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 _____	R-C 01/13/2025

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 01/08/2025, with information gathered through 01/13/2025, Surveyors conducted a verification visit at The Koselig House. Four deficiencies were identified. Four of the 4 deficiencies were repeat violations (see Statement of Deficiency (SOD)YSHR12, SOD YSHR11, SOD T56511, and SOD GRGR11). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 15	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 4 of 6 residents reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) T56511, dated 04/02/2024, and SOD YSHR12, dated 10/15/2024. Resident 16 did not receive his/her Systane lubricant eye drops as prescribed. Resident 20 did not receive his/her Fluticasone	{N 352}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	R-C 01/13/2025

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 352}	Continued From page 1	{N 352}		

(nasal spray) as prescribed.
Resident 20 received his/her 'as needed' (PRN) Oxymetazoline (nasal spray) as a scheduled medication.
Resident 23 did not receive his/her Fluticasone Propionate/Salmeterol inhaler as prescribed.

Findings include:

Example 1: Resident 16

On 01/08/2025, at approximately 10:00 AM, Surveyor and Med Passer VV reviewed the medication cart and observed Resident 16's box of individual vials of Systane lubricant eye drops with an open date of 12/31/2024. There were 16 out of 25 vials remaining.

On 01/08/2025, Surveyor reviewed Resident 16's record.

Resident 16 moved into the facility 08/11/2020.

Resident 16's December 2024 and January 2025 Medication Administration Records (MAR), dated 12/06/2024 to 01/08/2025, documented:
"Systane ULT PF 0.4-03% drops - Instill 1 drop in both eyes three times a day for dry eyes."
Scheduled at 7:00 AM, 12:00 PM, and 8:00 PM.

Surveyor determined there should be approximately 3 vials of eye drops remaining based on the box being opened 12/31/2024 8:00 PM and administered until 01/08/2025 8:00 AM which would be 22 opportunities. 25 - 22 = 3 remaining vials.

The MARs documented that the eye drops had been administered at each scheduled opportunity when the medication was not administered.

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 _____	R-C 01/13/2025

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 352}	Continued From page 2 On 01/08/2025 at approximately 2:50 PM, Surveyor reviewed concerns with Administrator SS. Administrator SS wrote down Surveyor's concern. Example 2: Resident 20 On 01/08/2025, at approximately 9:40 AM, Surveyor and Med Passer VV reviewed the medication cart and observed Resident 20's bottle of Fluticasone. Med Passer VV commented the bottle looked to be about half full. Surveyor noted the Fluticasone had an open date of 10/01/2024. On 01/08/2025, Surveyor reviewed Resident 20's record. Resident 20 moved into the facility 01/16/2024 and is currently on hospice. Resident 20's December 2024 and January 2025 MARs, dated 12/06/2024 to 01/08/2025, documented: "Fluticasone 50 MCG (microgram) spray - Inhale 2 sprays into each nostril once daily for nasal congestion/allergies." The MARs documented that the Fluticasone was administered on each scheduled day. "Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone	{N 352}		

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 _____	R-C 01/13/2025

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 352}	Continued From page 3 Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - January 14, 2025).) Resident 20's bottle of Fluticasone would have been empty in 11/01/2024 (120 sprays divided by 4 sprays per day = 30 days). Resident 20's December 2024 and January 2025 MARs, dated 12/06/2024 to 01/08/2025, also documented: "Oxymetazoline 0.05% spray - Inhale 2 sprays into each nostril twice daily as needed for congestion (Do Not Use For More Than 3 Consecutive Days)." The MARs did not document the PRN had been administered. "Oxymetazoline 0.05% spray - Inhale 2 sprays into each nostril twice a day for congestion." This order was listed on the MAR under the PRN section along with the Scheduled section. The medication was documented as administered at each scheduled opportunity. On 01/13/2025, Surveyor reviewed Resident 20's requested hospice documentation from his/her hospice provider which documented: "Dristan Nasal (Oxymetazoline) 0.05% nasal spray Administer 2 spray(s) in each nostril 2 times a day as needed for congestion. Start Date: 11/14/2024." Example 3: Resident 23 - Fluticasone Inhaler On 01/08/2025, at approximately 10:00 AM, Surveyor and Med Passer VV reviewed the medication cart and observed Resident 23's cartridge of Fluticasone Propionate/Salmeterol DISKUS Inhalation powder with 24 remaining inhalations. Surveyor noted the Fluticasone had an open date of 12/19/2024.	{N 352}		

