STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018802	A. BUILDING: _____ B. WING _____	R-C 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT SUSSEX CBRF (THE)	W235 N6350 HICKORY DRIVE SUSSEX, WI 53089

(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 08/13/2025, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation and verificaiton visit of statement of deficiency (SOD) ZXFY12 at The Courtyard At Sussex CBRF located at W235 N6350 Hickory Drive in Sussex, WI. Four citations of noncompliance were issued, including 1 repeat citation of noncompliance from SOD ZXFY11 and SOD ZXFY12, and 1 repeat citation of noncompliance from SOD ZXFY12. The complaint was substantiated. Census: 50 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{N 000}		
{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	{N 389}		

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interview, the provider did not ensure Resident 11's and Resident 12's individual service plan (ISP) were updated to reflect his/her needs, abilities, and physical condition related to mobility and fall risk interventions.

Resident 11's ISP did not address supervision of Resident 11 when seated in high back wheelchair related to repeated falls during transfers without caregiver assistance. Resident 11's ISP did not address Resident 11's described "antsy" behavior and/or inching forward in Resident 11's wheelchair seat attempting to stand up and/or sitting on the edge of the wheelchair seat in an attempt to scoot wheelchair forward with his/her feet. Resident 11's ISP was not updated with Resident 11's observations of lethargy and low blood pressure, bed to be positioned in lowest position, and the use of 2 floor mats. On 07/03/2025, Resident 11 experienced an unwitnessed fall in his/her room after being left unsupervised while seated in his/her high back wheelchair. This fall incident resulted in a fracture of Resident 11's left hip which required surgical intervention and skilled nursing care.

Resident 12's ISP did not address Resident 12's use of physical therapy services shortly after admission to the facility, Resident 12's change in ambulatory status in which Resident 12 became completely dependent on the use of a wheelchair for mobility, Resident 12's risk for falls and the increase in Resident 12's falls including at least 14 documented fall incidents between 06/14/2025 and 07/24/2025, and the use of a floor fall mat next to Resident 12's bed.

This requirement is being cited for the third time. See Statement of Deficiency (SOD) ZXFY11, issued 10/01/2024, and SOD ZYFY12, issued

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{N 389}	Continued From page 2 04/01/2025. The findings include: Example 1: Resident 11 On 07/29/2025 at approximately 9:57 A.M., Facility Nurse M told Surveyor Resident 11 was admitted to the facility on 04/01/2025 with hospice services. Facility Nurse M said Resident 11 was provided a high back wheelchair, where the back could be reclined, instead of a Broda chair. Facility Nurse M said Resident 11 was always inching forward in his/her wheelchair seat and attempting to stand up. Facility Nurse M said Resident 11 would also sit on the edge of the wheelchair seat and try to scoot wheelchair forward with his/her feet but was not able to propel the wheelchair any distance without assistance. Facility Nurse M said Resident 11 would attempt to get out of the wheelchair when s/he was "antsy" and experienced unwitnessed falls. Facility Nurse M said s/he did not believe Resident 11's record included documentation of Resident 11 being "ansty" when seated in the wheelchair and being brought to common areas when seated in wheelchair. Facility Nurse M said Resident 11 was diagnosed with a hip fracture following an unwitnessed fall at the facility on 07/03/2025, was hospitalized, and underwent hip surgery. On 07/29/2025 at 10:50 A.M., Surveyor conducted an interview with Resident 11's Hospice Nurse X. Hospice Nurse X told Surveyor Resident 1 was admitted to the facility from a different assisted living facility and with hospice services. Hospice Nurse X said Resident 11 utilized a Broda chair at the previous facility. Once at admitted to this facility, Resident 11	{N 389}		

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utilized a high back wheelchair related to their policy regarding Broda chairs. Hospice Nurse X said a couple of care conferences were conducted to address Resident 11 safety and his/her confusion related to Legal Representative AA transferring Resident 11 by self. Hospice Nurse X said following Resident 11's first or second unwitnessed fall at this facility, there was communication between Hospice Nurse X and the facility management regarding supervision encouraged when Resident 11 was in the high back wheelchair. Hospice Nurse X said having Resident 11 located in common areas was encouraged to provide increased observation of Resident 11 related to fall risk.

On 07/29/2025, Surveyor received Resident 11's demographic information, documentation of Resident 11's incidents, Resident 11's observation/caregiver notes, hospice documentation, and Resident 11's ISP as requested from Wellness Director (registered nurse, RN) L. Resident 11 was admitted to the facility on 04/01/2025 and had multiple diagnoses including dementia, Parkinson's disease, repeated falls, history of fractured right femur (leg bone), and history of "multiple fractures of pelvis..." Resident 11's demographic information included, "fall risk."
Resident 11's observation/caregiver notes titled, "04/01/2025 - [through] 04/30/2025" and "05/01/2025 - 07/29/2025," incident reports, and hospice notes included the following documentation:
* 04/29/2025 at 9:15 A.M. an observation note included, "Rolling upper body movement more pronounced today.."
* 05/05/2025 at 11:15 A.M. an observation note included, "[Resident 11] was visited by [hospice agency] nurse and aide with [sic] reported that

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[Resident 11] appeared more lethargy [sic] today.."
* 06/01/2025 at 10:45 A.M. incident report documentation included, "Fall - Unwitnessed" and "[Resident 11's] room." The documentation included, "When caregiver was completing rounds, caregiver opened door of room and [Resident 11] was found laying on floor on [his/her] back next to bed." The report included Resident 11's documented statement, "I don't [sic] know."
* 06/02/2025 at 12:15 P.M. an observation note included, "[Resident 11] was seen for a f/u [follow-up] fall on 06/01/2025...comments reported: found on floor, supine [positioned on back] at 10:50 A.M. full [sic] out of bed "trying to get up." The documentation included, "...floor mats mats [sic] x [times] 2, bed lower [sic] position."
* 06/11/2025 at 12:15 P.M. an observation note included, "[Resident 11] was seen by [Hospice Nurse X]: comments: Eating lunch, fall [sic] asleep very lethargic. Difficult to arose, encourage fluids, layed [sic] [him/her] down aleeping [sic]."
* 06/23/2025 at 2:00 P.M. observation note included, "[Resident 11] was seen by [Hospice Nurse X] with reporting [sic] that [Resident 11] is very lethargic today...B/P [blood pressure] very low again today."
* 06/25/2025 at 10:40 A.M. incident report documentation included, "Fall - Unwitnessed" and "[Resident 11's] Room." The documentation included, "While making round; found [Resident 11] on the floor next to [his/her] chair." The report included Resident 11's documented statement, "I [Resident 11] just wanted to get up."
* 06/25/2025 at 2:51 P.M. a hospice note included, "Problem: Risk for Falls/Injury. Intervention: Facility staff responsible for

