STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 05/21/2024, with information gathered through 06/06/2024, Surveyors conducted 3 complaint investigation at The Koselig House. Nine deficienies were identified. Three of 3 complaints were substantiated. One of the 9 deficiencies were a repeat violation (see Statement of Deficiency (SOD) GRGR11). Census: 27	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. This Rule is not met as evidenced by: Based on interview and record review, after	N 158		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 158	Continued From page 1	N 158		

receiving allegations of abuse for 2 of 2 residents, the provider did not take immediate steps to ensure the safety of residents, investigate and document the allegations to make a determination about the alleged caregiver misconduct.

The provider did not investigate after Caregiver G reported to Director C that Caregiver H and Caregiver I had verbally assaulted Resident 2.

The provider did not investigate after Caregiver G reported to Director C that Caregiver H had acted physically aggressive towards Resident 8.

Findings include:

The provider is licensed for a community based residential facility (CBRF), Class CNA (nonambulatory), to serve up to 40 residents within the client groups advanced aged, irreversible dementia/Alzheimer's, terminally ill, and physically disabled.

Example 1: Resident 2

On 05/13/2024, a concern was filed with the Department alleging that residents were being verbally assaulted due to staff misconduct.

On 05/21/2024, at approximately 1:45 PM, Surveyors interviewed Director A and Programming/Business Development (PBD) D. Surveyors explained the concern that had been called into the Department. Director A stated law enforcement had investigated the concern and s/he was unsure if there was documentation of an internal investigation. Surveyors requested Resident 2's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 158	Continued From page 2 On 05/21/2024, at approximately 1:57 PM, Surveyor interviewed Resident 2. Resident 2 stated there was a caregiver who had punched him/her in the arm and that it had happened about a month ago because Resident 2 called the caregiver a big mouth. Resident 2 stated the police were notified because the caregiver had come in the room and started arguing, then punched him/her in the bicep. Resident 2 stated caregivers would also refer to him/her as "pissy pissy pissy" because of incontinence and would sit in his/her bathroom and make fun of him/her. Resident 2 stated s/he had to sit in urine multiple times because the caregivers refused to assist helping him/her to the bathroom. On 05/30/2024, Surveyor reviewed the supporting documentation that was submitted with the filed concern, which documented: "04/18/2024 ... I [Detective L] conducted a follow up interview with [Caregiver G] ... [Caregiver G] stated last night, April 17, 2024, [s/he] was working with [Caregiver H] and [Caregiver I] and the both of them went into [Resident 2's] room. [Caregiver G] stated employees in the facility have been talking about [Resident 2] and how [s/he] needs to leave because [s/he] is a mess and does too much. [Caregiver G] stated employees do not want to do anything for [Resident 2] and have allowed [Resident 2's] call light to go off for '154 minutes.' [Caregiver G] stated [s/he] went into [Resident 2's] room and [Resident 2] had urinated in [his/her] clothing. [Caregiver G] stated [Caregiver H] and [Caregiver I] then came into the room and told [Resident 2] they heard [s/he] received a 30-day notice and that [his/her] new facility won't want to take [him/her]. [Caregiver G] then stated both [Caregiver H] and [Caregiver I] both took turns manipulating [Resident 2] and were calling	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 158	Continued From page 3	N 158		

[Resident 2] 'pissy pissy pissy' trying to agitate [Resident 2]. [Caregiver G] stated [Resident 2] then told [Caregiver H] and [Caregiver I] multiple times to get out of the room as they were not helping [him/her]. [Caregiver G] stated [Caregiver H] and [Caregiver I] were not listening, so [Resident 2] picked up a cup of water to throw it at them. [Caregiver G] then stated [s/he] was able to get [Resident 2] to put the cup of water down. ... [Caregiver G] stated [s/he] then called [Director A] about what actually happened and [Director A] told [Caregiver G] to write a statement about the incident. [Caregiver G] stated [s/he] wrote the statement and placed it under [Director A's] door. [Caregiver G] advised [s/he] spoke to [Director A] today and [Director A] advised [s/he] was trying to hire new people so [s/he] could then cut others."

Resident 2's record did not contain an incident report for the 04/17/2024 concern that Caregiver G described to law enforcement.

Example 2: Resident 8

On 05/13/2024, a concern was filed with the Department alleging that residents were being handled aggressively due to staff misconduct.

On 05/21/2024, at approximately 1:45 PM, Surveyor interviewed PBD D. PBD D stated s/he was not aware that Caregiver H had been observed by Caregiver G being aggressive towards Resident 8. PBD D stated, "I did observe [Resident 8] to have a huge gash/bruise on [his/her] leg. I have no idea what caused that or if anybody investigated the injury." Surveyor requested Resident 8's record.

Resident 8 moved into the facility, 09/14/2023,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 158	Continued From page 4	N 158		

with diagnosis including age related physical debility.

Resident 8's record did not contain an incident report regarding the 05/14/2024 observation. His/her record did not contain any documentation regarding PBD D's observation of Resident 8's gash/bruise on his/her leg.

