STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 000	Initial Comments On 09/12/2025 to 09/15/2025, Surveyors conducted 2 complaint investigations and a verification visit at The Courtyard at Fitchburg Assisted Living. Two deficiencies were identified. Two of 2 deficiencies were repeat violations. See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025 and SOD 93YW11, dated 05/23/2025. One complaint was unsubstantiated. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 33	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by:	N 381		

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

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N 381	Continued From page 1 Based on record review and interview, the provider did not ensure an assessment for Resident 22 was completed when there was a change in needs. Resident 22 was hospitalized from 08/24/2025 to 09/03/2025 due to a perinephric abscess caused by e faecalis. On 08/28/2025, Resident 22 was medically cleared to return to the facility with home health (HH) in place and Family Member PP providing support. The provider refused to accept Resident 22 back at the facility until s/he completed in-patient rehab. There was no evidence Resident 22 was reassessed prior to admission to rehab. This is a repeat violation. See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025. Findings include: On 09/08/2025, the Department received a complaint alleging concerns the provider would not accept a resident back after a hospitalization. The provider is licensed to care up to 72 residents in the following client groups: advanced age, physically disabled, irreversible dementia/Alzheimer's, and terminally ill. Surveyor reviewed the provider's program statement. The following was found: "Program Goals: 1. Care for the frail elderly, Alzheimer's and other related dementia population until they require discharge to a more advanced level of care or pass away. C. Provide intermittent medical nursing care when necessary (including medication supervision). Coordinating Health Care Services: We will assist residents with coordinating the following	N 381		

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healthcare services with outside providers; Home Health, Lab, X-Ray, Hospice, Therapy Services-PT, OT, ST, Oxygen, Medical Equipment/Supplies, Pharmacy Services."

On 09/10/2025, Surveyor reviewed Resident 22's record and identified the following:

Resident 22 was admitted to the facility on 03/21/2024 with diagnosis including chronic kidney disease stage 5, type 1 and 2 diabetes, and iron deficiency anemia. Resident 22 was his/her decision maker. Resident 22's individual support plan (ISP) dated 06/05/2025 indicated s/he was independent with activities of daily living.

Resident 22's record contained a pain tool assessment dated 06/12/2025 and a medication self-administration assessment dated 07/29/2025. There was no evidence Resident 22 was reassessed after his/her hospitalization on 08/24/2025 to 09/03/2025.

Resident 22's progress notes documented:
"-07/30/2025: [Resident 22] has returned from [his/her] liver [sic] transplant. [S/he] is self administering [his/her] own Tacrolimus, because the time [s/he] receives it depends on the time of the lab. [Family Member PP] will take to labs on Monday and Para transit will take on Thursdays, [Family Member PP] to set up appointments. [Resident 22's] incision is clean and has a dry dressing on that needs to be changed twice a day. [Resident 22] feels [s/he] can do the dressing change [him/herself], as [s/he] was trained in the hospital. Nurse will assess weekly. Any transplant concerns should go to RN transplant coordinator.
-08/07/2025: Incision line is drying and free of infection. It has some slight drainage but less

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than previous. Denies any pain at site.
-08/12/2025: Resident stated [s/he] was fine no complain of pain. Staff didn't see no drainage or redness on incision. Staff will continue to monitor resident for change of condition.
-08/15/2025: Resident stated [s/he] was just sleepy today. Resident has no pain or concern. Resident incision looks ok no drainage or redness on wound. Resident appears to be doing great.
-08/20/2025: Resident stated [his/her] tired but ok. Resident incision looks dry no drainage no redness. Staff will continue to monitor resident for change of condition.
-08/24/2025: Family informed executive director (ED) and [Regional Wellness Director C] that [Resident 22] was admitted to the hospital due to fluids around [his/her] kidney. Currently do not have a discharge date.
08/25/2025: Writer received notification from [LPN Supervisor QQ] that [s/he] received a voicemail from hospital regarding an update on resident. Per voicemail, resident has had peritoneal drains place and will very likely need to be drained and flushed daily. Writer left a voicemail requesting a return call. Writer informed [Family Member PP] that the above tasks require a higher level of care than we can provide. [Family Member PP] informed writer they are hopeful home health (HH) will step in and provide these skills some days and [s/he] would complete the other days. Writer expressed concern due to the risks associated with the drains and non 24 hour nurse present in the community. Writer to await return call, discuss with team, and then follow-up with [Family Member PP]."