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 _____	R-C 01/13/2025

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 352}	Continued From page 4 On 01/08/2025, Surveyor reviewed Resident 23's record. Resident 23 moved into the facility 06/09/2020. Resident 23's December 2024 and January 2025 MARs, dated 12/06/2024 to 01/08/2025, documented: "Fluticasone Propionate/Salmeterol - Inhale 1 puff by mouth twice a day for COPD (chronic obstructive pulmonary disease)." The MARs documented that the Fluticasone was administered on each scheduled day. "You should keep track of the number of inhalations used from your inhaler. Then throw away the inhaler after you have used 120 inhalations. Even though the canister might not be empty and will keep spraying, you might not get the right amount of medicine in each inhalation. Before you get to 120 inhalations, ask your doctor if you need to refill your prescription." (Source: FDA (US Food and Drug Administration) website, Advair HFA 45/21, Advair HFA 115/21, Advair HFA 230/21, undated, https://www.accessdata.fda.gov/drugsatfda_docs/label/2006/021254lbl.pdf (retrieval date - January 14, 2025).) Resident 23's inhaler of Fluticasone would have only 18 inhalations remaining (60 inhalations divided by 2 sprays per day = 30 days. 60 - 42 opportunities = 18 remaining inhalations). On 01/08/2025 at approximately 2:50 PM, Surveyor reviewed concerns with Administrator SS. Administrator SS wrote down Surveyor's concern.	{N 352}		

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 _____	R-C 01/13/2025

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 352}	Continued From page 5 Example 4: Resident 23 - Spiriva Inhaler On 01/08/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 23's record. Resident 23 was admitted to the provider's facility on 06/09/2020. Resident 23's physician orders included Spiriva Respimat 2.5 mcg inhaler (Start Date: 11/07/2024) - Inhale 2 puffs daily. Resident 23's Medication Administration Record (MAR), dated 12/06/2024 to 01/08/2025, documented Resident 23 did not receive his/her inhaler from 12/06/2024 to 12/11/2024 due to the medication being unavailable and on order. On 01/08/2025 at approximately 2:50 p.m., Surveyor shared concern with Administrator SS that Resident 23 did not receive his/her Spiriva Respimat inhaler as prescribed from 12/06/2024 through 12/11/2024. Administrator SS stated s/he did not have information as to why this occurred. On 01/10/2025 at 3:10 p.m., Surveyor interviewed an individual with the provider's pharmacy, Pharmacy XX. Pharmacy XX reviewed records and stated the pharmacy had last delivered a 30-day supply of Resident 23's Spiriva Respimat 2.5 mcg inhaler to the provider's facility on 09/09/2024. Pharmacy XX stated s/he had no record of the provider requesting a refill between 09/09/2024 and when the pharmacy stopped supplying the facility in mid-December 2024. Resident 23 did not receive his/her Spiriva Respimat 2.5 mcg inhaler as prescribed for 6 of 33 days reviewed. Cross Reference: N0415 83.37(2)(D) Documentation of Medication Administration	{N 352}		

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 _____	R-C 01/13/2025

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 389}	Continued From page 6	{N 389}		
{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 observation, record review and interview, the provider did not ensure that the Individualized Service Plan (ISP) was updated when there was change in needs and physical or mental condition for 3 out of 3 residents reviewed. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022, and SOD YSHR11, dated 06/06/2024, and SOD YSHR12, dated 10/15/2024. Resident 5's ISP did not document a toileting schedule to assist him/her with incontinence. Resident 17's ISP did not document interventions related to his/her fall risk. Resident 20's ISP did not document that s/he was a feed assist.	{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 _____	R-C 01/13/2025

