was not cut up into bite sized pieces. Friend N stated, "They probably assumed that I would do it, since I am here."

On 04/15/2025, at approximately 4:50 PM, Surveyor entered the dining room and observed Med Technician EE passing out drinks to the residents. Med Technician EE was also plating the food out of the steamtable for the residents. Surveyor observed Resident 6 sitting at a table, with 3 other residents, and his/her plate of food was brought to him/her at approximately 5:11 PM. The meal provided was an open-faced hot turkey

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sandwich. Med Technician EE did not cut the sandwich into bite sized pieces and did not sit down to assist Resident 6 with his/her meal. Med Technician EE proceeded to fill the to-go containers with meals for the residents who would be dining in their room and left to deliver the meals. Resident 6's family members had arrived, at approximately 5:00 PM, and observed this process. Surveyor approached Resident 6's Power of Attorney (POA) V and asked if s/he had concerns regarding mealtime for Resident 6. POA V stated, "It is frustrating to see my [dad/mom] just sitting here, watching [him/her] stare at [his/her] food, while others are eating." At approximately 5:20 PM, POA V's son/daughter said, "I can help you [grandma/grandpa]," and began to feed Resident 6.

On 04/18/2025, Surveyor reviewed Resident 6's record provided by Regional Vice President of Operations (RVPO) B.

Resident 6 moved into the facility, 12/30/2024, with diagnosis including Parkinson's disease.

Resident 6's "Care Plan," dated 02/13/2025, documented:
"Eating: Requires set-up assistance of meals. Ensure [s/he] drinks 2 glasses of fluids with each meal. Care staff to help [Resident 6] cut up food daily into bite sized pieces. Also open packets as needed. If [s/he] does not seem to be eating much, ask [him/her] if [s/he] needs assistance with eating. May need to assist with feeding for more difficult meals to manage on silverware."

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor discussed the concern that Resident 6, who required assistance with eating, was being

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provided his/her food but not receiving assistance, resulting in his/her food becoming cold and s/he is watching others eating. RVPO B and Executive Director F took notes.

Example 4: Resident 7

On 03/20/2025 and 04/21/2025, the Department received a concern alleging residents were not monitored for change of conditions so that adequate cares could be provided.

On 03/21/2025, at approximately 12:00 PM, Surveyor interviewed Resident 7's Family Member (FM) DD while s/he was cleaning Resident 7's room. Surveyor asked if s/he had any concerns with Resident 7's cares. FM DD stated Resident 7 dealt with incontinence and s/he did not believe staff were ensuring Resident 7 was monitored for this. FM DD stated, "Last Tuesday, [Concierge I] commented to me that [Resident 7] did not smell 'fresh' during exercises. I worry that staff are not recognizing [s/he] needs assistance with toileting and showering. [S/he] will hang [his/her] soiled clothing in the bathroom, and then re-wear them. It really becomes a dignity concern."

On 04/02/2025, at approximately 12:15 PM, Surveyor and Concierge O observed Resident 7's Surveyor observed a pair of black sweatpants that had a urine like scent hanging on the back of his/her shower chair. His/her clothes basket, located in the bathroom, had soiled clothing that had a urine like scent emanating from it.

On 04/10/2025, Surveyor reviewed Resident 7's record provided by RVPO (spell out the first time each cite) B.

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Y3244	Continued From page 68 Resident 7 moved into the facility, 07/29/2024. Resident 7's "Care Plan," dated 10/22/2024, documented: "Grooming: Independent" "Bathing: Independent" "Toileting: Independent" "Physical Disabilities - Falls: Requires occasional reminders to go to the bathroom and to change [his/her] depends. On 04/14/2025, at approximately 11:30 AM, Surveyor and Executive Director F observed Resident 7's room. Surveyor and Executive Director F commented that the room had a urine like scent emanating throughout it. Surveyor observed a soiled chuck pad that had a urine like scent and was damp to touch, sliding off his/her recliner. Surveyor stated to Executive Director F that Resident 7 was currently sitting in the common area. Executive Director F stated s/he would have a caregiver check on him/her to ensure s/he wasn't currently incontinent. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated care plans were being reviewed with family members. RVPO B explained that staff are directed by the tasks that are generated from the care plan, but staff are expected to monitor and update the nurse if a resident is experiencing a change of condition. On 04/21/2025, at approximately 11:00 AM, Surveyor interviewed FM MM. FM MM explained, "On 04/18/2025 when I went to visit my [Mom/Dad] [his/her] room smelled so bad. [S/He] had a wet chuck in [his/her] reclining chair and the waterproof cover we have was also soaked. There was a soaked chuck in [his/her] wheelchair	Y3244		

