STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014758	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERY MEMORY CARE	**215 BIRCH STREET WEST AMERY, WI 54001**

(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 Surveyor: Johansen, Madeleine On 05/21/2025, Surveyors conducted a self-report and complaint investigation at Amery Memory Care. Data was collected through 06/02/2025. Three of 5 complaints were substantiated. Three violations were identified. Two of 3 violations were repeat deficiencies. See Statement of Deficiency (SOD) CQ9P11, dated 10/18/2022, SOD QKNG11, dated 01/25/2022, SOD T19F11, dated 10/29/2020, and SOD 3NUV11, dated 07/16/2019. Census: 56.	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on interview and record review, the provider did not immediately notify the resident's legal representative and the resident's physician when there was an injury to the resident.	N 169		

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

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N 169	Continued From page 1 This is a repeat violation. See Statement of Deficiencies (SOD) CQ9P11, dated 10/28/2022 and SOD T19F11, dated 10/29/2020. Findings include: The provider is licensed to care for 68 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced age. On 03/03/2025, the Department received a complaint regarding resident care. Resident 2 was admitted on 11/22/2023 and has an activated power of attorney for healthcare (POAHC). On 05/21/2025 at approximately 10:54 AM, Surveyors interviewed Resident Health Coordinator (RHC) B, who stated that on 01/26/2025, the on-call staff were not notified when Resident 2 sustained a skin tear injury on his/her left bicep. RHC B stated that Resident 2's injury had been discovered by Resident Care Coordinator (RCC) E on 01/26/2025, but no follow-up was done by staff until a hospice aide discovered the injury on 02/05/2025. Hospice staff then reported the injury to Resident 2's family and Power of Attorney (POA). RHC B stated that when injuries were documented by floor staff, the RHCs are supposed to follow-up and notify the appropriate people. RHC B stated that staff had not communicated Resident 2's injury. On 05/21/2025 at approximately 12:59 PM, Surveyors interviewed RHC C, who stated that Resident 2's family was not notified of Resident 2's injury.	N 169		

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N 169	Continued From page 2 On 05/27/2025 at approximately 4:05 PM, Surveyors interviewed RCC E, who stated that when getting Resident 2 ready for bed on 01/26/2025, another staff member pointed out the injury on Resident 2's left bicep. RCC E stated that the injury was a skin tear that presented as a cut, was not bleeding, and was approximately 4 inches across and 5 inches long. RCC E stated that s/he thought Resident 2 may have sustained the injury when s/he was in the hallway in his/her Broda chair (specialized wheelchair). RCC E had observed Resident 2 earlier that day with his/her arm stuck between his/her Broda chair and the wall. RCC E stated that the injury did not appear to cause Resident 2 any pain. RCC E stated s/he had placed a bandage on Resident 2's arm and had filled out a skin assessment and an observation note. RCC E stated that the notes and skin assessment were supposed to be reviewed by an RHC the following day. RCC E stated staff were directed only to call the on-call RHC if a resident fell or went to the hospital. On 05/21/2025, Surveyors reviewed Resident 2's records, which included: -An observation note by RCC E, dated 01/26/2025, indicating a skin assessment had been filled out. -An observation note by RHC B, dated 02/05/2025, indicating the POA had been notified of the injury by hospice. -An observation note by Administrator D, dated 02/14/2025, stating, "[Facility] staff is taking full responsibility for not notifying of incident in [sic] timely manner. The incident was overlooked by [facility] and [hospice] ...[the injury] was not reported to management or hospice team. [sic] right away as it should have been due to the severity of the wound."	N 169		

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N 169	Continued From page 3 -The individualized service plan (ISP), dated 05/21/2025, regarding daily skin checks stated, "If any concerns are noted, staff are to complete a Skin Review and Investigation form in ECP [electronic health record], document skin concern in an observation note, and immediately notify RHC/DON [Director of Nursing]/Hospice." -A self-report, written by Administrator D and dated 02/13/2025, indicated that staff had discovered Resident 2's injury on 01/26/2025, but that hospice had notified the POA on 02/05/2025. -A Skin Review & Investigation form, dated 02/25/2025, indicated Resident 2's POA/Guardian was notified of the injury on 02/05/2025 by hospice. -Administrator D provided an investigation into the injury. The investigation indicated the provider failed to report the injury to hospice and Resident 2's POA. On 05/28/2025, Surveyors reviewed the provider's Injury of Unknown Origin Policy and Procedure, which read, "The CBRF [community based residential facility] shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident ..." The provider did not ensure that Resident 2's legal representative or physician was immediately notified when there was an injury of an unknown origin. Cross reference: Y3244 Chapter 50.09(1)(L) Care	N 169		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