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 389}	Continued From page 7 Findings include: The provider is licensed to care for up to 72 residents in client groups terminally ill, advanced aged, developmentally disabled, irreversible dementia/Alzheimer's and traumatic brain injury. Example 1: Resident 5 On 01/08/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider's facility on 04/25/2023. Resident 5's record included progress notes from 12/06/2024 through 01/08/2025. Surveyor noted an observation note dated 12/12/2025 at 2:45 p.m., that noted the condition of Resident 5 being soaked through the pants with urine and bowel movements. The note indicated that the resident should have incontinence care every 2 hours and as needed. Resident 5's record included an ISP, dated 11/01/2024, that stated s/he was a full assist with toileting, and toileting was scheduled daily as needed. On 01/08/2025 at approximately 3:00 p.m., Surveyor interviewed Administrator SS. Surveyor asked Administrator SS if Resident 5 had an updated ISP to indicate the incontinence care was scheduled for every 2 hours and as needed. Administrator SS stated that the facility talked with the staff about the frequency of incontinence cares for Resident 5. Administrator SS stated that staff were completing incontinence cares before and after meals. Administrator SS said, "It hasn't been a concern since 12/12/2024 so staff are completing it." Administrator SS acknowledged that the ISP, dated 11/01/2024 was not updated with the incontinence care every 2 hours and as needed schedule.	{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 _____	R-C 01/13/2025

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 389}	Continued From page 8 On 01/08/2025 at approximately 2:50 p.m., Surveyor reviewed concern with Administrator SS that Resident 5's ISP was not updated to include a toileting routine to assist with Resident 5's incontinence. Administrator SS wrote down Surveyor's concern. Example 2 - Resident 17 On 01/08/2025 at approximately 9:00 a.m., Surveyor reviewed a self-report submitted to the department on 10/03/2024 stating Resident 17 sustained a fall on 10/02/2024 resulting in a closed fracture of the proximal end of the right humorous. The self-report stated the facility was taking the following action to ensure Resident 17's safety: purchasing a remote chair bed/alarm for Resident 17 to use in his/her room, encourage him/her to call for assistance and not get up independently, check on him/her frequently and have family set up an appointment with orthopedics for the following week. On 01/08/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 17's record. Resident 17 was admitted to the provider's facility on 04/03/2024. Resident 17's record included an "Incident Investigation" regarding Resident 17's 10/02/2024 fall that identified the following actions taken/measure initiated to reduce the possibility of future falls: possible referral to OT/PT, consider chair/bed alarm, on behavior call, team to ensure floor in room is free of debris and team to offer assistance/reminders to use walker at all times. Surveyor noted the "Incident Investigation" was dated 01/08/2025 at 1:04 p.m., the same day as Surveyor's visit and after his/her request for Resident 17's record. Resident 17's record included an ISP, dated 11/10/2024, that stated	{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 _____	R-C 01/13/2025

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 389}	Continued From page 9	{N 389}		

"Resident is at a medium risk for falls due to [his/her] deficient [sic] of not knowing their own ability such as when using an assisted device and getting up without assistance." The only interventions from the 10/03/2024 self-report and 01/08/2025 investigation that were listed in Resident 17's ISP were reminders to use walker and the behavior call. Resident 17's ISP was not updated to identify fall interventions identified in the self-report and investigation following his/her fall.

On 01/08/2025 at approximately 11:10 a.m., Surveyor interviewed Med Passer UU. Surveyor asked Med Passer UU if Resident 17 had any fall interventions in place, such as a bed or chair alarm. Med Passer UU responded, "No, I thought alarms were a restraint."

On 01/08/2025 at approximately 2:50 p.m., Surveyor reviewed concern with Administrator SS that Resident 17's ISP was not updated with the fall interventions identified in the self-report and investigation following his/her fall. Administrator SS wrote down Surveyor's concern.