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and upon further inspection and sniff test it looked like there might have been fecal matter on the chair. [S/He] is not to be sitting in that wheelchair for any length of time. [His/Her] bathroom was filthy. I took a picture of [his/her] shower chair which had fecal matter on it as well. [S/He] had dirty laundry and [his/her] bathroom stunk. Once I was able to meet with [RVPO B] and [Executive Director F] I was told constantly that because [his/her] updated care plan isn't in place the staff didn't know to clean up and check on [his/her] room. [S/He] has only been changing [his/her] depends once a day which makes him soak through [his/her] pants. [Executive Director F] blamed me for not having a signed care plan for the delay in [his/her] care. That to me is actual neglect of a resident, risking skin breakdown on [his/her] buttocks and the possibility of sores. This is [his/her] dignity. [RVPO B] pointed blame at the staff as well. This isn't just a staffing issue as they have some amazing staff members there." FM MM stated s/he had communication with the provider, as s/he had been expressing his/her concerns for several months. The communication provided documented:
"03/25/2025 - Email to Executive Director F
I would really love to get a care plan in place for [Resident 7]. ... Below is an email I sent [Nurse G] before [s/he] left. This spells out what we want the staff to be on top of for [his/her] needs and care ... Below we have worked out what we think would work best [him/her], especially with working on changing [his/her] adult briefs. We know [his/her] dementia seems to be getting the best of [him/her], all while doing a great job hiding it from the staff and others.
1. [S/he] needs to shower daily. Full on shower, not washcloth and sink "shower" as [s/he] calls it. [S/he] tends to smell if [s/he] doesn't shower every day. This smell is because [s/he] doesn't

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Y3244	Continued From page 70 change [his/her] adult briefs in a timely manner every day. 2. [S/he] needs to notify the staff when [s/he] is getting in and out of the shower. [S/he] would also like to have a once-a-week spa bath. ... 3. Staff should come in and get out clean clothes out of [his/her] drawers/closet for [him/her]. [S/he] is hanging dirty soiled urine filled pants to dry overnight and puts them back on in the morning. ... 4. Staff also needs to come in and change [his/her] bed pad daily and [his/her] chair pad multiple times a day. It is important that [his/her] bed pad is changed out so [his/her] mattress and sheets don't end up smelling. [His/her] sheets and comforter should be washed weekly if not soiled and daily if soiled. [S/he] tends to "hide" [his/her] dirty urine pad under [his/her] pillows and re uses it the next night. We have washable pads, but if the staff would rather have disposable ones we can get those on order for [him/her]. 3. [sic] [s/he] needs to put on a clean new brief in the morning before heading down to breakfast. Along with clean clothes. This is after [s/he] showers. 4. After the morning exercise class, [s/he] needs to be assisted down to [his/her] room by a staff member and make sure [s/he] heads to the bathroom to change [his/her] brief. After [s/he] does that [s/he] can head back down to the great room to socialize with the other residents. A staff member may have to come back to get [him/her] to go down to the great room, [s/he] may end up going to [his/her] chair to sit. We want [him/her] socializing as much as possible. 5. [S/he] needs to be told and directed to change after lunch time. [S/he] will need to be assisted down to [his/her] room to change. Staff will have to walk [him/her] into [his/her] room and direct [him/her] into [his/her] bathroom. ...	Y3244		