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N 352	Continued From page 4 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure Resident 1's medication was administered as prescribed. This is a repeat violation. See Statement of Deficiencies (SOD) QKNG11, dated 01/25/2022, SOD T19F11, dated 10/29/2020, and SOD 3NUV11, dated 07/16/2019. Findings include: On 04/08/2025, the Department received a complaint about medication administration. The provider is licensed to care for 68 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced age. On 05/21/2025, Surveyors reviewed Resident 1's records: -The physician order form, dated 12/06/2024, read, "O2 [oxygen] @ 1 L [liter] anytime [s/he] is resting or sleeping." -The provider's physician order sheet, updated 12/06/2024, read, "Oxygen to be on at bedtime or anytime resident is resting/sleeping throughout the day at 1LPM [liter per minute] to keep saturations above 90%." -The individual service plan (ISP), dated 05/21/2025, read, "Resident currently needs	N 352		

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N 352	Continued From page 5	N 352		

oxygen at bedtime as ordered by [his/her] physician and as needed throughout the day to keep oxygen saturations above 90%."
-Observation note, dated 04/03/2025, read, "[Public Agency Official (PAO) A] was asking questions about medication list and [Resident 1's] oxygen order and how it is worded, and that [Resident 1] did not have oxygen on when [s/he] was sleeping in [his/her] wheelchair."
-Observation note, dated 04/30/2025, read, "[Resident 1] does not have [his/her] oxygen on in bed."

On 05/21/2025, from approximately 12:26 PM to 12:29 PM, Surveyors observed Resident 1 sleeping in the dining room in [his/her] Broda chair without oxygen.

On 05/21/2025, at approximately 10:54 AM, Surveyors interviewed Resident Health Coordinator (RHC) B. RHC B stated that s/he had observed Resident 1 not utilizing oxygen while napping.

On 05/21/2025, at approximately 12:43 PM, Surveyors interviewed Administrator D, who stated that Resident 1's Broda chair did not have an oxygen tank attached because it hindered Resident 1 from independently propelling in his/her chair.

On 05/21/2025 at approximately 12:59 PM, Surveyors interviewed RHC C. RHC C stated that s/he observed Resident 1 sleeping in his/her Broda chair in the bistro without oxygen. RHC C stated that s/he had observed Resident 1 resting, without utilizing oxygen, approximately 2 to 3 times in the past month.

The provider did not ensure Resident 1's oxygen

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N 352	Continued From page 6 was administered as prescribed by a practitioner.	N 352		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure every resident in the CBRF (community based residential facility) received adequate and appropriate care within the capacity of the facility. Findings include: On 03/03/2025, the Department received a complaint alleging a resident did not receive prompt care. The provider is licensed to care for 68 residents	Y3244		

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Y3244	Continued From page 7 in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 05/21/2025, Surveyors reviewed Resident 2's records. Resident 2 was admitted on 11/22/2023 and diagnosed with atrial fibrillation, renal cyst, diplopia, hyperlipidemia, hypertensive heart without heart failure, hypertension, and absolute glaucoma. Resident 2 had an activated power of attorney for healthcare (POAHC). Resident 2's records included: - The individualized service plan (ISP), dated 05/21/2025, read "Resident utilizes a high back self-propelling broda [sic] chair for mobility ...Resident has a history of getting hung up on the railings, walls, and tables while self-propelling around the facility ...[sic] Resident is at risk for skin breakdown due to being unaware of environmental surroundings and frequently bumping into surroundings. Staff are to document and report any skin breakdown. Staff to fill out skin assessment form for any skin assessment concerns ...Resident has a skin tear to upper left bicep ...Staff to check resident's entire body, paying close attention to areas that are prone to bruises and/or skin tears, such as arms and legs. If any concerns are noted, staff are to complete a Skin Review and Investigation Form in ECP [electronic health record], document skin concern in an observation note, and immediately notify RHC/DON [Resident Health Coordinator/Director of Nursing]/Hospice." - The Skin Review & Investigation form, dated 01/26/2025, and electronically signed by Resident Care Coordinator (RCC) E, indicated that Resident 2 had a skin tear that was	Y3244		