Resident 8's undated "Care Plan," documented:
"Transfer - Staff Assistance: Requiring 1 staff with walker for transfers."
"Ambulation - Assist: Resident requires assist with: supervision and walker. [Resident 8] may get up independently at times. Staff to monitor and if present when [s/he] gets up provide supervision/1 assist. Uses walker in [his/her] room. Wheel Chair for distance."

On 05/30/2024, Surveyor reviewed the supporting documentation that was submitted with the filed concern, which documented:
"04/18/2024 ... I [Detective L] conducted a follow up interview with [Caregiver G] ... I asked [Caregiver G] to explain [Caregiver H] to me and [Caregiver G] stated [Caregiver H] is aggressive with the residents both verbally and physically. [Caregiver G] explained [Caregiver H] tries to 'man handle' the residents. I asked [Caregiver G] to explain what [s/he] meant by a situation [s/he] had observed and [Caregiver G] stated [Caregiver H] has previously tried to get [Resident 8] to sit in a wheelchair by pulling the resident's shoulders while positioned behind them. [Caregiver G] explained this made the resident flop down in the wheelchair. [Caregiver G] stated [Caregiver H] was making [Resident 8] sit and was not assisting. [Caregiver G] stated [Caregiver H] also 'threw' [Resident 8's] legs in the bed when [Resident 8] was sitting on the side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 158	Continued From page 5 of [his/her] bed. ..." Caregiver G reported that s/he had shared his/her concerns with Director C. On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated an internal investigation should have been completed on these concerns. This concern will be discussed with staff.	N 158		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 occurrences of injuries of unknown origin, fractured ribs, experienced by Resident 1 were investigated. Findings include: On 05/13/2024, the Department received a concern alleging a resident had sustained multiple rib fractures. On 05/21/2024, at approximately 1:45 PM, Surveyors interviewed Director C and Programming/Business Development D. Surveyors explained the concern that had been called into the Department. Director C stated law enforcement had investigated the concern and	N 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 161	Continued From page 6	N 161		

s/he was unsure if there was documentation of an internal investigation. Surveyors requested Resident 1's record.

On 05/30/2024, Surveyor reviewed Resident 1's record:

Resident 1's "Observations" documented:
"04/10/2024 7:45 AM - [Resident 1] was screaming that [s/he] was in pain, so the ambulance came and took [him/her] vitals and [s/he] was sent out to the hospital at 8:00 AM."
"04/10/2024 3:15 PM - [Hospital] has contacted facility informing writer that resident has been admitted due to having multiple rib fractures, (10-12) on [his/her] right side. Resident also has a UTI (urinary tract infection) that will be treated. RN (registered nurse) has also stated that they are going to try to reduce the swelling in [his/her] lower extremities while [s/he] is in admission ..."

On 05/30/2024, Surveyor reviewed the police report that was submitted as supporting documentation with the complaint, which documented:
"04/18/2024 ... received communication from [Adult Protective Service (APS) E] ... [APS E] advised on April 11, 2024, [Resident 1] was hospitalized for chest pains. [APS E] stated [Resident 1] was discharged and hospital staff at [hospital] determined [Resident 1] had a fractured or bruised rib. ..."
"04/18/2024 ... I conducted a follow up interview with [Caregiver G] ... [Caregiver G] stated [Resident 1] had called the police due to allegations of [Caregiver H] had slammed [him/her] up against the wall. [Caregiver G] stated [s/he] had seen [Caregiver H] get aggressive with residents. ... [Caregiver G] stated [Caregiver H] is aggressive with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 161	Continued From page 7 residents both verbally and physically. [Caregiver G] explained [Caregiver H] tries to "[wo/man] handle" the residents. ... [Caregiver G] stated this was the first time [s/he] had ever heard [Resident 1] state someone had put their hands on [him/her]. ... [Caregiver G] stated [s/he] brought the concern to [Director C] and [Director C] told [Caregiver G] [Resident 1] was having mind games and going crazy. ... I asked [Caregiver G] about the incident where [Resident 1] alleged [Caregiver H] had pushed [him/her] against the wall and [Caregiver G] stated [s/he] did not witness what had occurred; as [s/he] was down the hall. [Caregiver G] stated [Resident 1] came out of [his/her] room irritated and screaming. [Caregiver G] stated [s/he] pointed at [Caregiver H] about pushing [him/her] up against the wall. [Caregiver G] reiterated [s/he] has never had a problem with [Resident 1]." As of 06/03/2024 at 9:00 AM, Surveyors did not receive any additional documentation. On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated an internal investigation should have been completed on this concern. This concern will be discussed with staff. Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury Cross Reference: N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations	N 161		
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	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 165	Continued From page 8	N 165		

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 Resident 1 sustained an injury of unknown origin, multiple rib fractures.

Findings include:

On 05/13/2024, the Department received a concern alleging a resident had sustained multiple rib fractures.