Example 3: Resident 20

On 01/08/2025, at approximately 8:50 a.m., Surveyor observed a Med Passer WW assist Resident 20 with eating who was sitting in a Broda chair. Surveyor interviewed Med Passer WW who stated that Resident 20 was always assisted with eating.

On 01/08/2025, at approximately 12:30 p.m., Surveyor observed Resident 20 be spoon fed his/her meal by a staff member.

On 01/08/2025, Surveyor reviewed Resident 20'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 _____	R-C 01/13/2025

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 389}	Continued From page 10 record. Resident 20 moved into the facility, 01/16/2024, with diagnosis including advanced Alzheimer's. Resident 20's ISP, dated 11/08/2024, did not document any dietary guidelines. On 01/08/2025 at approximately 2:50 p.m., Surveyor reviewed concern with Administrator SS that Resident 20's ISP was not updated to include dietary guidelines. Administrator SS wrote down Surveyor's concern. On 01/13/2025, Surveyor reviewed Resident 20's hospice documentation provided by his/her hospice provider which documented: "Facility remains responsible to provide feeding assistance to [Resident 20] at all meals and provide small, bite size pieces of food."	{N 389}		
{N 450}	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not have planned or posted menus readily available to the residents. This is a repeat deficiency. See Statement of	{N 450}		

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 _____	R-C 01/13/2025

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 450}	Continued From page 11 Deficiency (SOD) YSHR12, dated 10/15/2024. Findings include: On 01/09/2025 at approximately 8:35 a.m., Surveyors observed residents eating breakfast, which consisted of cereal and beverages, in the dining room. Surveyors observed the facility's daily menu board was blank. Surveyors were unable to locate a weekly menu posted anywhere in the facility. On 01/09/2025 at approximately 9:10 a.m., Surveyors observed Administrator SS filling out the breakfast and lunch section of the daily menu board. The supper section of the menu board remained blank. On 01/09/2025 at approximately 2:00 p.m., Surveyors observed the supper section of the menu board remained blank. On 01/09/2025 at approximately 2:50 p.m., Surveyors reviewed concern with Administrator SS that the provider did not have a menu posted. Administrator SS stated the provider's cook, who historically never called in sick, had called in that day. Administrator SS stated s/he was aware the cook had called in that morning, so s/he stopped at the store and picked up lunch ingredients s/he knew s/he would be able to make on his/her way into work. Surveyors shared concern that the daily menu still didn't have anything listed for supper and that kitchen staff was no longer present to prepare supper. Administrator SS responded, "I better figure out what we will be serving." Surveyor asked why the provider did not have a weekly menu posted in advance. Administrator SS did not comment on a weekly menu but made note of Surveyor's concern.	{N 450}		

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 _____	R-C 01/13/2025

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
Y3234	50.09(1)(e) Treatment (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: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Resident 5 and Resident 24, who had dietary requirements of mechanical soft, were served a different meal from the other residents and served approximately 15 minutes after all other residents had been served their noon meal. This is a repeat deficiency. See Statement of Deficiency (SOD) YSHR12, dated 10/15/2024. Findings include: Example 1 - Resident 24	Y3234		

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 _____	R-C 01/13/2025

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
Y3234	Continued From page 13 On 01/08/2025 at approximately 8:35 a.m., Surveyor observed Resident 24 eating his/her breakfast, which consisted of cereal and thickened liquids, the same meal as other residents in the dining room but a different liquid consistency. On 01/08/2025 at approximately 12:30 p.m., Surveyor observed Resident 24 receive his/her lunch, greater than 15 minutes after others had been served. Surveyor observed Resident 24's plate consisted of spaghetti and meatballs, cooked carrots and pudding with thickened liquids, while other residents were served a hot dog, chips and donut. On 01/08/2025 at approximately 2:00 p.m., Surveyor interviewed Caregiver VV and Caregiver UU. Surveyor shared observation that Resident 24 was served a different meal than the other residents. Caregiver UU stated Resident 24 was served a different meal because it was Caregiver UU's understanding that hotdogs were a food that had a higher risk of choking. Caregiver UU and Caregiver VV stated they assessed what Resident 24 should be served on a day-to-day basis. Surveyor asked if Resident 24 was on a modified diet and if the caregivers had any documentation to reference regarding Resident 24's diet. Caregiver UU responded, "No special diet, but s/he has a history of aspiration." Caregiver VV stated (did you interview this resident?) the facility used to have "dietary cards," but s/he wasn't able to locate them. Surveyor asked Caregiver UU and Caregiver VV if anyone asked Resident 24 if s/he would prefer the posted meal of a hot dog versus an alternate meal of spaghetti. Caregiver UU responded, "No, but [s/he] seemed to enjoy the pudding."	Y3234		