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assessing [Resident 11] for needs frequently when hospice not present for a visit" and "FS [facility staff] will provide safety checks when [Resident 11] is up in high back w/c [wheelchair]. FS responsible when hospice not present." The note included, "Facility staff to encourage [Resident 11] to stay in common area when alone, or up in chair." This note included, "[Facility Nurse M] also given updated [sic]."
* 07/02/2025 at 5:00 P.M. an observation note included, "[Resident 11] was seen by [Hospice Nurse X] with report:....Seen post fall [no incident report received and no observation note detailing this fall], PROM [passive range of motion] to all 4 ext [extremities]." The documentation included, "BP [blood pressure] low again."
* 07/03/2025 at 10:30 A.M. incident report documentation included, "Fall - Unwitnessed" and "[Resident 11's] Room." The documentation included, "[Resident 11] was found on the floor next to [his/her] bed after a fall from [Resident 11] trying to self transfer from [his/her] wheelchair to bed. The report included Resident 11's documented statement, "I [Resident 11] try to stand up and fall [sic]."
* 07/03/2025 at 6:34 P.M. a hospice note included, "...results [of x-ray] just came in which are positive for left hip fracture. Family requesting [Resident 11] be sent to hospital for evaluation and pain management."
*07/07/2025 at 12:50 P.M. an observation note included, "[Resident 11] was discharged from the [facility] system. Unable to provide required care."
Resident 11's ISP signed/dated on 04/04/2025 included the following interventions:
* "Due to [Resident 11's] cognitive impairments, [s/he] requires frequent cueing and reminders throughout the day."
* "[Resident 11] uses a wheelchair for all mobility

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and ambulation [Resident 11 was nonambulatory] due to Parkinson's disease and weakness. [Resident 11] requires assistance with propelling wheelchair around community."
* "Due to [Resident 11's] Parkinson's [disease] and weakness, [Resident 11] requires use of a Hoyer lift with 2 caregivers for all transfers."
* "[Resident 11] receives hospices [sic] services through [hospice agency]."
Resident 11's ISP did not address supervision of Resident 11 when seated in high back wheelchair related to repeated falls during transfers without caregiver assistance. Resident 11's ISP did not address Resident 11's described "antsy" behavior and/or inching forward in Resident 11's wheelchair seat attempting to stand up and/or sitting on the edge of the wheelchair seat in an attempt to scoot wheelchair forward with his/her feet. The only mention of Resident 11's fall risk within Resident 11's ISP was documented, "[Resident 11] requires assistance from 2 caregivers to complete shower task including getting into/out of shower, washing/drying upper and lower extremities and washing hair. [Resident 11] utilizes a shower chair during task to reduce the risk for falls." Resident 11's ISP was not updated with Resident 11's observations of lethargy and low blood pressure, bed to be positioned in lowest position, and the use of 2 floor mats.

On 07/29/2025 at 4:29 P.M., and 4:46 P.M., Surveyor conducted interviews with Wellness Director L. Wellness Director L told Surveyor s/he recommended Resident 11 utilize a high back wheelchair instead of a Broda chair related to Resident 11's attempts to exit the chair and get up without assistance. Wellness Director L said Resident 11 could scoot self in the wheelchair, but it was not purposeful propelling of the

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wheelchair. Wellness Director L said Resident 11 required assistance with propelling the wheelchair. Wellness Director L told Surveyor Resident 11 had few verbalizations.
Wellness Director L said s/he was responsible for developing and updating resident ISPs and this "encouragement" and "expectation" and other interventions related to fall risk were not included within Resident 11's ISP, it was an oversight.

Example 2: Resident 12

On 07/29/2025 at 8:58 A.M., Surveyor observed Resident 12's room which included a fall mat on the floor next to Resident 12's bed and a folder located on a desk including the name of a hospice agency.

On 07/29/2025 at approximately 9:15 A.M., Caregiver V told Surveyor approximately 2 to 3 weeks after Resident 12's admission to the facility at the end of May 2025, Resident 12 could no longer ambulate. Caregiver V said s/he supervised Resident 12 ambulate to the bathroom and sit on the toilet. Caregiver V said Resident 12 was unable to stand up from the toilet and ambulate without Caregiver V's physical assistance. Caregiver V said it was if Resident 12 forgot how to walk. Caregiver V said s/he reported this change in Resident 12's mobility to the caregiver team at the end of the shift and Resident 12 experienced a fall incident that same night or the next day. Caregiver V said Resident 12 required the use of a wheelchair after that incident.

On 07/29/2025 at approximately 9:40 A.M., Caregiver W told Surveyor Resident 12 was independently ambulatory when s/he was admitted to the facility in May 2025. Caregiver W

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said, "one day [Resident 12] was just unable to walk." Caregiver W said Resident 12 started receiving hospice services shortly after this change and continued to experience several falls related to Resident 12's attempts to transfer self.

On 07/29/2025, Surveyor received Resident 12's demographic information, Resident 12's pre-admission assessment, documentation of Resident 12's incidents, Resident 12's observation/caregiver notes, and Resident 12's ISPs as requested from Wellness Director L.
Resident 12's pre-admission assessment dated 05/22/2025 included the following documentation within "Section: Mobility/Transfer/Escort (select all that apply): [Resident 12] uses walker/wheeled walker - address fall risk" and within "Section: Orientation/Behaviors (select all that apply): Requires regular prompting due to confusion and disorientation." Resident 12 was admitted to the facility on 05/27/2025 and had multiple diagnoses including dementia, "cognitive communication deficit," "frontal lobe and executive function deficit," "muscle weakness," and "repeated falls." Resident 12's demographic information included, "fall risk."
Resident 12's observation/caregiver notes titled, "05/17/2025 - 07/29/2025," and incident reports included the following documentation:
* Resident 12's observations notes began on 07/07/2025. At 3:55 P.M., Wellness Director L told Surveyor there were no observation notes documented within Resident 12's record between 05/17/2025 and 07/07/2025.
* 06/14/2025 at 3:30 P.M. incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included; [Resident 12] was found on [his/her] left side next to [his/her] bed on the floor. [Resident 12] reports [s/he] hit [his/her] bed [s/he] fell."

