

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 10/08/2024, Surveyors conducted 1 verification visit and 2 complaint investigations at Sebring Assisted Care Residence. One deficiency was identified. The 1 deficiency from SOD Z1LL13, dated 0/09/2024 was substantially corrected. One complaint was substantiated and 1 unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 43	{N 000}		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure adequate staffing to meet resident's needs. Certified Medication Aid SS worked the entire night shift alone 08/04/2024 PM into 08/05/2024, Certified Medication Aid TT worked alone 11:00 PM on 08/16/2024 to 12:39 AM on 08/17/2024, and residents experienced call pendant wait times exceeding 20 minutes. Findings include: The facility is licensed as a Class CNA	N 396		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 396	Continued From page 1 (nonambulatory) CBRF able to serve up to 81 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. The facility is divided into 2 units, "memory care" and "assisted living". On 08/19/2024, the Department received a complaint regarding staffing. On 10/08/2024, Surveyor reviewed the nursing/caregiver schedule dated 08/01/2024-10/07/2024, and Time Detail by Labor Account (staff timecards) dated 08/05/2024 and 08/17/2024. On 10/09/2024 at 11:30 AM, Surveyor received staff timecards dated 08/04/2024 and 08/16/2024 and census dated 08/16/2024 via email from Administrator QQ. On 10/09/2024 at 2:51 PM, Surveyor received the census dated 08/04/2024 via email from Administrator QQ. Census on 08/04/2024 was 44 (10 in memory care and 34 in assisted living) From 10:45 PM on 08/04/2024 to 7:00 AM on 08/05/2024 Certified Medication Aid SS was the only staff scheduled to work both units. Certified Medication Aid SS punched in at 10:48:00 PM on 08/04/2024 and out on 08/05/2024 at 7:36:00 AM. No additional nursing/caregiving staff were punched in that night shift. Census on 08/16/2024 was 44 (12 in memory care and 32 in assisted living). From 10:45 PM on 08/16/2024 to 7:00 AM on 08/17/2024 Certified Medication Aid TT was the only staff originally scheduled to work on the staff schedule and Certified Medication Aid UU's name was circled on the staff schedule identifying s/he	N 396		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 396	Continued From page 2 was added to the original schedule. Certified Medication Aid TT punched in on 08/16/2024 at 10:44 PM and out on 08/17/2024 at 7:05 AM. Certified Medication Aid UU punched in on 08/17/2024 at 12:39 AM and out on 08/17/2024 at 7:16 AM. No other nursing/caregiving staff were punched in that night shift. Certified Medication Aid TT worked alone 11:00 PM on 08/16/2024 to 12:39 AM on 08/17/2024. Example 1- Resident 12 On 10/08/2024 at 3:08 PM, Surveyor interviewed Resident 12 who stated s/he lived at Sebring Assisted Care Residence for approximately 6 weeks and moved out the beginning of September 2024. Resident 12 stated s/he required assistance to use the bathroom and due to understaffing at night, s/he had laid in urine "for a long time" on several occasions. Resident 12 stated s/he moved to a different assisted living facility due to staffing shortage and long call light wait times. On 10/08/2024, Surveyor reviewed Resident 12's record. S/he was admitted 08/02/2024. Diagnoses included: diabetes mellitus with diabetic neuropathy, unspecified; acute pain, not elsewhere classified; tremor, unspecified; and repeated falls. ISP dated 08/02/2024 (summarized): Resident 12 required staff assistance with: minimizing fall risk due to high risk for falls; physical assist with transfers and occasional verbal cues with ambulation, 1 person assist for emergency evacuation; standby supervision with bathing;	N 396		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 396	Continued From page 3 dressing; toileting and incontinence care, monitoring for symptoms of high blood sugar; and medications. Device Activity Report (call pendant) dated 08/01/2024-08/31/2024- Call pendant wait times exceeding 20 minutes when Certified Medication Aid SS worked the entire night shift alone 08/04/2024 PM into 08/05/2024 AM: 08/04/2024 10:56 PM-11:21:06 PM; 24 minutes, 17 seconds 08/05/2024 1:18:56 AM- 2:06:AM; 47 minutes, 58 seconds 08/05/2024 6:34:43 AM-7:29:03 AM; 54 minutes, 20 seconds Call pendant wait times exceeding 20 minutes when Certified Medication Aid TT worked alone: 11:00 PM on 08/16/2024 to 12:39 AM on 08/17/2024: 08/16/2024 11:03:30 PM- 11:37:18 PM; 33 minutes, 48 seconds 08/17/2024 6:19:49 AM-6:40:59 AM; 21 minutes, 10 seconds Additional call pendant wait times exceeding 20 minutes 08/01/2024-08/31/2024: 08/26/2024 6:01:07 AM- 6:50:09 AM; 49 minutes, 2 seconds 08/25/2024 8:20:20 AM- 8:57:36 AM; 37 minutes, 16 seconds 08/23/2024 7:10:13 PM- 7:50:29 PM; 40 minutes, 16 seconds 08/20/2024 3:57:35 AM-4:46:12 AM; 48 minutes, 37 seconds 08/15/2024 6:00:52 PM-6:33:49 PM; 32 minutes. 