On 05/21/2024, at approximately 1:45 PM, Surveyors interviewed Director C and Programming/Business Development D. Surveyors explained the concern that had been called into the Department. Director C stated law enforcement had investigated the concern and s/he was unsure if a written report had been submitted to the Department. Surveyors requested Resident 1's record.

On 05/30/2024, Surveyor reviewed Resident 1's record:

Resident 1's "Observations" documented:
"04/10/2024 7:45 AM - [Resident 1] was screaming that [s/he] was in pain, so the ambulance came and took [him/her] vitals and [s/he] was sent out to the hospital at 8:00 AM."
"04/10/2024 3:15 PM - [Hospital] has contacted facility informing writer that resident has been admitted due to having multiple rib fractures, (10-12) on [his/her] right side. Resident also has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 165	Continued From page 9 a UTI (urinary tract infection) that will be treated. RN (registered nurse) has also stated that they are going to try to reduce the swelling in [his/her] lower extremities while [s/he] is in admission ..." On 05/30/2024, Surveyor reviewed the police report that was submitted as supporting documentation with the complaint, which documented: "04/18/2024 ... received communication from [Adult Protective Service (APS) E] ... [APS E] advised on April 11, 2024, [Resident 1] was hospitalized for chest pains. [APS E] stated [Resident 1] was discharged and hospital staff at [hospital] determined [Resident 1] had a fractured or bruised rib. ..." On 05/30/2024, Surveyor reviewed the Department file and noted that no written reports had been submitted to the Department regarding Resident 1's rib fractures. On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated this incident should have been reported to the Department. Cross Reference: N0161 DHS 83.12 (3)(a) Investigate Injuries of Unknown Source Cross Reference: N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations	N 165		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s	N 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 170	Continued From page 10	N 170		

legal representative within 72 hours when there is an allegation of misappropriation of property.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not immediately notify 1 of 1 resident's representative when there was an allegation of abuse.

Resident 1 alleged Caregiver H had thrown him/her up against the wall and his/her Guardian F was not informed of the allegation.

Resident 1 was hospitalized with injuries of unknown origin and the provider did not inform his/her managed care organization (MCO) Care Manager Q.

Findings include:

On 05/13/2024, the Department received a concern alleging a resident had sustained multiple rib fractures.

On 05/21/2024, at approximately 1:45 PM, Surveyors interviewed Director A and Programming/Business Development D. Director A stated law enforcement had investigated the concern and s/he was unsure if Guardian F had been contacted regarding the allegation. Surveyors requested Resident 1's record.

On 05/30/2024, Surveyor reviewed Resident 1's record:

Resident 1's "Observations" documented:
"04/10/2024 7:45 AM - [Resident 1] was screaming that [s/he] was in pain, so the ambulance came and took [his/her] vitals and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 170	Continued From page 11	N 170		

[s/he] was sent out to the hospital at 8:00 AM."
"04/10/2024 3:15 PM - [Hospital] has contacted facility informing writer that resident has been admitted due to having multiple rib fractures, (10-12) on [his/her] right side. Resident also has a UTI (urinary tract infection) that will be treated. RN (registered nurse) has also stated that they are going to try to reduce the swelling in [his/her] lower extremities while [s/he] is in admission ..."

Resident 1's record did not contain an incident report regarding a fall on 04/10/2024.

On 05/30/2024, Surveyor reviewed the police report, which documented:
"04/18/2024 ... received communication from [Adult Protective Service (APS) C] ... [APS E] advised on April 11, 2024, [Resident 1] was hospitalized for chest pains. [APS E] stated [Resident 1] was discharged and hospital staff at [hospital] determined [Resident 1] had a fractured or bruised rib. ..."
"04/18/2024 ... I [Detective L] conducted a follow up interview with [Caregiver G] ... [Caregiver G] stated [Resident 1] had called the police due to allegations of [Caregiver H] had slammed [him/her] up against the wall. [Caregiver G] stated [s/he] had seen [Caregiver H] get aggressive with residents. ... [Caregiver G] stated [Caregiver H] is aggressive with the residents both verbally and physically. [Caregiver G] explained [Caregiver H] tries to "[wo/man] handle" the residents. ... [Caregiver G] stated this was the first time [s/he] had ever heard [Resident 1] state someone had put their hands on [him/her]. ... [Caregiver G] stated [s/he] brought the concern to [Director A] and [Director A] told [Caregiver G] [Resident 1] was having mind games and going crazy. ... I asked [Caregiver G] about the incident where [Resident 1] alleged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 170	Continued From page 12	N 170		