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Y3244	Continued From page 8	Y3244		

approximately 5 cm long and 3 cm wide on his/her upper left arm and that Resident 2 did not indicate any pain or burning.
- The Skin Review & Investigation form, dated 02/05/2025, and electronically signed by RHC B, indicated that a hospice nurse reported a large skin tear on Resident 2's left bicep. The form read, "Staff [sic] it is very important that we are reporting any skin concerns and filling out skin assessments when they happen." The form also indicated that the hospice staff removed the bandage (dated 01/26/2025) and that the injury was "very wet and actively bleeding." The form also indicated that Resident 2's Power of Attorney (POA) had been updated on the injury by hospice on 02/05/2025.
- An observation note, dated 01/26/2025, indicated a Skin Review & Investigation form had been filled out by RCC E.
- An observation note written by Administrator D, dated 02/14/2025, read "There were other skin tears that were being monitored regularly by [facility] staff, so this documented 'new' skin tear was overlooked."
- The provider's investigation into Resident 2's injury-of-an-unknown source, which included staff statements, Hospice Aide (HA) F's statement, and hospice visit notes and orders. HA F's statement indicated s/he had given Resident 2 a bed bath on 01/27/2025, a shower on 01/29/2025, and a shower on 02/05/2025. HA F's statement indicated s/he had not seen a skin tear on Resident 2's left bicep until 02/05/2025, and then reported it to the hospice nurse.

On 05/21/2025 at approximately 9:50 AM, Surveyors interviewed Administrator D, who stated Resident 2 was very active and had experienced more than 1 injury.

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Y3244	Continued From page 9 At approximately 1:05 PM, Surveyor interviewed RHC B who stated RCC E did not inform the after-hours on-call team about an injury found on Resident 2's left arm. RHC B stated that Resident 2 used a Broda chair that was low to the ground, and Resident 2 propelled him/herself around. RHC B stated that since the injury was first discovered on 01/26/2025 hospice had been onsite to bathe/shower Resident 2 on 2 occasions. RHC B stated that if hospice had showered Resident 2, they would have seen the injury. RHC B stated hospice found the injury on 02/05/2025. RHC B stated the provider's procedures regarding unknown injuries were for staff to fill out a skin assessment and the RHC to follow up. At approximately 1:30 PM, Surveyors interviewed RHC C, who stated that hospice staff had been on site after 01/26/2025 to shower Resident 2 and concluded hospice could not have showered Resident 2 or they would have seen the bandaged injury. At approximately 3:00 PM, Administrator D stated that Resident 2's injury had not been bleeding initially, and that the injury started bleeding when it was discovered by hospice on 02/05/2025. Administrator D also stated the injury affected only the skin and was not deep. Administrator D stated s/he thought Resident 2 may have sustained the injury from the corner of a handrail in the hallway. On 05/27/2025, from 4:05 PM to 4:20 PM, Surveyors interviewed RCC E, who stated that when s/he discovered Resident 2's left arm injury, it was approximately 5 inches long, 4 inches wide, that the injury did not affect the muscle, presented as a cut, required very little clean-up,	Y3244		

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Y3244	Continued From page 10	Y3244		

and did not appear to be bleeding or causing pain. RCC E stated the injury was discovered when RCC E and another staff member were getting Resident 2 ready for bed. RCC E stated s/he covered the area with a Mepilex bandage. RCC E stated s/he made an observation note in Resident 2's record and filled out a skin assessment. RCC E stated the skin assessment and observation note would be reviewed by an RHC. RCC E recalled that Resident 2 may have gotten the injury between 3-7 PM in a hallway when his/her left arm had been stuck between the wall and chair. RCC E stated it was the provider's policy for staff to call the on-call RHC only if a resident fell out of bed or went to the hospital. RCC E stated that on 02/05/2025, hospice discovered the injury and reported it to the provider. RCC E stated that when hospice discovered the injury, it appeared worse than it had on 01/26/2025.

On 05/29/2025, from approximately 1:00 PM to 1:44 PM, Surveyors interviewed Administrator D and Senior Administrator (SA) J. SA J stated that when management reviewed Resident 2's skin assessment form from 01/26/2025, it was assumed that the injury being referenced was a pre-existing one. SA J stated that there was oversight on management's part and "[management] take[s] 100% accountability for that."

In summary, Resident 2 sustained an injury-of-unknown-origin to his/her left bicep on 01/26/2025, which was bandaged by staff. A skin assessment and an observation note were filled out, but the injury was not treated or followed-up on until 02/05/2025.

On 02/25/2025, Resident 2 was discharged from

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Y3244	Continued From page 11 the provider facility per his/her family wishes. The provider did not provide adequate treatment when an injury discovered on 01/26/2025 was dressed and documented. The injury had no follow up until 02/05/2025 when observed by a hospice nurse. Cross Reference: N-0169 83.12(5)(a) Notification: Incident, Injury, Changes	Y3244		