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{N 389}	Continued From page 9 * 06/28/2025 at 11:30 A.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "Staff was making round and heard a called [sic] out for help for [sic] the resident room. Upon entering resident room, staff found [Resident 12] on the floor and notice of [sic] skin tear to left elbow. [Resident 12] denied pain." * 06/29/2025 at 5:35 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found on the floor next to [his/her] bed laying on [his/her] left side. [Resident 12] had a pillow under [his/her] head and wheelchair next to [him/her]." * 07/06/2025 at 3:45 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found in [sic] resident bedroom floor yelling for help, just a little before staff went to get [Resident 12] for dinner. [Resident 12]...use [sic] wheel [sic] walker..." * 07/06/2025 at 10:30 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found laying with pillow under [his/her] head in [sic] resident bedroom floor yelling for help, just a little before staff make round check. [Resident 12]...use wheel [sic] walker..." * 07/07/2025 at 2:30 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found by caregiver laying on floor on in front of wheelchair in hallway to bedroom with bathroom door open." * 07/09/2025 at 6:45 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found laying on the	{N 389}		

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ground on [his/her] left side next to [his/her] dresser. [Resident 12's] wheelchair was flipped over with the brakes on."
* 07/10/2025 at 6:10 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found laying on the floor infront [sic] of [his/her] couch with wheelchair next to it."
* 07/11/2025 6:00 A.M., incident report documentation included, "While completing rounds, [Resident 12] was found laying next to [his/her] bed on [his/her] left side."
* 07/16/2025 at 6:20 P.M., incident report documentation included, "Fall - Unwitnessed" and "Common Area." The documentation included, "[Resident 12] was found laying face down in common area with wheelchair next to [him/her]."
* 07/17/2025 at 5:45 A.M., incident report documentation included, "Observed on floor" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found kneeling next to [his/her] bed. [Resident 12] was able to stand up with minimal staff assistance."
* 07/22/2025 at 3:30 P.M., incident report documentation included, "Fall - Witnessed" and "Common Area." The documentation included, "Care staff went to check on the residents sitting in TV room watching TV, when care staff noticed that [Resident 12] was scoot [sic] to edge of [his/her] wheelchair, slide [sic] out of [his/her] wheelchair onto [his/her] foot rest and hitting [his/her] left wrist on another resident [sic] wheelchair."
* 07/23/2025 at 8:10 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "Care staff was making rounding check and notice [sic] [Resident 12] is laying on [his/her] right side on the floor mat in [sic] [his/her]

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bedroom floor next to [his/her] bed.
* 07/24/2025 at 3:30 P.M., incident report documentation included, "Fall - Unwitnessed" and "[Resident 12's] Room." The documentation included, "[Resident 12] was found sitting on the floor on [his/her] buttocks next to [his/her] bed." The documentation included, "[Resident 12] reports [s/he] slid off [his/her] bed in an attempt to get up to go to the bathroom."
* 07/28/2025 at 10:30 A.M. an observation note included, "Care conference completed on this date which included: ...answered questions family had including how to better manage [Resident 12's] increase in falls." This was the only observation note specifically discussing Resident 12's falls.
Resident 12's ISP dated/signed 05/29/2025 included, "Physical disabilities - falls" with the following interventions: "[Resident 12] occasionally experiences bladder incontinence and requires assistance from caregivers to change product and ensure proper skin integrity and personal hygiene" and "[Resident 12] requires assistance with medication management and administration due to cognitive impairments."
Resident 12's ISP included, "Physical disabilities - ambulation" with the following intervention: "[Resident 12] utilizes a wheeled walker for all ambulation through community and does not require assistance from caregivers."
Resident 12's ISP dated/signed 07/07/2025 included the same interventions as documented in his/her 05/29/2025 within the "physical disabilities" within the addition of "[Resident 12] utilizes a wheelchair for all mobility that require [sic] [Resident 12] to go long distances or on days that [s/he] feels [s/he] is experiencing increased weakness." Resident 12's ISP included the addition of, "[Resident 12] requires assistance of 1 for all transfers due to increased weakness."

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{N 389}	Continued From page 12 Resident 12's ISPs did not address Resident 12's fall risk and interventions related to increased falls experienced by Resident 12 in June 2025 and July 2025. On 07/29/2025 at 3:55 P.M., Wellness Director L told Surveyor Resident 12 had physically therapy working with shortly after his/her admission to the facility until it was discontinued. Wellness Director L reviewed Resident 12's ISPs and told Surveyor s/he did not include Resident 12's physical therapy services within Resident 12's ISP. On 07/29/2025 at 4:46 P.M., Wellness Director L told Surveyor Resident 12 should be using a wheelchair for all mobility. Wellness Director L said Resident 12 required one caregiver to assist Resident 12 transfer to and from the toilet and bed. Wellness Director L said Resident 12 had not utilized his/her walker for ambulation for the last couple of weeks. Wellness Director L said Resident 12 experienced a quick transition from being about to walk with the walker to requiring the use of the wheelchair exclusively. Wellness Director L said s/he was responsible for developing and updated resident ISPs and s/he had not updated Resident 12's ISP with Resident 12's current dependence on the wheelchair, use of floor matt on floor next to Resident 12's bed, and increased fall incidents. Cross Reference: N0426 DHS 83.38(1)(b) Supervision	{N 389}		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication.	N 408		

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N 408	Continued From page 13 When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that the individual service plans (ISPs) for 2 residents reviewed, who were prescribed as needed (PRN) psychotropic medication, included the rationale for use and detailed description of the behaviors indicating the need for its administration, and documentation in each resident's record included rationale for use, description of behaviors requiring the PRN psychotropic medications, the effectiveness of the medication, and the presence of any side effects. Resident 12's ISPs did not include the rationale for the use and detailed description of Resident 12's behaviors associated with agitation, anxiety, restlessness, seizure, dyspnea [difficulty	N 408		