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Y3244	Continued From page 71 6. Right before the 3:00 social time (maybe around 2:30) [s/he] will need to change again. The staff needs to have eyes on [him/her] going into [his/her] bathroom and direct [him/her] to change. 7. After dinner [s/he] will need to be assisted down to [his/her] room to change. Staff will need to have eyes on [him/her] going into [his/her] bathroom and direct [him/her] to change. 8. When [s/he] gets [his/her] nightly pills if that staff member could give [him/her] [his/her] meds and help direct [him/her] into the bathroom. ... Eyes on [him/her] to make sure [s/he] gets into the bathroom. 9. We would love for [him/her] to change one more time before [s/he] heads to bed, but I don't know when [s/he] goes to bed at night. 10. The staff has to do a daily sweep of [his/her] room to check for any soiled pants, wet pee pads, etc. If they see hanging shirts or pants hanging on [his/her] shower chair or towel bar they need to be put in the hamper to be washed so [s/he] doesn't wear them again. ... [his/her] room is starting to become a real problem smelling like urine. We are getting [him/her] a new chair already because [s/he] has ruined the one [s/he] has had for 6 months. The staff is starting to take note how bad [s/he] smells. Our [Mom/Dad] always took care of [him/herself] and took pride in how [s/he] looked and smelled. We also know the facility does not want their rooms smelling like urine. We truly think our [Mom/Dad] has very little sensation from the waist down so [s/he] has no idea if [s/he] is wet or not. [S/he] has told us that [s/he] doesn't know when [s/he] has urinated or when [s/he] happens to have the sensation to urinate [s/he] says [s/he] has about 30 seconds to get to the bathroom. ... [S/he] says that sometimes [s/he] goes in [his/her] brief and then forgets	Y3244		

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Y3244	Continued From page 72 immediately that [s/he] went and forgets to change. [S/he] also has very poor sense of smell, so [s/he] has no idea [s/he] smells." "03/25/2025 - Response from Executive Director F to Family Member MM I want to first start off by apologizing for the previous care and communication you received previously. ... I will then be working on the floor with training new hires and staff and changing the currently care. This email is the detailed information that is needed to ensure that your [mother/father] is receiving the care [s/he] needs and deserves. I please ask that you give me a week to two weeks to get into this AL building and learn the residents, from there is will update their care plans and meet with all the families and have care plan meetings. ... "01/28/2025 - Email to Nurse G: With [Family Member DD] visiting this past week [s/he] realized that our [Mom/Dad] has slipped back into [his/her] old ways of not changing [his/her] briefs regularly. We would love for [him/her] to be changing every 3-4 hours, or 4 times a day, but [s/he] isn't, and [s/he] is having frequent accidents. Which leads to [his/her] chair pad being soaked through and [him/her] going through many pairs of pants. ... As we have discussed in the past, I am so worried [s/he] will end up with a huge rash on [his/her] bottom, which leads to weeks of trying to clear up." "01/11/2025 - Text to Nurse G: A friend was visiting my [mom/dad] yesterday ... [S/he] said there were pee pads on [his/her] couch also. ... As you know I worry about [him/her] not changing and having accidents everywhere."	Y3244		

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Y3244	Continued From page 73 "12/04/2024 - Text to Nurse G: 1. [Resident 7] seems to not be wiping [him/herself] after [s/he] [toilets] ... having accidents. 2. [S/he] is not changing [his/her] [under garment] before going to bed, therefore soaking the bedding and all of [his/her] clothes. 3. [S/he] won't tell anyone [s/he] has soaked [his/her] bedding or clothes." "08/23/2024 - Text to Nurse G: I talked to my [mom/dad] and [s/he] told me [s/he] is back to changing only once a day. ...." Example 5: Resident 10 On 03/20/2025, the Department received a concern alleging staff did not provide cares to a resident who was new to the facility. On 04/02/2025, at approximately 1:30 PM, Surveyor interviewed Resident 10. Resident 10 explained that when s/he moved in they had given him/her a call pendant, but the pendant was coded to a different resident, so when s/he pressed the call pendant it did not ring to his/her room. Resident 10 stated, "I had to call out to try to get staff to assist me. It didn't go well. I had to sleep in my chair the first night because nobody checked on me." On 04/08/2025, Surveyor reviewed Resident 10's record provided by RVPO B. Resident 10 moved into the facility 03/17/2025. Resident 10's pre-admission assessment, dated 03/18/2025, documented: "Mobility/Transfer/Escort - Requires staff to escort resident (standby or physical assist with ambulation) or push wheelchair because of	Y3244		