[Caregiver H] had pushed [him/her] against the wall and [Caregiver G] stated [s/he] did not witness what had occurred; as [s/he] was down the hall. [Caregiver G] stated [Resident 1] came out of [his/her] room irritated and screaming. [Caregiver G] stated [s/he] pointed at [Caregiver H] about pushing [him/her] up against the wall. [Caregiver G] reiterated [s/he] has never had a problem with [Resident 1]."
"04/18/2024 ... I conducted a follow up phone call with [Resident 1's] [Guardian F] ... I explained to [Guardian F] the concerns with [Resident 1] and asked [Guardian F] if [s/he] had been notified of anything regarding [Resident 1] and [Guardian F] advised [s/he] had not been notified of anything. ... I asked [Guardian F] if [s/he] had spoke with medical staff regarding [Resident 1's] hospitalization and diagnosis of a fractured or bruised rib and [Guardian F] advised [Resident 1] was admitted to the hospital for a urinary tract infection and a rib fracture. [Guardian F] explained the hospitalization was following a fall where [Resident 1] was found on the floor and [Resident 1] was experiencing breathing issues. [Guardian F] stated [Resident 1's] fall occurred on April 10th. [Guardian F] advised there was nothing of concern reported to [him/her]."

On 06/01/2024, Surveyor requested Resident 1's MCO documentation from the organization.

On 06/04/2024, Surveyor reviewed Resident 1's MCO documentation which read:
"received a voicemail from [Director C] ... this is [Director C], the Executive Director at the [provider name] calling regarding [Resident 1]. I just got your e-mail stating that you have not been notified of [him/her] going to the and subsequent hospitalization yesterday. I apologize for that. My staff told me that they had updated all parties

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 170	Continued From page 13 involved including [son/daughter] and [his/her] health care, power of attorney and So I was under the impression that Y'all had been updated. ... yesterday morning ... [S/He] was complaining of some side like rib pain and chest pain while staff was getting [him/her] dressed. They called me and stated it stating [s/he] was complaining of chest pain and so I told them to call the doctor or I'm sorry, called 911 immediately because [s/he] was experiencing the chest pain. They ended up taking [him/her] to [Hospital] where they found a UTI (urinary tract infection) and they also discovered that [s/he] had two fractured ribs. [S/He] has had no fall that we are aware of. I know that [s/he] has been transferring [him/herself] from [his/her] chair to [his/her] bed sometimes and we have caught [him/her] almost falling or kind of leaning on the side on [his/her] side, but there is no downfall that we are aware of. I am currently working on a self-report to the state to notify them that there is an injury of unknown origin with the findings from the hospital which will be turned in by tomorrow. So that is all the information that I have currently." On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated s/he understood the concern and would discuss the proper process with staff. Cross Reference: N0161 DHS 83.12 (3)(a) Investigate Injuries of Unknown Source Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury	N 170		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 196	Continued From page 14 operation comply with all laws governing the CBRF. 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 regular license on 10/01/2022, as a class CNA (nonambulatory) CBRF able to serve up to 40 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 05/21/2024, with information gathered through 06/06/2024, Surveyors conducted 3 complaint investigations. As a result of the survey, nine deficiencies were identified: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12 (3)(a) Investigate Injuries of Unknown Source N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0205 DHS 83.14(2)(j) Not Permit A Condition Of Substantial Risk N0216 DHS 83.15(3)(c) Qualified Staff Designated As In Charge N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Changes. This is a repeat	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 196	Continued From page 15	N 196		

deficiency. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022.
N0431 DHS 83.38(1)(g) Health Monitoring

Review of facility records documented 7 previous survey events identifying noncompliance, as follows:

SOD GNOK11 - dated 02/17/2022
On 02/17/2022, Surveyor conducted a complaint investigation at The Koselig House. One deficiency was identified. One complaint was substantiated.

N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan

SOD GRGR11 - dated 06/02/2022
On 05/26/2022, Surveyor conducted a standard survey at The Koselig House. Five deficiencies were identified.

N0310 DHS 83.29(2) Admission Agreement Include Services, Charges
N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes
N0393 DHS 83.35(5)(a) Initial Evaluation of Evacuation Limitations
Z0010 DHS 50.065(2)(bb) Determine Final Disposition of Charges

SOD GNOK12 - dated 07/20/2022
On 07/20/2022, with information gathered through 08/05/2022, Surveyor conducted a verification visit and complaint investigation at The Koselig House. One deficiency was identified. Once complaint was substantiated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 196	Continued From page 16	N 196		

N0489 DHS 83.44(2)(a) Rooms Clean And Free From Odors

SOD PXZ011 - dated 10/27/2022
On 10/27/2022, Surveyor conducted a complaint investigation at The Koselig House. One deficiency was identified. The complaint was substantiated.

N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change

SOD 2U5R11 - dated 02/01/2023
On 01/30/2023, Surveyor conducted 2 complaint investigations at The Koselig House. Two deficiencies were identified. Two of 2 complaints were substantiated.