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breathing], nausea, vomiting which indicated the need for administration of PRN lorazepam. Resident 12's ISPs did not include the rationale for the use and detailed description of Resident 12's behaviors associated with anxiety and restlessness which indicated the need for administration of PRN quetiapine fumarate. Resident 12 was administered prescribed PRN lorazepam on multiple occasions in July 2015. The documentation did not include the rationale for use, a description of Resident 12's behaviors requiring the administration of Resident 12's PRN lorazepam, and the effectiveness of the medication. Resident 12 was administered prescribed PRN quetiapine fumarate twice in July 2025. The documentation did not include the rationale for use, a description of Resident 12's behaviors requiring the administration of Resident 12's PRN quetiapine fumarate, and the effectiveness of the medication.

Resident 11's ISP did not include the rationale for the use and detailed description of Resident 11's behaviors associated with a diagnosis of anxiety which indicated the need for administration of PRN (as needed) lorazepam. Resident 11 was administered prescribed PRN lorazepam on multiple occasions in June 2025 and July 2025 and the documentation did not include the rationale for use, the description of Resident 11's behaviors requiring the administration of Resident 11's PRN lorazepam, and the effectiveness of the medication.

The findings include:

Example 1: Resident 12

On 07/29/2025 at 8:58 A.M., Surveyor observed Resident 12's room which included a fall mat on

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the floor next to Resident 12's bed and a folder located on a desk including the name of a hospice agency.

On 07/29/2025, Surveyor received Resident 12's demographic information, Resident 12's pre-admission assessment, Resident 12's practitioner's orders, Resident 12's ISPs, Resident 12's July 2025 medication administration record (MAR), and Resident 12's observation/caregiver notes as requested from Wellness Director (registered nurse, RN) L.
Resident 12's pre-admission assessment dated 05/22/2025 included the following documentation within "Section: Orientation/Behaviors (select all that apply): Requires regular prompting due to confusion and disorientation." No other behavior indicators were documented/selected. Resident 12 was admitted to the facility on 05/27/2025 and had multiple diagnoses including dementia, "cognitive communication deficit" and "frontal lobe and executive function deficit."
Resident 12's practitioner's orders included the following PRN psychotropic medications to be administered to Resident 12:
* Lorazepam 0.5 mg (milligrams) prescribed as of 07/02/2025, "Take 1 tablet by mouth or sublingually [under tongue] every hour as needed (agitation, anxiety, restlessness, seizure, dyspnea, nausea, vomiting."
* Quetiapine fumarate (Seroquel) 25 mg prescribed as of 07/08/2025, "Take 1 tablet by mouth every 4 hours as needed (anxiety, restlessness)."
Resident 12's ISP dated/signed 05/29/2025 did not include documented needs and/or services related to behavior and/or the use of PRN psychotropic medication.
Resident 12's ISP dated/signed 07/07/2025 included, "[Resident 12] utilizes scheduled

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N 408	Continued From page 16 psychotropic medications to assist in the management of the following symptoms related to dementia diagnoses: agitation, anxiety, restlessness, confusion." This ISP did not include documented rationale for use of the PRN prescription of lorazepam nor quetiapine. This ISP did not include documented, detailed description of the behaviors indicating the need for their administration. Resident 12's July 2025 MAR included documentation of administration of Resident 12's prescribed PRN lorazepam on 07/06/2025 at 10:42 A.M., 07/07/2025 at 4:18 P.M., 07/13/2025 at 1:46 P.M. and 7:15 P.M., 07/16/2025 at 12:03 P.M., 07/17/2025 at 12:59 P.M. and 2:31 P.M., 07/22/2025 at 1:17 P.M., 07/23/2025 at 9:16 P.M., 07/24/2025 at 5:40 P.M., and 07/28/2025 at 3:12 P.M. Resident 12's July 2025 MAR included documentation of administration of Resident 12's prescribed PRN quetiapine fumarate on 07/10/2025 at 11:43 A.M. and on 07/17/2025 at 2:05 P.M. This last dose's documentation included, "Hospice nurse told me [caregiver] to give it, c/o [complaint of] resident being restless." The documentation did not include the rationale for use, the description of Resident 12's behaviors requiring the administration, nor the effectiveness of Resident 12's administered PRN lorazepam and PRN quetiapine fumarate. Resident 12's observation/caregiver notes titled, "05/17/2025 - [through] 07/29/2025" did not include documentation of the rationale for use, the description of Resident 12's behaviors requiring the administration, nor the effectiveness of Resident 12's administered PRN lorazepam and PRN quetiapine fumarate. At 7:03 P.M., Surveyor received an email from Wellness Director L including, "...[Resident 12] was admitted to hospice [services] on 07/07 [2025]."	N 408		

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N 408	Continued From page 17 On 07/29/2025 at 4:29 P.M. and 4:46 P.M., Wellness Director L told Surveyor Resident 12 may be administered prescribed PRN lorazepam when Resident 12 exhibited target behaviors including complaints of urinary urgency and repetitive verbalizations. Wellness Director L told Surveyor Resident 12 may be administered prescribed PRN quetiapine fururate when Resident 12 exhibited the same target behaviors but at an elevated, significant level and a couple of hours after Resident 12's administered PRN lorazepam was not effective. Wellness Director L told Surveyor s/he had documentation of Resident 12's practitioner that would further described target behaviors for Resident 12's prescribed PRN psychotropic medications. At 7:03 P.M., Surveyor received an email from Wellness Director L including attached documentation dated 06/30/2025. The documentation included, "BHI (Behavioral Health Integration) initial visit note...[Resident 12] was referred to BHI for depression and grief related to adjustment, as [Resident 12 was] new to the memory care setting. [Facility Nurse M] reports episodes of confusion, restlessness, and wandering behavior observed at times searching for [family member]. Recommend: Staff to maintain a predictable daily schedule to reduce confusion and anxiety. Gently encourage participation in activities or one-on-one interactions with peers or staff. When [Resident 12] expresses confusion or searches for [family member], use validation ("You must really miss [him/her]") and offer redirection ("Let's see if we can find a nice place to sit and talk about [him/her])." Wellness Director L told Surveyor s/he was responsible for developing and updating resident ISPs and s/he had missed including target behaviors related to Resident 12's	N 408		

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prescribed PRN lorazepam and prescribed PRN quetiapine fumarate.