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physical limitations - address fall risk."
"Mobility Transfers Escorts - Can they transfer and ambulate independently - No - stand-by assist."

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated that s/he had heard about this concern and immediately followed up on the concern. RVPO B stated it had sounded like the call pendant had been coded incorrectly, but staff should have been ensuring Resident 10 was settled into his/her new living arrangements by making frequent checks those first few days until staff were comfortable with the cares Resident 10 would require. RVPO B stated it was unacceptable that Resident 10 did not receive assistance his/her first night in the facility.

Example 6: Resident 11

On 04/15/2025, at approximately 4:10 PM, Surveyor interviewed Resident 2, who is the spouse to Resident 11. Resident 2 stated Resident 11 had sustained a fall in the bathroom. Resident 2 stated, "Somebody said they saw blood, so they called 911." Surveyor asked how staff were alerted to Resident 11's fall. Resident 2 stated Resident 11 had pressed his/her call pendant.

On 04/16/2025, Surveyor reviewed Resident 11's record which was provided by RVPO B.

Resident 11 moved into the facility, 09/23/2024, with a history of falling.

Resident 11's "Observations," documented:
03/20/2025 9:45 PM - Resident had a fall during pm shift and was sent out to the hospital to be

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	0020580	A. BUILDING: _____ B. WING _____	R 04/22/2025

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
Y3244	Continued From page 75 checked out On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. Surveyor stated s/he had been informed that Resident 11 had sustained a fall which required 911 to be called; it was determined upon further review that the staff scheduled to the second floor, where Resident 11 resides, were not available to assist Resident 11. RVPO B explained that s/he had been notified by a staff member that Resident 11 had sustained a fall and was complaining of pain and possible head injury, so 911 needed to be contacted. RVPO B stated Administrator A informed him/her that s/he had found out that Med Technician BB and Med Technician CC had taken lunch together, therefore, there were no assigned staff to the second floor when the fall occurred. RVPO B stated this was unacceptable and the staff members were reprimanded. Surveyor asked if first floor staff were aware that the staff on second floor were unavailable. RVPO B stated that when s/he interviewed them, they were not aware that Med Technician BB and Med Technician CC had left the building. Surveyor stated that staff s/he had interviewed were stating that Resident 11 had remained on the floor for approximately 40 minutes. RVPO B stated s/he did not recall it being that long, the call light report showed "something like 20 minutes." On 04/18/2025, Surveyor reviewed Resident 11's "Alarm History" which did not document a recorded call on 03/20/2025 during the lunch timeframe. The report documented 2 calls from the 2nd floor dining room and one call from his/her apartment at 10:32 AM that was responded to within one minute.	Y3244		

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Y3244	Continued From page 76 Example 7: Laundry On 03/18/2025, the Department received alleging family members are completing laundry such as linen changes. On 04/15/2025, the Department received a concern regarding the timeliness of laundry completion. On 04/21/2025, the Department received a concern alleging laundry was not completed as needed. On 03/21/2025, at approximately 11:40 AM, Surveyor interviewed Med Technician P. Surveyor asked if s/he was aware of concerns regarding laundry being completed when scheduled and that laundry was misplaced. Med Technician P stated, "The laundry doesn't always get finished, so it doesn't get returned until the next day, which can be upsetting to the residents. There are times items don't get returned, and I don't understand how that happens. Laundry is to be done separately." On 03/21/2025, at approximately 12:00 PM, Surveyor interviewed Resident 7's Family Member (FM) DD. Surveyor asked if s/he had concerns with Resident 7's laundry being completed. FM DD stated s/he felt that Resident 7's laundry needed to be completed more often, due to his/her incontinence. On 03/22/2025, at approximately 1:30 PM, Surveyor observed Resident 13's room. Surveyor observed clothing items and bed linen lying around the room. Surveyor observed a sign in Resident 13's bathroom that stated, "Your laundry and housekeeping will be done Monday	Y3244		