57 seconds 08/15/2024 1:06:04 PM- 1:37:55 PM; 31 minutes, 51 seconds	N 396		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 396	Continued From page 4 08/15/2024 6:11:46 AM- 6:58:25 A; 46 minutes, 39 seconds 08/15/2024 1:29:08 AM- 2:06:49 AM; 37 minutes, 41 seconds 08/14/2024 5:50:31 AM-6:29:10 AM; 38 minutes, 39 seconds 08/14/2024 1:53:26 AM- 2:18:02 AM; 24 minutes, 36 seconds 08/13/2024 3:11:33 AM- 3:35:31 AM; 23 minutes, 58 seconds 08/12/2024 5:31:03 AM-5:55:31 AM; 24 minutes, 28 seconds 08/11/2024 4:40:23 AM- 5:37:21 AM; 56 minutes, 58 seconds 08/09/2024 11:15:59 AM-11:38:09 AM; 22 minutes, 10 seconds 08/07/2024 6:54:21 AM-7:24:14 AM; 29 minutes, 53 seconds 08/07/2024 4:36:50 AM-4:58:36 AM; 21 minutes, 46 seconds 08/07/2024 12:28:30 AM- 12:53:17 AM; 24 minutes, 47 seconds 08/06/2024 5:22:24 AM- 6:23:11 AM; 60 minutes, 47 seconds Example 2- Resident 10 On 10/08/2024 at 10:21 AM, Surveyor interviewed Resident 10 who stated call pendant wait times varied and at times s/he had to wait up to 30 minutes. Resident 10 stated s/he needed assistance with toileting, transfers and getting in and out of bed. On 10/08/2024, Surveyor reviewed Resident 10's record. S/he was admitted 05/27/2022. Diagnoses included unspecified dementia, primary osteoarthritis of right and left hands, other abnormalities of gait and mobility, weakness, age-related physical debility, nonexudative age-related macular degeneration of left eye and	N 396		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 396	Continued From page 5 exudative age-related macular degeneration of right eye. Individual Service Plan (ISP) dated 10/01/2024 (summarized): Resident 10 required staff assistance with glasses, medications, wheelchair escort to all meals and activities of choice, bed mobility, bathing, grooming, dentures, dressing, toileting, incontinence care, and 2 assist sit to stand mechanical lift transfers and emergency evacuation, Device Activity Report dated 09/24/2024-10/08/2024- Call pendant wait times exceeding 20 minutes: 10/08/2024 8:19:45 AM-9:21:14 AM; 61 minutes, 29 seconds 10/04/2024 6:56: 39 AM-7:18:40 AM; 22 minutes, 1 second 10/01/2024 11:38:57 AM-12:11:27 PM; 32 minutes, 30 seconds 09/28/2024 8:12:30 PM- 9:32:45 PM; 80 minutes, 15 seconds 09/26/2024 8:26:12 AM-9:26:46 AM; 60 minutes, 34 seconds 09/25/2024 2:02:47 PM- 2:35:53 PM; 33 minutes, 6 seconds Example 3- Resident 11 On 10/08/2024 at 10:32 SM, Surveyor interviewed Resident 11 who stated call pendant response time was "lffy" and varied from 5 minutes to more than 20 minutes. Resident 11 stated s/he was recently late for breakfast due to lengthy call light wait time and s/he required assistance with getting in and out of bed, dressing, showers, and stand-by assistance with transfers. On 10/08/2024, Surveyor reviewed Resident 11's	N 396		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 396	Continued From page 6 record. S/he was admitted 02/10/2022. Diagnoses included repeated falls, other abnormalities of gait and mobility, weakness, age-related physical debility, and reduced mobility. ISP dated 07/03/2024 (summarized): Resident 11 required staff assistance with positioning tubing of suprapubic catheter, medications, glasses, stand-by supervision for ambulation, staff escort to all meals and events of choice, fall monitoring due to high risk for falls, minimal assist and/or cues with transfers, bathing, grooming, dressing, toileting, and incontinence care. Device Activity Report dated 9/24/2024-10/08/2024- Call pendant wait times exceeding 20 minutes: 10/07/2024 8:07:10 AM- 8:37:21 AM: 30 minutes, 11 seconds 10/01/2024 9:14:12 AM- 9:46:53 AM: 32 minutes, 41 seconds 09/28/2024 7:19:24 AM- 7:52:49 AM: 33 minutes, 25 seconds 09/27/2024 6:40:36 AM- 7:34:15 AM: 22 minutes, 39 seconds 09/24/2024 7:41:43 AM- 8:04:48 AM: 23 minutes, 5 seconds 09/24/2024 8:12:56 AM- 8:45:14 AM: 32 minutes, 18 seconds On 10/08/2024 at 12:36 PM, Surveyor interviewed Administrator QQ who stated they scheduled a minimum of 3 night shift staff. On 10/08/2024 at 1:25 PM, Surveyor interviewed Administrator QQ who stated Certified Medication Aid TT worked alone 08/16/2024 11:00 PM to 08/17/2024 12:39 AM. Administrator QQ stated the prior shift were to stay to prevent any staff	N 396			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2024
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 396	Continued From page 7 working alone. Administrator QQ stated staff always needed to be on the memory care unit. When Surveyor asked if 1 staff was able to adequately meet the resident's needs when working alone, Administrator QQ stated, "Absolutely not especially with memory care and assisted living." On 10/08/2024 at 2:09 PM, Surveyor discussed concern of adequate staffing with Administrator QQ who the problem was due to call-ins and PM shift staff not staying over into the night shift. Administrator QQ stated call pendant activation alerted to staff pagers and was displayed on the computer in the medication rooms. Administrator AA stated staff frequently lost the pagers, so they checked the computer screens. Administrator AA stated s/he would make staff more accountable for the pagers. On 10/10/2024 at 1:03 PM, Surveyor received an email from Administrator QQ who verified Certified Medication Aid SS worked the entire night shift 08/04/2024 into 08/05/2024 alone for both assisted living and memory care units, and 08/16/24 into 08/17/24 night shift- Certified Medication Aid TT worked alone 11:00 PM-12:45 AM for both assisted living and memory care units.	N 396		