Example 2: Resident 11

On 07/29/2025, Surveyor received Resident 11's demographic information, Resident 11's practitioner's orders, Resident 11's ISP, Resident 11's June 2025 and July 2025 MARs, and Resident 11's observation/caregiver notes as requested from Wellness Director L. Resident 11 was admitted to the facility on 04/01/2025 and had multiple diagnoses including dementia, Parkinson's disease, repeated falls, history of fractured right femur (leg bone), and history of "multiple fractures of pelvis..."
Resident 11's practitioner's orders included the following PRN psychotropic medications to be administered to Resident 11:
* Lorazepam 1 mg prescribed as of 04/08/2025, "Take 1 tablet by mouth every hour as needed [PRN] (anxiety)."
Resident 11's ISP dated/signed 04/04/2025 did not include documented rationale nor a detailed description of the behaviors indicating the need for administration of the PRN prescription of lorazepam.
Resident 11's June 2025 MAR included documentation of administration of Resident 11's prescribed PRN lorazepam on 06/09/2025 at 10:14 A.M., 06/24/2025 at 8:32 A.M., and 06/28/2025 at 1:38 P.M. Resident 11's July 2025 MAR included documentation of administration of Resident 11's prescribed PRN lorazepam on 07/03/2025 at 10:50 A.M. following a fall incident experienced by Resident 11. Neither of Resident 11's June 2025 nor July 2025 MARs included the rationale for use, the description of Resident 11's behaviors requiring the administration, nor the effectiveness of Resident 11's administered PRN

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lorazepam.
Resident 11's observation/caregiver notes titled, "04/01/2025 - [through] 04/30/2025" and "05/01/2025 - 07/29/2025" did not include documentation of the rationale for use, the description of Resident 11's behaviors requiring the administration, nor the effectiveness of Resident 11's administered PRN lorazepam. Resident 11 experienced a fall incident resulting in diagnoses including a left hip fracture on 07/03/2025 and was subsequently discharged from the facility.

On 07/29/2025 at 4:29 P.M. and 4:46 P.M., Wellness Director L told Surveyor Resident 11 was to be administered prescribed PRN lorazepam when Resident 11 was unable to be redirected from attempting to continually transfer out of his/her high back wheelchair without assistance. Wellness Director L told Surveyor s/he was responsible for developing and updating resident ISPs and not including target behaviors related to Resident 11's prescribed PRN lorazepam was an oversight.

On 08/11/2025 at 9:21 A.M., Surveyor conducted an interview with Resident 1's Family Member Z with Resident 11's Legal Representative AA present. Family Member Z said Resident 11 would nonverbally communicate wanting to get up and out of the wheelchair with a rocking motion. Family Member Z said Resident 11 would rock and gain momentum before falling out of the wheelchair if not assisted. Family Member Z said s/he had observed this behavior during visits with Resident 11 at the facility. Family Member Z said Resident 11 exhibited his/her anxiety with the rocking movement with unclear verbalizations while seated in the wheelchair more so in the mornings prior to Legal Representative AA's daily

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N 408	Continued From page 20 visits. Family Member Z said Resident 11 also had a very short attention span related to the dementia and Parkinson's disease diagnoses.	N 408		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 11 was provided supervision appropriate to Resident 11's needs related to fall risk. Resident 11 had diagnoses including dementia, Parkinson's disease, repeated falls, and a history of fractures. Resident 11 was known to attempt to transfer out of his/her wheelchair and bed without assistance, including episodes in which Resident 11 would fall. Resident 11's record included documentation including Resident 11 experiencing lethargy with low blood pressure, weakness, and requiring a Hoyer mechanical lift for all transfers. Resident 11 experienced at least 3 falls between 06/01/2025 and 07/03/2025, all of which occurred between 10:30 A.M. and 10:45 A.M., based on the facility's documentation.	N 426		

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Based on Resident 11's hospice agency documentation, the facility was encouraged to provide safety checks and have Resident 11 stay in common areas when seated in wheelchair related to Resident 11's risk for falls and/or injury. On 07/03/2025 at 10:30 A.M., Resident 11 experienced an unwitnessed fall in his/her room after being left unsupervised while seated in his/her high back wheelchair. This fall incident resulted in a fracture of Resident 11's left hip which required surgical intervention and skilled nursing care.

The findings include:

On 07/09/2025, the department received a complaint alleging a resident was not supervised appropriate to needs and experienced a fall incident resulting in significant injury.

On 07/09/2025, the department received an "Assisted Living Facility Self-Report" submitted by the facility. The document included a description of fall incident with injury experienced by Resident 11 on "07/03/2025" at "10:30 A.M." The description included, "While caregivers [Caregiver W and Caregiver E] were completing their rounds, [Resident 11] was found lying on the floor on [his/her] back in front of [his/her] wheelchair in [Resident 11's] bedroom. [Resident 11] immediately evaluated for injuries, initially denied pain and was able to complete range of motion of [his/her] upper and lower extremities. [Resident 11] was transferred into [his/her] wheelchair and brought down for lunch. [Resident 11] reported pain to another resident during lunch. [Facility Nurse M] and hospice RN [registered nurse] were immediately updated and responded to memory care dining room; [Resident 11] was taken to [Resident 11's] room to be re-evaluated and x-ray

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orders placed by hospice." The documentation included, "[Resident 11] currently remains in the hospital..."

On 07/29/2025 at 9:40 A.M., Caregiver W told Surveyor Resident 11 had diagnoses including dementia and Parkinson's disease, required the use of a high back wheelchair and a Hoyer mechanical lift for transfers. Caregiver W told Surveyor Resident 11 experienced falls prior to Resident 11's last fall at the facility on 07/03/2025. Caregiver W said Resident 11 would attempt to get out of his/her wheelchair and out of bed regularly without assistance. Caregiver W said caregivers tried to keep Resident 11 in the common areas of the facility when Resident 11 was seated in his/her wheelchair to make sure s/he was not attempting transfer out of the wheelchair without assistance. Caregiver W said s/he took Resident 11's vital signs after Resident 11's fall on 07/03/2025 but was not involved in caring for Resident 11 that morning prior to his/her fall.