N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment
N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary
N0381 DHS 83.35(1)(a) Pre-Admission and Ongoing Assessments

SPECIAL ORDERS: Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., EFFECTIVE IMMEDIATELY, the licensee shall comply with requirements specified by Wis. Admin. Code § DHS 83.32(3)(i). That is, the licensee shall provide prompt and adequate treatment appropriate to the needs of the residents. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) 2U5R11. The licensee's corrective measures, at a minimum, shall include the development (or review) of written procedures to address: Pre-Admission and Ongoing Assessments
- The provider shall assess each resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 196	Continued From page 17	N 196		

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, at a minimum, shall include all areas applicable to the resident in accordance with Wis. Admin. Code § DHS 83.35(1)(c). - The provider shall prepare a written report of the results of the assessment and shall retain the assessment in the resident's record. - All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures required in Order #1 will be made available to department representatives upon request.

SOD 2U5412 - dated 06/01/2023
On 06/01/2023, Surveyor completed a verification visit and complaint investigation at The Koselig House. Six deficiencies were identified. The complaint was substantiated.

N0381 DHS 83.35(1)(a) Pre-Admission and Ongoing Assessments. This is a repeat deficiency. See SOD 2U5411, dated 02/01/2023.
N0409 DHS 83.37(1)(j) Proof-of-Use Record
N0425 DHS 83.38(1)(a) Personal Care
N0441 DHS 83.39(3) Hand Washing
N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable
N0487 DHS 83.44(1)(b) Separate Laundry Storage Areas or Containers

SOD T56511 - dated 04/02/2024
On 03/13/2024, with information gathered through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 196	Continued From page 18 04/02/2024, Surveyors conducted a standard licensure survey and 3 complaint investigations at The Koselig House. Twelve deficiencies were identified. Two of 3 complaints were substantiated. N0301 DHS 83.28(3) Provide Admission Agreement as Required N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0355 DHS 83.32(3)(k) Rights of Residents: Self-Determination N0364 DHS 83.33(3) Assistance With Grievance Procedure N0383 DHS 83.35(1)(c) Listed Areas For Assessments N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan. This is a repeat deficiency. See SOD BNOK11, dated 02/17/2022, N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0417 DHS 83.37(3)(a) Medication Storage: Original Containers N0425 DHS 83.38(1)(a) Personal Care. This is a repeat deficiency. See SOD 2U5411, dated 02/01/2023. N0432 DHS 83.38(1)(h) Medication Administration N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable. This is a repeat deficiency. See SOD 2U5R12, dated 06/01/2023. On 05/23/2024 at 10:32 AM, Surveyor received a phone call from Executive Director B informing Surveyor that Director C had given his/her resignation effective immediately.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 196	Continued From page 19	N 196		

On 05/24/2024 at 7:49 AM, Executive Director B emailed the Department and requested that his/her name replace Director C's name in the facility file.

On 05/26/2024 at 11:21 AM, Executive Director B emailed the Department and requested that his/her name be removed from the facility file.

On 05/26/2024 at 1:24 PM, Surveyors attempted to call Licensee A and did not reach Licensee A and was not able to leave a voicemail.

On 05/29/2024 at 7:30 AM, Surveyor emailed Licensee A and requested guidance as to who would be assisting with the survey process. As of 06/01/2024 at 9:00 AM, Surveyor did not receive a response.

On 05/29/2024 at 6:06 PM, after visiting the facility, Surveyor attempted to contact Co-Owner J. As of 06/03/2024 at 9:00 AM, Surveyor did not receive a response.

On 06/01/2024 at 5:05 PM, Surveyor located another potential email for Licensee A and emailed requesting guidance as to who would be assisting with the survey process and be managing the facility.

On 06/02/2024 at 10:59 AM, Chief Executive Officer N emailed Surveyor and stated, "I apologize for [Executive Director B] not communicating that I had stepped in. [Co-Owner J] and [Co-Owner P] were out of town and only received your message this weekend."

On 06/03/2024 at 2:48 PM, Chief Executive Officer N emailed Surveyor and stated, "Darrin Companies continues to be owned by the [family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 196	Continued From page 20 name]. [Licensee A] is no longer a board member." On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated a new executive director had been hired and they would be utilizing agency staff until a new team of caregivers could be hired.	N 196		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not prohibit the existence of a condition which may create substantial risk to the welfare of residents. The provider's front doorbell to alert staff that visitor(s) or emergency personnel have arrived at the facility, was not loud enough for staff to hear unless they were standing in the common area. There were not enough phones for each staff member that is scheduled to work, to carry, that notifies them that a resident has pressed their call button or the doorbell has been rung. Findings include: On 05/13/2024, the Department received a concern that staff are not responding to call lights	N 205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 205	Continued From page 21	N 205		

in a timely manner.

On 05/16/2024, the Department received a concern that emergency personnel were unable to enter the facility in a timely manner.

On 05/21/2024, at approximately 1:30 PM, Surveyors and Detective L arrived at the facility and attempted to enter the building. The building is a locked facility and visitors are required to ring a doorbell to alert staff. There were two doorbells and Surveyors pressed both. A resident walked up to the door and attempted to open it. The door did not alarm. Surveyors and Detective L waited for approximately 5 minutes until a staff member saw us and opened the door.