A review of Resident 22's hospital records dated 08/24/2025 to 09/03/2025 documented:
"Hospital Course: [Resident 22] who underwent a

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N 381	Continued From page 4 deceased donor kidney transplant on 7/25/25. Presented to the ED on 8/24 with decreased urine output, fatigue, diarrhea, and hyperkalemia. Renal US and CT A/P completed on arrival revealing a perinephric fluid collection. CT cystogram was negative for urine leak. IR drain placed and studies revealed a perinephric abscess (+E faecalis), currently treated with Zosyn. Blood cultures with no growth to date. Repeat CT a/p 9/2 with no significant residual fluid collection and no new or enlarging collections. Patient will discharge to Inpatient Rehab with drain in place. Plan for repeat imaging in 2 weeks to guide drain removal and total antibiotic duration. [S/he] will remain on Zosyn until CT scan where final duration will be determined by ID provider. [S/he] was initiated on Tamsulosin during admission with improvement in urine output. Creatinine improved to 2.63 on discharge. Discharge immunosuppression: Myfortic 360mg two times a day, Tacrolimus 5mg two times a day, Prednisone 10mg daily. [S/he] will continue on standard transplant ID prophylaxis: Acyclovir, Bactrim. Blood pressure controlled with Coreg, Nifedipine and addition of Hydralazine. Diabetes Management Service consulted for blood glucose management ... ...May Shower - Keep Drain Tube Clean and Dry Maintain Abscess Drain. How do I care for my ABSCESS drain at home? Most patients are sent home with the drainage tube in place. It is very important that you know how to care for the tube once you are home. The dressing should be changed every 3 days. The tube site is cleaned when the dressing is changed. The site should be cleaned with mild soap and water. Then, a small sterile gauze should be placed over the site and covered with a Tegaderm (Trademark) dressing. If your skin is sensitive to the Tegaderm (Trademark) dressing, you will follow the same	N 381		

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N 381	Continued From page 5 steps, but the gauze can be taped in place. In this case the dressing needs to be changed daily. -08/26/2025 Discharge Planning Note by [Social Worker SS]: Update/Plan: Social Work/Case Management team following. Chart reviewed. Discussed patient and discharge plan with interdisciplinary team. -Pt is not medically ready for discharge. Barriers to Discharge: treatment issues and home safety concerns. [Provider's name] ATTN: [Regional Wellness Director RR] and [Regional Wellness Director C] stated that they have concerns about patient discharging back to [provider's name]. They requested UWHC PT and OT to evaluate patient prior to discharge before they would agree to accept patient. Anticipated Discharge Plan. Date: TBD. Destination: TBD depending on patient's progress with PT and OT. Common Heart Home Health has agreed to provide home service for patient 3 times weekly for drain cares and teaching. [Family Member PP] stated that [s/he] plans to assist patient with drain care as well. -08/28/2025 Discharge Planning Note by [Social Worker SS]: Update/Plan: Social Work/Case Management team following. Chart reviewed. Discussed patient and discharge plan with interdisciplinary team. -Pt is medically ready for discharge. Barriers to Discharge: waiting on placement. [Provider name] (where patient had been staying) .....ATTN: [Regional Wellness Director RR] declined to accept patient. [Regional Wellness Director RR] feels that patient is too weak to go back to ALF and [Regional Wellness Director RR] stated that patient cannot return to the above stated ALF with a drain." Surveyor reviewed an email from Family Member PP sent to Regional VP of Operations B and	N 381		

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Regional Wellness Director C dated 08/28/2025:
"Dear Care Team at [Provider's name]:
I want to ensure I am appropriately understanding your verbal communications to me and the UW Hospital's Social Worker regarding [Resident 22's] return to [Provider's name] after [his/her] hospital discharge.
This is a very stressful time for [Resident 22] and myself, which is what is prompting this request for confirmation or clarity in the verbal information received.
My understanding is that you are terminating [his/her] contractual agreement effective immediately, and [s/he] may never return to [his/her] residence at the [Provider's name].
The steps I must immediately take to provide for [his/her] care depend on your confirmation or clarification of my understanding.
Since [Resident 22] is expected to be discharged from the hospital today, I would appreciate your confirmation or clarification about [his/her] return before the close of business today (5:00 p.m. Central Time). If no response or clarification is received, I will necessarily understand this to be a confirmation.
Below is my contact information.
Thank you.
[Family Member PP]."