On 07/29/2025 at approximately 9:57 A.M., Facility Nurse M told Surveyor Resident 11 was admitted to the facility on 04/01/2025 with hospice services. Facility Nurse M told Surveyor Resident 11 had an order for Broda chair use upon admission, but the facility's policy was to "stay away from" using Broda chairs if not for positioning. Facility Nurse M said Resident 11 was provided a high back wheelchair, where the back could be reclined, instead of a Broda chair. Facility Nurse M said Resident 11 was always inching forward in his/her wheelchair seat and attempting to stand up. Facility Nurse M said Resident 11 would also sit on the edge of the wheelchair seat and try to scoot wheelchair forward with his/her feet but was not able to

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propel the wheelchair any distance without assistance. Facility Nurse M said Resident 11 would attempt to get out of the wheelchair when s/he was "antsy" and experienced unwitnessed falls. Facility Nurse M said Resident 1's Legal Representative AA visited daily in the afternoon and would transfer Resident 1 from the wheelchair on his/her own. Facility Nurse M said this practice confused Resident 11 and s/he would attempt to transfer self when Legal Representative AA was not at the facility. Facility Nurse M said the caregivers were to bring Resident 11 out to the common areas with others present when s/he was seated in the wheelchair related to attempts to self-transfer. Facility Nurse M said s/he did not believe Resident 11's record included documentation of Resident 11 being "ansty" when seated in the wheelchair and being brought to common areas when seated in wheelchair. Facility Nurse M said Resident 11 was diagnosed with a hip fracture following an unwitnessed fall at the facility on 07/03/2025, was hospitalized, and underwent hip surgery.

On 07/29/2025 at 10:50 A.M., Surveyor conducted an interview with Resident 11's Hospice Nurse X. Hospice Nurse X told Surveyor Resident 1 was admitted to the facility from a different assisted living facility and with hospice services. Hospice Nurse X said Resident 11 utilized a Broda chair at the previous facility. Once at admitted to this facility, Resident 11 utilized a high back wheelchair related to their policy regarding Broda chairs. Hospice Nurse X said a couple of care conferences were conducted to address Resident 11 safety and his/her confusion related to Legal Representative AA transferring Resident 11 by self. Hospice Nurse X said following Resident 11's first or second unwitnessed fall at this facility, there was

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communication between Hospice Nurse X and the facility management regarding supervision encouraged when Resident 11 was in the high back wheelchair. Hospice Nurse X said having Resident 11 located in common areas was encouraged to provide increased observation of Resident 11 related to fall risk.

On 07/29/2025 at approximately 11:17 A.M., Administrator A told Surveyor Resident 11's family requested Resident 11 utilize a Broda chair. Administrator A said a care conference was held on 06/09/2025 with Family Member Z and Legal Representative AA to discuss the facility management not recommending Resident 11's use of a Broda chair. Administrator A said Legal Representative AA said s/he wanted this request revisited and another care conference was set up for 07/07/2025.

On 07/29/2025, Surveyor received Resident 11's demographic information, documentation of Resident 11's incidents, Resident 11's observation/caregiver notes, hospice documentation, and Resident 11's ISP as requested from Wellness Director (registered nurse, RN) L. Resident 11 was admitted to the facility on 04/01/2025 and had multiple diagnoses including dementia, Parkinson's disease, repeated falls, history of fractured right femur (leg bone), and history of "multiple fractures of pelvis..." Resident 11's demographic information included, "fall risk."
Resident 11's observation/caregiver notes titled, "04/01/2025 - [through] 04/30/2025" and "05/01/2025 - 07/29/2025," incident reports, and hospice notes included the following documentation:
* 04/29/2025 at 9:15 A.M. an observation note included, "Rolling upper body movement more

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pronounced today.."
* 05/05/2025 at 11:15 A.M. an observation note included, "[Resident 11] was visited by [hospice agency] nurse and aide with [sic] reported that [Resident 11] appeared more lethargy [sic] today.."
* 06/01/2025 at 10:45 A.M. incident report documentation included, "Fall - Unwitnessed" and "[Resident 11's] room." The documentation included, "When caregiver was completing rounds, caregiver opened door of room and [Resident 11] was found laying on floor on [his/her] back next to bed." The report included Resident 11's documented statement, "I don't [sic] know."
* 06/02/2025 at 12:15 P.M. an observation note included, "[Resident 11] was seen for a f/u [follow-up] fall on 06/01/2025...comments reported: found on floor, supine [positioned on back] at 10:50 A.M. full [sic] out of bed "trying to get up."
* 06/11/2025 at 12:15 P.M. an observation note included, "[Resident 11] was seen by [Hospice Nurse X]: comments: Eating lunch, fall [sic] asleep very lethargic. Difficult to arose, encourage fluids, layed [sic] [him/her] down aleeping [sic]."
* 06/23/2025 at 2:00 P.M. observation note included, "[Resident 11] was seen by [Hospice Nurse X] with reporting [sic] that [Resident 11] is very lethargic today...B/P [blood pressure] very low again today."
* 06/25/2025 at 10:40 A.M. incident report documentation included, "Fall - Unwitnessed" and "[Resident 11's] Room." The documentation included, "While making round; found [Resident 11] on the floor next to [his/her] chair." The report included Resident 11's documented statement, "I [Resident 11] just wanted to get up."
* 06/25/2025 at 2:51 P.M. a hospice note

