STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 02/01/2024, Surveyors conducted a verification visit, complaint investigation, and licensure survey at Rolling Meadows of Strum. Data collection continued through 02/23/2024. The complaint was substantiated. Ten deficiencies were identified. Four of 10 deficiencies were repeat violations. See Statement of Deficiency (SOD) LHMG11, dated 10/05/2021, SOD ZY4713, dated 02/29/2023, and SOD ZY4714, dated 07/28/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 19	{N 000}		
{N 158}	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should	{N 158}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 158}	Continued From page 1	{N 158}		

have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not report caregiver misconduct to the Department after they concluded Caregiver D was given Resident 3's debit card and there were allegations s/he may have withdrawn money that Resident 3 did not receive.

This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4713, dated 02/09/2023, and SOD ZY4714, dated 07/28/2023.

Findings include:

The facility is licensed to serve up to 19 residents in the following client groups: physically disabled, terminally ill, advanced aged, and irreversible dementia/Alzheimer's disease.

Wis. Admin. Code § DHS 13.03(12). Defines misappropriation as any of the following:
"(e) Violating s. 943.38, Stats., involving the property of a client, or s. 943.41, Stats., involving fraudulent use of a client's financial transaction card."

The provider's policy, "Abuse, Neglect, Misappropriation, and injuries of Unknown Sources," read, in part: "If the Administrator, or his or her Designee, determines that there is sufficient information or evidence to show the alleged incident occurred (or that another agency could obtain such evidence) and the evidence gives rise to a reasonable belief that the incident constituted abuse, neglect, or misappropriation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 158}	Continued From page 2	{N 158}		

property, the Administrator must report the allegations as follows:
1. If the incident was committed by a caregiver, submit an incident report (DQA form F-62447) to the DQA within seven days of the date the Facility knew or should have known of the incident ...
2. If the incident potentially involved criminal activity, contact local law enforcement."

On 02/01/2024 at approximately 1:00 PM, Surveyor requested any misappropriation investigations in the past 6 months.

Surveyor received a misconduct investigation, undated and signed by Director A. The investigation indicated Resident 3 alleged Caregiver D withdrew 500 dollars from Resident 3's debit card and the money was missing. On 11/26/2023, Resident 3 had given Caregiver D his/her debit card and pin number to buy something at a store for Resident 3. Caregiver D was interviewed and denied the allegations. The investigation indicated the allegations were reported to the police department, which was investigating.

An incident report, dated 11/29/2023, read, in part, "Writer was notified that [Resident 3] was missing money of 500 dollars ...[Resident 3] gave [Caregiver D] [his/her] debit card and pin ...and [s/he] noticed that [his/her] card has no more money ...Writer and [Assistant Director (AD) J] did an investigation this morning and called [Resident 3's] bank on a speaker phone together with [Resident 3] ...As per [the bank] there was a withdrawal transaction last 11/19/23 at 8:21Pm [sic] in [a neighboring town] express mart and on 11/21/23 a withdrawal transaction twice in [a farther away town] atm [sic] [gas station] with 200 dollars at 6:19pm [sic] and another 200 dollars