Surveyor reviewed a complaint/grievance form dated 08/28/2025. The following was documented:
"Nature of complaint: see email.
How complaint was investigated and when investigation was completed: Had a phone conversation with [Family Member PP] and [Resident 22], [Regional Wellness Director RR], [Regional VP of Operations B] to explain/review [his/her] email.
Findings of investigation: No 30 day notice was

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N 381	Continued From page 7 being given. Due to [Resident 22's] fragile medical state-recommended rehab stay to get stronger and have oversight with frequent med changes. Actions taken to correct or address any issues or problems: Follow up/assessment based on [Resident 22's] progress. Response to person originating the complaint: Phone call on 8.28.25." On 09/12/2025 at 10:48 AM, Family Member PP sent the following email to the Surveyor: "Thank you for looking into this situation when you at the [provider's name] facility this week. As of late yesterday afternoon, [provider name] confirmed that [Resident 22] is allowed to return to [his/her] facility today instead of discharging to a hotel. From my verbal conversation with [Regional VP of Operations B] yesterday afternoon, [Resident 22] is allowed to return because [Resident 22] will be managing the drain [him/herself]. I asked what had changed as that was what was communicated (through [Social Worker SS] at UW Hospital) prior to discharge, instead of discharging from the hospital to a rehab (OT/PT could have been provided through the OT/PT services on-site at [provider's name]; [Social Worker SS] and [provider's name] were aware of that). [Regional VP of Operations B] indicated [s/he] 'had not been part of those conversations.'" On 09/10/2025 at 10:38 AM, Surveyor interviewed Regional VP of Operations B. Surveyor questioned why Resident 22 was not able to be discharged to the provider following his/her hospitalization from 08/24/2025 to 09/03/2025. Regional VP of Operations B reported s/he was not involved with the clinical side of things, but after talking with the	N 381		

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management team, Resident 22 was weak, anemic, and had drains inserted. Regional VP of Operations B noted the provider asked for therapy to assess prior to discharge. Regional VP of Operations B stated our staff could not manage the drains. Regional VP of Operations B reported s/he did not know if Resident 22 was medically stable before going to rehab and do not recall the hospital discussing HH. Regional VP of Operations B reported Resident 22 was set to discharge from rehab on 09/12/2025, but until s/he can come back, we want HH to see him/her daily and s/he would manage his/her drains independently.

On 09/10/2025 at 11:15 AM, Surveyor interviewed Regional Wellness Director C. Regional Wellness Director C reported later in August, Resident 22 started to get weak, s/he couldn't walk to meals, so [Family Member PP] took him/her to the hospital. Regional Wellness Director C stated s/he never talked to the hospital social worker, Regional Wellness Director RR did. Regional Wellness Director C reported therapy assessed Resident 22 while in the hospital, but s/he could use more. Regional Wellness Director C stated the provider was worried about the drains (risk of infection), draining the tubes, and Resident 22's ability to see his/her incision sites. Surveyor questioned if Resident 22 was medically stable enough to return home with supports in place instead of going to rehab. Regional Wellness Director C stated rehab wouldn't have taken him/her if s/he didn't need it. Regional Wellness Director C reported s/he and Regional Wellness Director RR did not reassess the resident before going to rehab. Surveyor asked why Resident 22 was not reassessed. Regional Wellness Director C did not provide an answer and noted if s/he comes back now, we feel better about accepting

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him/her, s/he's stronger, the tubes are older, and we are developing a plan for nurse coverage.

On 09/11/2025 at 10:28 AM, Surveyor interviewed Social Worker SS. Social Worker SS reported Resident 22 was medically stable to return to the provider on 08/28/2025. Surveyor asked for clarification on why the provider would not accept Resident 22 back before going to in-patient rehab. Social Worker SS reported the provider stated 2 reasons, one was the drain care, and two was s/he was too weak. Social Worker SS stated the provider asked for Resident 22 to receive therapy while in the hospital, so Resident 22 was assessed by therapy staff. Social Worker SS reported the hospital set up home health 3x/week with Family Member PP agreeing to come on the off days to perform drain care. Social Worker SS stated Resident 22 expressed s/he wanted to return to the provider. Social Worker SS stated Resident 22 and Family Member PP were trained on drain care prior to discharge. Social Worker SS reported after the above was coordinated, the provider still did not want to accept him/her back and instead suggested Resident 22 go to in-patient rehab. Social Worker SS stated s/he was not aware of any provider staff coming to the hospital to assess Resident 22.