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included, "Problem: Risk for Falls/Injury. Intervention: Facility staff responsible for assessing [Resident 11] for needs frequently when hospice not present for a visit" and "FS [facility staff] will provide safety checks when [Resident 11] is up in high back w/c [wheelchair]. FS responsible when hospice not present." The note included, "Facility staff to encourage [Resident 11] to stay in common area when alone, or up in chair." This note included, "[Facility Nurse M] also given updated [sic]."
* 07/02/2025 at 5:00 P.M. an observation note included, "[Resident 11] was seen by [Hospice Nurse X] with report:....Seen post fall [no incident report received and no observation note detailing this fall], PROM [passive range of motion] to all 4 ext [extremities]." The documentation included, "BP [blood pressure] low again."
* 07/03/2025 at 10:30 A.M. incident report documentation included, "Fall - Unwitnessed" and "[Resident 11's] Room." The documentation included, "[Resident 11] was found on the floor next to [his/her] bed after a fall from [Resident 11] trying to self transfer from [his/her] wheelchair to bed. The report included Resident 11's documented statement, "I [Resident 11] try to stand up and fall [sic]."
* 07/03/2025 at 6:34 P.M. a hospice note included, "...results [of x-ray] just came in which are positive for left hip fracture. Family requesting [Resident 11] be sent to hospital for evaluation and pain management."
*07/07/2025 at 12:50 P.M. an observation note included, "[Resident 11] was discharged from the [facility] system. Unable to provide required care."
Resident 11's ISP signed/dated on 04/04/2025 included the following interventions:
* "Due to [Resident 11's] cognitive impairments, [s/he] requires frequent cueing and reminders

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throughout the day."
* "[Resident 11] uses a wheelchair for all mobility and ambulation [Resident 11 was nonambulatory] due to Parkinson's disease and weakness. [Resident 11] requires assistance with propelling wheelchair around community."
* "Due to [Resident 11's] Parkinson's [disease] and weakness, [Resident 11] requires use of a Hoyer lift with 2 caregivers for all transfers."
* "[Resident 11] receives hospices [sic] services through [hospice agency]."
Resident 11's ISP did not address supervision of Resident 11 when seated in high back wheelchair related to repeated falls during transfers without caregiver assistance. Resident 11's ISP did not address Resident 11's described "antsy" behavior and/or inching forward in Resident 11's wheelchair seat attempting to stand up and/or sitting on the edge of the wheelchair seat in an attempt to scoot wheelchair forward with his/her feet. The only mention of Resident 11's fall risk within Resident 11's ISP was documented, "[Resident 11] requires assistance from 2 caregivers to complete shower task including getting into/out of shower, washing/drying upper and lower extremities and washing hair. [Resident 11] utilizes a shower chair during task to reduce the risk for falls."

On 07/29/2025 at 4:29 P.M., and 4:46 P.M., Surveyor conducted interviews with Wellness Director L. Wellness Director L told Surveyor s/he recommended Resident 11 utilize a high back wheelchair instead of a Broda chair related to Resident 11's attempts to exit the chair and get up without assistance. Wellness Director L said Resident 11 could scoot self in the wheelchair but it was not purposeful propelling of the wheelchair. Wellness Director L said Resident 11 required assistance with propelling the wheelchair.

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Wellness Director L told Surveyor Resident 11 had few verbalizations.
Wellness Director L told Surveyor Resident 11 was to be administered prescribed PRN lorazepam when Resident 11 was unable to be redirected from attempting to continually transfer out of his/her high back wheelchair without assistance.
Wellness Director L said caregivers were encouraged to keep Resident 11 in common areas and/or involved with supervised activities when seated in the high back wheelchair.
Wellness Director L said it was an expectation to have Resident 11 out of his/her bedroom when seated in the high back wheelchair related to his/her attempts to get out of the wheelchair on own. Wellness Director L said s/he was responsible for developing and updating resident ISPs and this "encouragement" and "expectation" and other interventions related to fall risk were not included within Resident 11's ISP, it was an oversight.
Wellness Director L told Surveyor Resident 11 was found on Resident 11's room floor on 07/03/2025 after falling out of Resident 11's wheelchair. Wellness Director L said Resident 11 was left in his/her room seated in the wheelchair without supervision after being returned to his/her room sometime after breakfast. Wellness Director L said Administrator A conducted an investigation regarding this incident because Caregiver E and Caregiver Y determined Resident 11 was not in pain and did not ask Facility Nurse M to assess Resident 11 before they transferred Resident 11 off of the floor and back into his/her wheelchair. Wellness Director L said Facility Nurse M and Hospice Nurse X were in the building at the time of this incident.
Wellness Director L said the caregivers should not have left Resident 11 in his/her room alone

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while seated in the wheelchair. Wellness Director L said Resident 11 later complained of pain to another resident during the lunch meal.

On 07/29/2025 at 5:15 P.M., Administrator A told Surveyor Caregiver E and Caregiver Y took Resident 11 back to his/her room on 07/03/2025 after breakfast and activity time, Resident 11 was seated in his/her high back wheelchair. Administrator A said both Caregiver E and Caregiver Y left Resident 11 alone in his/her room before going down the hallway to assist Resident 14 residing 2 doors down the hallway from Resident 11's room. Administrator A said Resident 14 required one caregiver to assist with cares so Caregiver E left Resident 14's room, walked down the hall towards Resident 11's room, and heard noises coming from Resident 11's room. Administrator A said Caregiver E entered Resident 11's room, observed Resident 11 on the floor, and yelled for Caregiver Y's assistance. Administrator A said based on his/her interview with Caregiver E and Caregiver Y, they left Resident 11 alone in the wheelchair in his/her room approximately 5 minutes before finding Resident 11 on the floor. Administrator A said Resident 11's fall happened that quickly. Administrator A said s/he conducted an investigation related to the caregivers transferring Resident 11 off of the floor without having a nurse assess Resident 11 following the fall on 07/03/2025. Administrator A said Resident 11 did not complain of any pain, but Resident 11 has diagnoses including dementia and could have been assessed for injury before being transferred from the floor.
Administrator A provided a copy of his/her investigation dated 07/14/2025 to Surveyor. The investigation documentation included Caregiver E's statement including, "[Caregiver E] reported