On 05/21/2024, at approximately 1:45 PM, Surveyor interviewed Programming/Business Development (PBD) D. Surveyor asked how staff were alerted that an individual was trying to enter the facility and/or that a resident had pressed their call lights. PBD D explained that staff are to carry a phone with them to be alerted when a call pendant has been pressed. PBD D explained, "There is only one phone available. I do not know what has happened to the other phones except staff have left with them after their shift is done and then they never come back." Surveyor asked which staff member was currently carrying the phone. PBD D stated, "It is probably at the front desk because staff usually leave it there." PBD D and Surveyor walked to the front desk, in the entrance way, and observed the phone sitting on the desk. PBD D stated, "Another concern is not all residents have pendants because we do not have enough for each resident. I keep saying we need to get more ordered, but I do not know if that has been done. Also, I have heard that not all of the pendants work properly." Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 205	Continued From page 22	N 205		

asked if staff were able to hear the door alarms. PBD D stated, "They are difficult to hear if you are not in the common area."

On 05/21/2024, at approximately 2:15 PM, Surveyors and Detective L interviewed Director C and PBD D. Surveyors reviewed the concern with Director C and PBD D which documented: On 05/14/2024 at 4:02AM, [Resident 2] called EMS (emergency medical services) for having back pain. Police and EMS responded. Officers attempted entering the secure building by ringing both doorbells; there was no answer despite there being two vehicles in the parking lot. After 4 minutes, officers entered the building with the use of a Knox Box key. Two staff members ([Caregiver H] and [Caregiver I]) were in the general dining room/common area with bedding laid out on the couch. Staff was not aware of the patient calling for EMS.

On 05/21/2024, Surveyors requested the provider's call light report, dated 05/09/2024 to 05/23/2024, for Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7 who were randomly selected. The report documented the following:

Resident 2's call pendant report documented the following response times: 05/09/2024 at 2:02 PM for 57 minutes, 05/09/2024 at 6:22 PM for 44 minutes, 05/09/2024 at 8:47 PM for 39 minutes, 05/11/2024 at 2:00 PM for 58 minutes, 05/11/2024 at 7:34 PM for 52 minutes, 05/12/2024 at 5:37 AM for 47 minutes, and 05/13/2024 at 9:53 AM for 1 hour and 2 minutes. Resident 3's call pendant report documented "FAULT: Battery low," from 05/09/2024 to 05/10/2024. The report documented that the light appeared to be activated in various intervals of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 205	Continued From page 23	N 205		

every 3 to 5 seconds. The report documented the following response times: 05/15/2024 for 30 minutes, 05/16/2024 for 56 minutes, 05/16/2024 at 9:59 PM for 47 minutes, 05/17/2024 at12:37 AM for 1 hour and 24 minutes, 05/17/2024 at 3:34 AM for 45 minutes, 05/18/2024 at 4:12 AM for 50 minutes, 05/18/2024 at 7:07 AM for 29 minutes, 05/19/2024 at 4:30 AM for 50 minutes, and 05/19/2024 at 3:14 PM for 38 minutes.
Resident 4's call pendant report documented the following response times: 05/10/2024 at 8:33 AM for 43 minutes, 05/10/2024 at 10:20 AM for 36 minutes, 05/11/2024 at 2:14 PM for 45 minutes, 05/15/2024 at 2:14 PM for 42 minutes, 05/15/2024 at 6:55 PM for 46 minutes, and 05/16/2024 at 9:39 AM for 51 minutes.
Resident 5's call pendant report documented the following response times: 05/14/2024 at 5:52 PM for 4 hours and 45 minutes. The call pendant report documented "FAULT: Battery Low" from 05/15/2024 to 05/18/2024.
Resident 6's call pendant report documented "FAULT: Battery low," from 05/09/2024 to 05/19/2024. The report documented that the light appeared to be activated in various intervals of every 3 to 5 seconds. There were no report documented calls after 05/19/2024.
Resident 7's call pendant report documented "FAULT: Battery low," on 05/11/2024 and 05/21/2024.

On 06/01/2024 at 12:38 PM, Surveyor emailed Officer M, who had responded to Resident 2's concern on 05/14/2024. Surveyor asked for explanation on the description, "Two staff members ([Caregiver H] and [Caregiver I]) were in the general dining room/common area with bedding laid out on the couch." Officer M stated, "The room was dark and the bedding appeared to be for caregiver use."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 205	Continued From page 24 On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated a new executive director had been hired and they would be utilizing agency staff until a new team of caregivers could be hired. CEO O stated s/he would verify the status of the phones that staff are to be carrying during their shift.	N 205		
N 216	83.15(3)(c) Qualified staff designated as in charge. A qualified resident care staff shall be designated as in charge whenever the administrator is absent from the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a qualified care staff was designated in charge when Licensee A, Executive Director B and Director C was absent from the facility. Findings include: On 05/21/2024, at approximately 1:00 PM, Surveyors conducted 3 complaint investigations. Surveyors were greeted by Programming/Business Development (PBD) D who informed Surveyors Director C had stepped away from the facility for medical reasons and s/he was unsure when s/he would return. PBD D contacted Director C via telephone. Director C returned to the facility and informed Surveyors that s/he had been on his/her way to urgent care. Surveyors returned to the facility on 05/22/2024, at approximately 8:00 AM, and was once again greeted by PBD D who informed Surveyors that Director C had worked the evening shift and was	N 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 216	Continued From page 25	N 216		

not available. Surveyors interviewed PBD D who stated s/he was in "charge" when PBD D was out of the building.

