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	0018802	A. BUILDING: _____ B. WING _____	R-C 12/08/2025

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

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{N 000}	Initial Comments On 12/08/2025, the Bureau of Assisted Living, Southern Regional Office conducted a verificaiton visit of statement of deficiency (SOD) ZXFY13 at The Courtyard At Sussex CBRF located at W235 N6350 Hickory Drive in Sussex, WI. Two citations of noncompliance were issued, including 1 repeat citation of noncompliance from SOD ZXFY12 and SOD ZXFY13, and another repeat citation of noncompliance from SOD ZXFY13. Census: 47 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{N 000}		
{N 408}	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. 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,	{N 408}		

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

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{N 408}	Continued From page 1 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 Resident 15's and Resident 16's record included documentation describing the behaviors requiring administration of the PRN (as needed) psychotropic medication and the effectiveness of the medication administered. Resident 15 was administered prescribed PRN lorazepam on 3 occasions in November 2025. Resident 15's record did not include a description of Resident 15's behaviors requiring the administration of Resident 15's PRN lorazepam and the effectiveness of the medication. Resident 16 was administered prescribed PRN quetiapine on 2 occasions in December 2025. Resident 16's record did not include a description of Resident 16's behaviors requiring the administration of Resident 16's PRN quetiapine and the effectiveness of the medication. This requirement is being cited for the second time. See Statement of Deficiency (SOD) ZXFY13, issued 09/03/2025. The findings include: Example 1: Resident 15 On 12/08/2025 at 9:00 A.M., Surveyor observed Resident 15 ambulating independently in the hallway of the memory care unit.	{N 408}		

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{N 408}	Continued From page 2 On 12/08/2025 at 10:06 A.M., Caregiver BB told Surveyor Resident 15 would regularly wander in to other resident's rooms without invitation and would require redirection from caregivers related to this behavior. Caregiver BB said Resident 15 may require administration of a PRN psychotropic medication related to this behavior if caregivers were not able to successfully redirect Resident 15. On 12/08/2025, Surveyor received Resident 15's demographic information, Resident 15's practitioner's orders, Resident 15's individual service plan (ISP), Resident 15's November and December 2025 medication administration records (MARs), Resident 15's observation/caregiver notes, and Resident 15's psychotropic PRN medication review for November 2025 as requested from Vice President of Clinical Services CC. Resident 15 was admitted to the facility on 06/25/2025 and had multiple diagnoses including dementia and "frontotemporal lobe neurocognitive disorder." Resident 15's practitioner's orders included lorazepam 0.5 mg (milligrams) prescribed to "Take 1 tablet by mouth or sublingually [under tongue] every 2 hours as needed (anxiety)." Resident 15's ISP dated/signed 11/19/2025 included "[Resident 15] wanders into other resident's rooms requiring redirection. Care staff will redirect [Resident 15] into the common areas or back into [his/her] room." Resident 15's ISP included, "When [Resident 15] begins pacing, fidgeting, inability [sic] to sit still or becoming [sic] verbally aggressive such as argumentative or yelling, [Resident 15] is administered PRN lorazepam." Resident 15's November 2025 MAR included	{N 408}		

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{N 408}	Continued From page 3	{N 408}		

documentation of administration of Resident 15's prescribed PRN lorazepam on 11/01/2025 at 10:30 A.M., 11/10/2025 at 5:19 P.M., and 11/16/2025 at 7:55 A.M. Resident 15's administered dose documented on 11/10/2025 at 5:19 P.M. included, "per nurse." Resident 15's November 2025 MAR did not include documentation of the rationale for use, the description of Resident 15's behaviors requiring the administration, nor the effectiveness of the three doses of PRN lorazepam administered to Resident 15 in November 2025.
Resident 15's observation/caregiver notes for November 2025 did not include documentation of the rationale for use, the description of Resident 15's behaviors requiring the administration, nor the effectiveness of Resident 15's administered PRN lorazepam in November 2025.
Resident 15's December 2025 MAR did not include documentation of administration of PRN lorazepam.
Resident 15's psychotropic PRN medication review for November 2025 performed by Wellness Director L dated 11/26/2025 included the 3 doses documented as administered to Resident 15 in November 2025 and "yes" checked for "appropriate use of PRN?"