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that on [07/03/2025], after completing cares for another resident, [s/he] observed [Resident 11] lying on [his/her] side on the floor in [his/her] apartment. [Resident 11] was supporting [his/her] head with [his/her] arm, and based on [his/her] positioning, staff did not believe [s/he] had struck [his/her] head. Historically, [Resident 11] is able to verbalize when [s/he] is in pain or has experienced an injury." The documentation included, "[Caregiver E] immediately alerted [Caregiver Y] for assistance. [Caregiver Y] retrieved the Hoyer lift, and together they transferred [Resident 11] into her high back wheelchair. [Resident 11] denied any pain during multiple inquiries. [Caregiver E] notified [Facility Nurse M], the LPN [licensed practical nurse], who instructed them to complete an incident report. [Resident 11] was then brought to the dining room to join the other residents for lunch." The documentation included, "During lunch, [Resident 11] began complaining of pain and vocalizing discomfort. When asked again, [Resident 11] pointed to [his/her] hip and confirmed [s/he] was in pain. Staff notified [Facility Nurse M] of this change in condition. [Caregiver E] emphasized that [Resident 11] was lifted off the floor promptly not because [s/he] was in obvious pain, but because [s/he] appeared uncomfortable lying on the ground [floor]." The documentation included, "[Resident 11] was eventually assessed by both the facility nursing staff and [hospice agency]. An x-ray was conducted, and [Resident 11] was sent to the hospital due to increased pain and at the family's request."

On 08/11/2025 at 9:21 A.M., Surveyor conducted an interview with Resident 1's Family Member Z with Resident 11's Legal Representative AA present. Family Member Z told Surveyor Resident 11 was not able to verbalize in clear

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N 426	Continued From page 31 words leading up to Resident 11's fall on 07/03/2025, Resident 11's words were jumbled. Family Member Z said Resident 11 would nonverbally communicate wanting to get up and out of the wheelchair with a rocking motion. Family Member Z said Resident 11 would rock and gain momentum before falling out of the wheelchair if not assisted. Family Member Z said s/he had observed this behavior during visits with Resident 11 at the facility. Family Member Z said Resident 11 exhibited his/her anxiety with the rocking movement with unclear verbalizations while seated in the wheelchair more so in the mornings prior to Legal Representative AA's daily visits. Family Member Z said Resident 11 also had a very short attention span related to the dementia and Parkinson's disease diagnoses. Family Member Z told Surveyor s/he and Resident 11's Legal Representative AA requested Resident 11 be supervised in the facility's main living/common areas while seated in the high back wheelchair related to fall risk. Family Member Z said s/he and Legal Representative AA made this request during a care conference with facility management and Hospice Nurse X present. Family Member Z said s/he did not receive anything in writing from the facility regarding this request, but it was agreed upon during the care conference with facility management and Hospice Nurse X. Family Member Z told Surveyor Resident 11 was diagnosed with a fractured left hip following the fall incident on 07/03/2025, was hospitalized with surgical repair of the hip, and admitted to a skilled nursing rehabilitation center for continued treatment. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 426		

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{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 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 interview and record review, the provider did not document communication with the resident's physician related to changes in the resident's health status. The provider did not update Resident 13's physician of 3 of 5 falls, or when Resident 13's blood pressure was out of physician specified	{N 431}		

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{N 431}	Continued From page 33 parameters. This requirement is being cited for the second time. See Statement of Deficiency (SOD) ZXFY12, issued 04/01/2025. Findings include: On 07/29/2025 at approximately 9:00 AM, Surveyor interviewed Resident 13. Resident 13 stated s/he has had a recent increase in falls and has been requiring more assistance from staff. S/he did not have concerns related to receiving his/her medications aside from "They aren't always fast about it". On 07/29/2025, Surveyor reviewed Resident 13's records which documented the following: Resident 13 admitted to the provider on 05/14/2022 with diagnosis including diabetes mellitus type 2, hypertension, and asthma. His/her facesheet also identifies him/her as a fall risk. Surveyor reviewed incident/ fall reports from May 18th 2025 - July 29th 2025 and identified 5 separate fall incidents which occurred on 06/05/2025, 06/07/2025, 07/07/2025, 07/11/2025, and 07/12/2025. The incident reports indicates if the physician was updated. The following falls were documented as "no" in the physician updated section: 06/05/2025, 06/07/2025, and 07/12/2025. Review of the medication administration record (MAR), dated 06/01/2025 - 07/29/2025, documented the following: Diltiazem 24 HR ER 120 mg- Take 1 capsule by mouth in the morning **Hold and **call Doctor**	{N 431}		

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{N 431}	Continued From page 34 for Sbp less than 100 or Dbp less than 50** (hypertension). On the following 6 dates the medication was held due to blood pressure being out of parameters: 06/02/2025, 06/04/2025, 07/14/2025, 07/16/2025,07/21/2025, and 07/24/2025. The MAR contains notations to include what the blood pressure was but does not document whether the physician was notified. Resident 13's observations, dated 05/17/2025 - 07/29/2025, contained no documentation of the physician being updated regarding falls or blood pressures resulting in held doses of the diltiazem. On 07/29/2025 at approximately 2:40 PM, Surveyor interviewed Wellness Director L regarding the falls and held doses of diltiazem. Wellness Director L stated it was standard practice to update the physician of all falls, and to follow update the physician if the medication orders say to do so. Wellness Director L could not state if the physician was updated on the 3 falls that were selected "no" for updating the physician and could not provide an explanation for why it would not have been done. S/he deferred Surveyor to speak with Facility Nurse M. Wellness Director L stated the staff administering the medication would not be expected to call the physician themselves if the medication needed to be held, but to notify the nurse on call who would then notify the physician. Wellness Director L is on call 50% of the time and stated s/he had not been made aware of Resident 13's blood pressure being out of parameters, so s/he has not updated the physician. Wellness Director L stated s/he did not believe the physician had been updated, but to speak with Facility Nurse M, who is on call the other 50% of the time.	{N 431}		

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COURTYARD AT SUSSEX CBRF (THE)	W235 N6350 HICKORY DRIVE SUSSEX, WI 53089

(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 35 On 07/29/2025 at approximately 3:10 PM, Surveyor interviewed Facility Nurse M. Facility Nurse M initially stated s/he was not sure if staff notified him/her regarding the blood pressures for Resident 13, but that s/he does believe s/he had updated the physician. Facility Nurse M called the physician's office, who could not confirm if they received an update or not from the facility staff. Facility Nurse M confirmed there was no documentation that the physician was updated on concerns related to falls or the blood pressures resulting in the diltiazem being held.	{N 431}		