On 05/23/2024 at 10:32 AM, Surveyor received a phone call from Executive Director B informing Surveyor that Director C had given his/her resignation effective immediately.

On 05/24/2024 at 7:49 AM, Executive Director B emailed the Department and requested that his/her name replace Director C's name in the facility file.

On 05/26/2024 at 11:21 AM, Executive Director B emailed the Department and requested that his/her name be removed from the facility file.

On 05/29/2024, at approximately 4:30 PM, Surveyor visited facility to determine if a qualified staff member was in charge. Surveyor interviewed PBD D. PBD D informed Surveyor that s/he was not sure who was the 'acting administrator.' PBD D stated Caregiver H and Caregiver I had quit. PBD D stated, "I am trying to utilize agency staff, so I do not have to work. I am not a trained caregiver. I know I am not, but someone has to put these residents first. I don't want to get myself into trouble, but I do not know what else to do." PBD D stated, "They promoted [Caregiver K] to Resident Care Coordinator. Basically, they wanted someone they could call every time someone calls in, which is daily. [S/he] is making mistakes because they (management) have never properly trained [him/her]. Staff just walk off the job, so I end up working, especially the NOC shift."

On 05/29/2024, Surveyor reviewed the Wisconsin Community-Based Care and Treatment Training

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

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N 216	Continued From page 26 Registry. PBD D was not certified in Medication Administration, Fire Safety, and First Aid and Choking. On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated a new executive director had been hired and they would be utilizing agency staff until a new team of caregivers could be hired. CEO O stated PBD D was promoted to assistant executive director and would be receiving the required training. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 216		
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 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 record review and interview, the provider did not ensure 1 of 1 resident record reviewed was updated when there was a change in condition.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 389	Continued From page 27 This is a repeat deficiency. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022. Resident 1's Individual Service Plan (ISP) was not updated when s/he experienced edema (swelling caused by too much fluid trapped in the body's tissues). Findings include: On 05/28/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the facility, 10/11/2021, with diagnoses including dementia and disorder of kidney and ureter. Resident 1's "Observations," dated 01/01/2024 to 05/23/2024, documented: "01/22/2024 - When writer took [Resident 1's] ted hose off [his/her] legs were indented from them and [his/her] edema looked pretty bad." "02/02/2024 - Resident complained of leg pain which I believe was caused by [his/her] compression socks not being on properly." "02/25/2024 - Only has one ted hose stocking and [his/her] edema seems to be getting worse. [S/he] also complained of leg pain this morning. It would be great to get [him/her] two of them so [s/he] can wear them during the day. I would also keep an eye on [his/her] legs to make sure they do not keep getting worse." "04/10/2024 - [Hospital] has contacted facility informing writer that resident has been admitted ... they are going to try to reduce the swelling in [his/her] lower extremities while [s/he] is in admission at the hospital." "05/08/2024 - [HIs/Her] legs were real swollen" "05/10/2024 - Said [his/her] legs are hurting super	N 389		

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	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

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KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 389	Continued From page 28 bad they look very swollen." "05/19/2024 - Resident was found on bathroom floor [s/he] had fallen trying to use the restroom. The bottom of [his/her] pant leg and floor had a good amount of drainage from [his/her] leg and blood on them. The drainage was not stopping and [s/he] had +3 pitting (The pressure applied by the doctor leaves an indentation of 5-6 mm (millimeter) that takes up to 60 seconds to rebound.) edema in [his/her] lower legs and feet bilaterally. Sent [him/her] out to the hospital to be checked out." Resident 1's undated ISP did not document that s/he wore ted stockings and did not provide guidance regarding his/her symptoms of edema. On 05/29/2024, at approximately 4:30 PM, Surveyor interviewed Programming/Business Development (PBD) D. Surveyor asked if there was a signature page for Resident 1's ISP to determine the date of the ISP. PBD D stated s/he was unable to locate that documentation. Surveyor explained the concerns of the ISP. PBD D stated s/he was not responsible for the resident ISPs and was unsure who would be responsible for the updates, due to Executive Director B and Director C no longer working with the provider.	N 389		
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	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 29	N 431		

of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid 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 1 of 1 resident received appropriate health monitoring to meet his/her needs.

Resident 1's edema and weights were not monitored.

Findings include:

On 05/13/2024, the Department received a concern that resident health was not being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 30	N 431		

monitored.

On 05/21/2024, Surveyor requested Resident 1's record from Director C and Programming/Business Development D.