On 09/12/2025 at 12:58 PM, Surveyor interviewed Family Member PP. Family Member PP reported on 08/28/2025, Resident 22 was medically stable to return to the provider with HH, myself helping with drain care, and PT/OT provided in house, but the provider refused to accept him/her back due to the drain. Surveyor asked if s/he was contacted about a reassessment being completed by provider staff prior to admission to rehab. Family Member PP

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N 381	Continued From page 10 stated s/he had not and was unaware if Resident 22 was reassessed prior to going to in-patient rehab. Family Member PP expressed frustration as Resident 22's admission agreement noted if appropriate external nursing services are needed the provider will help coordinate these services, which the provider did not, instead required Resident 22 to go to rehab. Family Member PP shared after talking with Regional VP of Operations B, Resident 22 will be allowed to return to the facility in the coming days instead of discharging to a hotel. Family Member PP reported Resident 22's drain was still not removed and questioned what had changed with Resident 22's care. Family Member PP noted Regional VP of Operations B was not part of those discussions with other management staff. Cross Reference: N0431 83.38(1)(g) Health Monitoring	N 381		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N	N 431		

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N 431	Continued From page 11 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 22 had their health monitored and communication with the resident's physician was documented in the resident's record. Resident 22 had 1 occurrence in which his/her blood sugar was over 350, there was no evidence of staff notifying his/her physician. Resident 22 had 3 occurrences in which his/her blood pressure was over 180/90, there was no evidence of staff notifying his/her physician. This is a repeat violation. See Statement of Deficiency (SOD) WYGZ11, dated 01/28/2025 and SOD 93YW11, dated 05/23/2025. Findings include: On 09/10/2025, Surveyor reviewed Resident 22's record and identified the following: Resident 22 was admitted to the facility on 03/21/2024 with diagnosis including chronic kidney disease stage 5, type 1 and 2 diabetes,	N 431		

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and iron deficiency anemia. Resident 22 was his/her decision maker. Resident 22's individual support plan (ISP) dated 06/05/2025 indicated medications administered by staff.

Resident 22's hospital records dated 07/25/2025 to 07/30/2025 documented: "Primary discharge diagnosis: Kidney transplant. Other procedure orders: Measure blood pressure and pulse for kidney transplant patients. Measure and record blood pressure and pulse two times each day and alert Transplant Coordinator if systolic blood pressure (top number) is greater than 180, and diastolic blood pressure (bottom number) is greater than 90. Diabetes Care: Check blood sugar 3 times a day. If blood sugar is out of your goal range, you may need your insulin dose changes. When to Call. Blood sugar is greater than 150mg/dL more than half of the time, Blood sugar is greater than 400 mg/dL, Blood sugar is less than 70 mg/dL."

Resident 22's physician orders documented: "-Accu-Chek Guide Mtr with instructions to check blood sugar 2 times a day and if needed for signs and symptoms of Hypo or Hyperglycemia, contact physician for glucose levels below 60 or above 350, with a start date of 08/08/2025.
-Blood pressure and pulse with instructions to get blood pressure and pulse twice a day, with a start date of 07/31/2025.
-Blood sugar related to transplant, with instructions to get blood sugar 3 times day with a start date of 07/31/2025."

Surveyor reviewed Resident 22's medication administration record (MAR) from 08/01/2025 to 08/24/2025. Surveyor observed 1 occurrence in which Resident 22's blood sugar was within notification parameters, there was no evidence in

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-C 09/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 431	Continued From page 13 which Resident 22's medical provider was notified of the high blood sugar readings: -08/18/2025 (noon): Blood sugar documented as 428 Surveyor reviewed Resident 22's medication administration record (MAR) from 08/01/2025 to 08/24/2025. Surveyor observed 3 occurrences in which Resident 22's blood pressure was within notification parameters, there was no evidence in which Resident 22's medical provider was notified of the high blood pressure readings: -08/02/2025 (HS): Blood pressure documented as 141/91. -08/21/2025 (AM): Blood pressure documented as 181/82. -08/21/2025 (HS): Blood pressure documented as 185/82. On 09/10/2025 at 1:45 PM, Surveyors interviewed Regional VP of Operations B and Regional Wellness Director C. Surveyor again requested evidence Resident 22's physician and/or transplant coordinator was notified of the above blood sugars and blood pressure results. Regional Wellness Director C reported Resident 22 would bring blood sugar and blood pressure results on a piece of paper to his/her physician when going to appointments. Both staff acknowledged Resident 22's record did not currently have evidence his/her physician was notified of the above results but requested additional time to review the record. Surveyor noted any additional evidence would need to be submitted by 5:00 PM on 09/10/2025. As of 09/11/2025, no additional evidence was submitted. Cross Reference:	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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