On 12/08/2025 at 1:15 P.M., Wellness Director L told Surveyor s/he completed Resident 15's psychotropic PRN medication review for November 2025 on 11/26/2025, as documented. Surveyor asked Wellness Director L how s/he was able to check "yes" for "appropriate use of PRN?" regarding Resident 15's administered doses of PRN lorazepam. Wellness Director L said Surveyor's question was a fair question and verbally acknowledged the caregivers had not documented the rationale for use and description

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{N 408}	Continued From page 4 of Resident 15's behaviors related to the administration of the 3 doses administered in November 2025. Wellness Director L verbally agreed the caregivers had not documented the effectiveness of each PRN lorazepam dose, as administered to Resident 15 in November 2025. Example 2: Resident 16 On 12/08/2025 at 10:06 A.M., Caregiver BB told Surveyor Resident 16 often exhibited exit seeking behaviors looking for his/her spouse typically following family visits and would require redirection from caregivers. Caregiver BB said Resident 16 may require administration of a PRN psychotropic medication related to this behavior if caregivers were not able to successfully redirect Resident 16 from exit seeking. On 12/08/2025, Surveyor received Resident 16's demographic information, Resident 16's practitioner's orders, Resident 16's ISP, Resident 16's November and December 2025 MARs, and Resident 16's observation/caregiver notes, as requested from Vice President of Clinical Services CC. Resident 16 was admitted to the facility on 02/18/2025 and had multiple diagnoses including dementia. Resident 16's practitioner's orders included quetiapine 50 mg (milligrams) prescribed to "Take 1 tablet by mouth 3 times a day as needed for (anxiety) (restlessness)." Resident 16's ISP dated/signed 11/14/2025 included "[Resident 16] will begin exit seeking, becoming paranoid, and pacing when [s/he] feels agitated and is looking for [his/her spouse]. Care staff will attempt to redirect [him/her] by distraction such as turning [his/her] TV on, engaging [him/her]	{N 408}		

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{N 408}	Continued From page 5	{N 408}		

in an activity within the community, or encouraging [him/her] to read [his/her] book." Resident 16's ISP included, "[Resident 16] receives PRN quetiapine to assist in the management of [his/her] behaviors and moods related to [his/her] dementia diagnosis."
Resident 16's December 2025 MAR included documentation of administration of Resident 16's prescribed PRN quetiapine on 12/04/2025 at 11:33 A.M. and 12/05/2025 at 8:42 P.M. Resident 16's administered dose documented on 12/04/2025 at 11:33 A.M. included, "[Resident 16's spouse] asked if we [caregiver/s] could administer a PRN medication for [Resident 16] so [s/he] can calm down, says [s/he] was anxious the whole visit [s/he] had with [him/her]." Resident 16's December 2025 MAR did not include documentation of the rationale for use, the description of Resident 16's behaviors requiring the administration, nor the effectiveness of Resident 16's administered PRN lorazepam in December 2025.
At 12:41 P.M., Vice President of Clinical Services CC told Surveyor there were no observation/caregiver notes documented for Resident 16 thus far in December 2025.
Resident 16's November 2025 MAR did not include documentation of administration of PRN quetiapine.

On 12/08/2025 at 1:40 P.M., Wellness Director L told Surveyor s/he realized caregivers had not documented the rationale for use, the description of behaviors requiring the administration, nor the effectiveness of Resident 15's administered PRN lorazepam in November 2025 and Resident 16's administered PRN quetiapine in December 2025. Wellness Director L said s/he had met with

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{N 408}	Continued From page 6 caregivers since SOD ZXFY13 was issued and verbalized the importance of documenting the rationale, target behaviors, and effectiveness of each administration of PRN psychotropic medications in resident records, primarily the MAR. Wellness Director L said s/he will continue to educate and remind caregivers to document, as required.	{N 408}		
{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.	{N 431}		

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{N 431}	Continued From page 7	{N 431}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not take or document a required vital sign with administration of a scheduled medication.

The provider did not measure or record Resident 17's heart rate before administering his/her scheduled metoprolol.

This requirement is being cited for the third time. See Statement of Deficiency (SOD) ZXFY12, issued 04/01/2025, and SOD ZXFY13, issued 09/03/2025.

Findings include:

On 12/08/2025, Surveyor reviewed Resident 17's records which documented the following:

Resident 17 admitted to the provider on 04/25/2025 with diagnosis including essential hypertension, pulmonary hypertension, and chronic diastolic heart failure.

Resident 17's physician orders include:
Metoprolol Succinate 50 mg - Take ½ tablet by mouth in the morning (hypertension) notify MD for SBP (systolic blood pressure) less than 90 or greater than 180 or HR (heart rate) less than 50 and hold.

Surveyor reviewed Resident 17's medication administration record (MAR) from 10/18/2025 - 12/08/2025. The MAR documented the metoprolol start date was 11/14/2025. Charting notations for

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{N 431}	Continued From page 8 the metoprolol from 11/14/2025 - 12/08/2025, included monitoring of Resident 17's blood pressure, but did not include documentation of heart rate checks. On 12/08/2025 at approximately 1:30 PM, Surveyor interviewed Wellness Director L. Wellness Director L stated s/he noted the missing heart rate checks when s/he ran the medication administration record report. S/he said that when processing the medication order in their electronic medical record, someone didn't press the "pulse" button, to include the requirement for staff during the medication pass. Wellness Director L confirmed both blood pressure and heart rate should be monitored based on the physician orders.	{N 431}		