On 05/30/2024, Surveyor reviewed the police report, which documented:
"04/18/2024 ... I [Detective L] conducted a follow up phone call with [Resident 1's] [Guardian F] ... I explained to [Guardian F] the concerns with [Resident 1] ... [Guardian F] did advise there were concerns regarding [Resident 1's] legs retaining water ... [Guardian F] advised [s/he] was concerned about [Resident 1's] legs and how nothing was done regarding the swelling. I asked [Guardian F] how long [Resident 1's] legs were swollen and [Guardian F] advised Physical Therapy indicated for weeks and they told the nursing staff about it. [Guardian F] stated there is no reason for [Resident 1] to have swollen legs like [s/he] did."

On 05/30/2024, Surveyor requested Resident 1's managed care organization (MCO) documentation from the organization.

On 06/01/2024, Surveyor reviewed Resident 1's MCO documentation which stated:
03/04/2024 - [managed care organization (MCO) Care Manager (CM) Q], Before the meeting the team spoke with the staff regarding [Resident 1's] care. ... PT Therapist stopped by and shared [his/her] concerns regarding [Resident 1's] legs.
03/05/2024 - I [MCO Registered Nurse (RN) N] also left a message for [Executive Director B] to discuss my concerns about [Resident 1], including [his/her] shower situation, compression stockings, physician follow up and weights.
03/06/2024 - [RN N] Attempted to call [Executive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 431	Continued From page 31	N 431		

Director B and Director C], LTCFS (long term care functional screen). No answers from either number. Messages left to call back on issues noted while at visit Monday.
03/07/2024 - [RN N] Check in on all to [Doctor R] office and noted that [s/he] ordered Lasix increased to 40 MG (milligram) BID (twice a day) for 3 days and daily weights. Facility was informed and orders were faxed to them. They are to call back after the 3rd day with an update.
03/12/2024 - [RN N] Hey [Executive Director B], [Resident 1's] doctor ordered daily weights and increase in [his/her] Lasix medication for the past 3-4 days. [S/he] also wants [him/her] to wear tubi grips daily. [S/he] wanted an update on [his/her] legs and weights after this was completed which would have been Monday. I am looking in [his/her] chart at [health care provider] and there are no updates. Can you please call me and [his/her] office know how things are going? I'm concerned about [his/her] congestive heart failure is getting worse. [S/he] is trying to determine if [his/her] normal daily dose of Lasix should be increased daily going forward.
03/14/2024 - [RN N] Nurse contacted facility after looking [his/her] member's chart ongoing case management for [health care provider] again and noticing still no calls to the doctor's office. Talked with [Executive Director B] about the weights, tubi grips, and medication. [S/he] does not see anything in charting about daily weights. [S/he] does see member has tubi grips be put on daily. Read the note to [Executive Director B] from [Doctor R] about daily weights and update wanted. [S/he] is going to add daily weight to member's orders. [S/he] is also going to take member's weight right now and look at [his/her] legs and contact doctor with everything right now. Educated [Executive Director B] on how daily weights should be done. Talked about how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 32	N 431		

usually people have orders that is a 3-5 weight gain in 24 hours is noted that an increased dose of medication is given. If more than 5 lbs (pounds) the doctor normally needs to be notified and new orders will be given. Advised this would be helping orders to have from doctor if they don't already have them. [Executive Director B] is going to talk to doctor more about all this and states [s/he] will update nurse via email and add [Director C] email to message for nurse to have. Last weight [Executive Director B] could find was from 03/09/2024 and it was 180 lbs.
03/19/2024 - [RN N] No updates received from [Executive Director B]. Nurse contacted [Executive Director B] requesting an update. Checked members [health care provider's] chart for [medical notes] and no notes seen in there. Awaiting answers back.
03/27/2024 - [RN N] message from [Director C] - [Resident 1] has been doing well. [S/he] has had some days where [s/he] is a little more emotional than others, but that is not abnormal for [her/him]. I faxed weights to [his/her] doctor. They are as follows: 03/14/2024 175.6, 03/15/2024 182.3, 03/17/2024 180.3, 03/18/2024 183.2, 03/20/2024 183.5. [His/her] legs look much better as of late. The edema has definitely diminished. PT (physical therapy) has also noted that the BLE (bilateral lower extremities) edema has gotten better.

On 06/01/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility, 10/11/2021, with diagnoses including dementia and disorder of kidney and ureter.

Resident 1's "Observation" notes documented:
03/06/2024 - written by Director C - Received vm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 431	Continued From page 33 (voicemail) from [Doctor R's] office. New orders from [Doctor R]: Daily weights, Lasix increased to 40 MG BID for three days. Resident 1's March 2024 Medication Administration Record did not record any weights. On 06/06/2024 at 3:00 PM, Surveyor interviewed Chief Executive Officer (CEO) O. CEO O stated a new executive director had been hired and Programming/Business Development D was promoted to assistant executive director. CEO O stated s/he would have them review the ISPs and update themselves on the cares and monitoring that each resident needs. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Changes	N 431		