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Y3244	Continued From page 77 Mornings!" On 04/02/2025, at approximately 1:20 PM, Surveyor and Concierge O observed Resident 7's room, which had a urine like scent emanating throughout. Surveyor observed Resident 7's laundry basket overflowing with clothing that had a urine like scent. Surveyor observed black sweatpants hanging on the back of his/her shower chair that had a urine like scent. Surveyor observed a sign hanging in Resident 7's room that stated, "Shower/Laundry Days: Mondays AM, Tuesdays AM, Wednesdays - SPA, Thursdays AM, Fridays AM." On 04/02/2025, Wednesday, at approximately 1:20 PM, Surveyor walked into Resident 13's room and observed slippers, mail, used Kleenexes, clothing items, oxygen tubing, pill bottles, books, pens, and miscellaneous other items laying on his/her floor, around his/her recliner. Surveyor observed a sign in Resident 13's bathroom that stated, "Your laundry and housekeeping will be done Monday Mornings!" On 04/14/2025, at approximately 11:15 AM, Surveyor interviewed Housekeeping FF, who was completing laundry in the laundry room. Surveyor asked him/her to explain the laundry process. Housekeeping FF stated that each resident had a laundry basket and a scheduled laundry day, and their clothes were washed separately in the washer, then dried. Surveyor asked how resident laundry would be misplaced. Med Technician FF stated, "I am new, but I am not sure how that would happen since we do everyone's laundry individually." Surveyor observed a stack of folded laundry on a table in the laundry room. Surveyor asked who those clothes belonged to. Med Technician FF stated, "We don't know who those	Y3244		

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Y3244	Continued From page 78	Y3244		

belong to."

On Monday, 04/14/2025, at approximately 11:25 AM, Surveyor observed Resident 4's room. Surveyor observed his/her laundry basket overflowing with soiled clothing, linens, and blankets. Surveyor observed a sign hanging on his/her door that stated, "Shower/Laundry Dates: Sundays AM & Thursdays AM."

On Monday, 04/14/2025, at approximately 11:26 AM, Surveyor observed Resident 20's room. Surveyor observed his/her laundry basket full with soiled clothing, a white hand towel that was covered in a brown substance, sitting on the shower bench, a soiled towel lying on the bathroom floor. Surveyor did not observe a sign in his/her room that identified his/her laundry days.

On 04/14/2025, at approximately 11:45 AM, Surveyor and Executive Director F observed Resident 7's room, which had a urine like scent emanating throughout. Surveyor observed Resident 7's laundry basket overflowing with clothing that had a urine like scent. Executive Director F stated s/he would be discussing the concern with staff to ensure resident laundry is completed as scheduled.

On 04/15/2025, at approximately 4:55 PM, while Surveyor was onsite, Surveyor heard over the walkie talkie system that staff were unable to locate a resident's laundry.

On 04/15/2025, at approximately 4:30 PM, Surveyor interviewed Resident 8. Surveyor asked if s/he had any concerns regarding the completion of his/her laundry. Resident 8 stated they started doing his/her laundry in the evening

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Y3244	Continued From page 79 and s/he did not like that because s/he would end up waiting for his/her linens to be returned so s/he could make his/her bed. On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated that there had been a breakdown in shift responsibilities and who was responsible for what tasks. On 04/21/2025, at approximately 11:00 AM, Surveyor interviewed Resident 7's FM MM. FM MM expressed concerns that Resident 7's laundry is not completed as scheduled. Resident 7 dealt with incontinence and his/her clothing always smelled of incontinence, his/her chair covering, his/her bedding and when s/he visits, the laundry basket is always full of soiled clothing.	Y3244		