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 _____	R-C 01/13/2025

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
Y3234	Continued From page 14 On 01/08/2024 at approximately 2:00 p.m., Surveyor reviewed Resident 24's individual service plan (ISP), dated 11/02/2024. The ISP did not indicate Resident 23 required a modified diet or had choking tendencies. On 01/08/2025 at approximately 2:30 p.m., Surveyor requested physician orders related to Resident 24's diet. Administrator SS provided Surveyor with a physician order, dated 08/22/2019, which stated "Puree food [as needed] for comfort/dysphagia." On 01/08/2025 at approximately 2:45 p.m., Surveyor went into the provider's kitchen and observed a "dietary card" for Resident 24 which stated, "[Resident 24] Quick Notifications: Diet = Regular, Portion = Normal, Food Intolerance or Allergy = No Known Allergy, Cut up foods before serving, thickened liquids to honey liquids consistency, mechanical soft diet." On 01/08/2025 at approximately 2:50 p.m., Surveyors interviewed Administrator SS. Surveyors shared inconsistencies with Resident 24's documentation regarding his/her dietary needs and observation that Resident 24 was served an alternate meal without being asked if s/he would like an alternate meal and had to wait greater than 15 minutes after other residents to be served. Administrator SS acknowledged inconsistencies with Resident 24's dietary needs and did not comment as to why Resident 24 was served a different meal from the other residents. Administrator SS was given until 01/09/2025 at 5:00 PM to provide documentation regarding Resident 24's dietary needs. No additional information was received.	Y3234		

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 _____	R-C 01/13/2025

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
Y3234	Continued From page 15	Y3234		

Example 2 - Resident 5

On 01/08/2025 at approximately 8:35 a.m., Surveyors observed Resident 5 eating his/her breakfast, which consisted of cereal, the same meal as other residents in the dining room.

On 01/08/2025 at approximately 9:35 a.m., Surveyors observed a sign posted in the kitchen stating that Resident 5 was on a mechanical soft diet. The posted sign stated mechanical soft diet means foods must be soft, easy to chew and swallow.

On 01/08/2025 at approximately 12:30 p.m., Surveyors observed Resident 5 receive his/her lunch, greater than 15 minutes after others had been served. Surveyors observed Resident 5's plate consisted of spaghetti and meatballs, cooked carrots, and pudding, while other residents were served a hot dog, chips, and donut.

On 01/08/2025 at approximately 12:35 p.m., Surveyors interviewed Caregiver UU. Surveyors shared observation that Resident 5 did not receive his/her meal until greater than 15 minutes after others had been served. Caregiver UU stated that s/he was just bringing out the meals when the kitchen had food ready.

On 01/08/2024 at approximately 2:00 p.m., Surveyors reviewed Resident 5's individual service plan (ISP), dated 11/02/2024. The ISP did indicate Resident 5 required a mechanical soft diet.

On 01/08/2025 at approximately 2:50 p.m., Surveyors interviewed Administrator SS.

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 _____	R-C 01/13/2025

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
Y3234	Continued From page 16 Surveyors shared observation that Resident 5 was served an alternate meal and had to wait greater than 15 minutes after other residents to be served at his/her table. Administrator SS acknowledged that the table should all be served lunch at the same time.	Y3234		