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 158}	Continued From page 3 6:21Pm [sic] and total of 400." Resident 3 filed a dispute on the matter with the bank. The provider attempted to see video footage from the stores where the transactions took place, but was unable to due to Resident 3 reporting after too much time had passed. The provider contacted the police department to report the incident. A self-report, dated 01/03/2024, read, in part, "According to [Resident 3] [Caregiver D] had [his/her] card in [his/her] possession for about a week. When finally returning the card [Caregiver D] had [another caregiver] bring it back to [him/her]. They ended up telling [Resident 3] that on their way back from Eau Claire they stopped at the bar and someone took [Caregiver D's] purse off the bar with [Resident 3's] things. [Caregiver D's] story is that [s/he] took money out of the atm [sic] to purchase the things [s/he] said [s/he] did not end up purchasing the Itunes [sic] cards like requested [s/he] only bought [his/her] cigarettes and returned the other 470 some dollars to [Resident 3] [him/herself]." The self-report further stated Resident 3 claimed s/he never got any of the money back from Caregiver D. After calling his/her bank, s/he found out 500 dollars total was withdrawn from his/her card. On 02/09/2024 at 3:48 PM, Surveyor asked via email if this incident was reported to the Office of Caregiver Quality (OCQ). On 02/12/2024 at 2:55 PM, Surveyor received from Licensee B via email, a response indicating the provider had submitted a report for this incident to OCQ. On 02/16/2024 at 12:26 PM, Surveyor reached out to OCQ and confirmed they did not receive a report from the provider for this incident.	{N 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 158}	Continued From page 4 On 02/16/2024 at 4:23 PM, Surveyor requested via email that Licensee B report this incident to OCQ and send a confirmation when it had been completed. On 02/20/2024 at 12:42 PM, Surveyor received a confirmation from Licensee B that the incident was reported to OCQ. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C. Licensee B stated they initially reported the incident to the local police department and were waiting for the result before reporting it to OCQ. Licensee B stated Caregiver D did not come to work during their investigation for a few days but was still working at the facility. Staff were educated to not go in by Resident 3 without a second staff and a training took place about resident money.	{N 158}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after Resident 12 fell, resulting in emergency room (ER) treatment for a fractured right wrist and head injury.	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 165	Continued From page 5 This is a repeat deficiency. See Statement of Deficiency (SOD) LHMG11, dated 10/05/2021. Findings include: The facility is licensed to serve up to 19 residents in the following client groups: physically disabled, terminally ill, advanced aged, and irreversible dementia/Alzheimer's disease. Resident 12 was admitted on 07/07/2021 and had an activated power of attorney (POA). Resident 12 had diagnoses that included seizure disorder, depression, and anxiety. An incident report, dated 12/03/2023, read, in part, "[Resident 12] was coming back from the ER and when the transportation company came to drop [him/her] [sic] [Resident 12] reported to staff that [s/he] had fallen later on not right away. Sunday 12/4 Med passer ...reported to this staff that [Resident 12] was complaining about [his/her] hand hurting. [S/he] told [him/her] that [s/he] had fallen when coming back from the ER. [S/he] didn't tell staff when it happened." A medical note, dated 12/03/2023, indicated Resident 12 was diagnosed with a fracture of the right ulna styloid process and head injury. The note read, in part, "Patient had a fallen [sic] 2 days ago while [s/he] was outside. [S/he] would [sic] fallen backwards onto the cement. [S/he] hit the left side of [his/her] head and injured [his/her] right wrist ...[S/he] was seen in the emergency department last night because of a choking episode. [S/he] was discharged home. [S/he] states that [s/he] had symptoms last night but did not report them because they were not severe."	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 165	Continued From page 6 A medical note, dated 12/04/2023, indicated Resident 12 was seen for a sprained left wrist from his/her fall on 12/03/2024. On 02/01/2024 at 10:07 AM, Surveyor interviewed Assistant Director (AD) J. AD J indicated Resident 12 had 2 falls in the past few months. One of the falls was in the facility parking lot upon his/her return from the ER on 12/03/2023. Surveyor requested the incident report and self-report for the fall, which AD J provided. Surveyor asked AD J if the self-report had been submitted to the department. AD J stated s/he had been having some trouble submitting self-reports and was not sure if the self-report had been submitted for the 12/03/2023 incident. On 02/02/2024, Surveyor reviewed records submitted to the department from the provider. There was not a documented report of Resident 12's fall on 12/03/2023. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C. Licensee C stated s/he had reached out and Director A indicated the self-report had been submitted to the department for the 12/03/2023 incident. Surveyor asked for proof to demonstrate Director A had submitted the self-report and Licensee B stated they would not be able to get proof due to Director A being on vacation out of the country. The provider did not report Resident 12's fall resulting in ER treatment for a right wrist fracture, head injury, and left wrist sprain.	N 165		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws	{N 196}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 196}	Continued From page 7 The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and observation, the licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4713, dated 02/09/2023 and SOD ZY4714, dated 07/28/2023. Findings include: The facility is licensed to serve up to 19 residents in the following client groups: physically disabled, terminally ill, advanced aged, and irreversible dementia/Alzheimer's disease. On 02/01/2024, Surveyors conducted a licensure survey, verification visit, and complaint investigation at Rolling Meadows of Strum. Surveyors confirmed with Director A s/he received the SOD and order letter on 10/04/2023 for SOD ZY4714, dated 07/28/2023. The order letter, dated 10/04/2023, had special orders that stated the licensee shall develop and implement corrective measures to resolve each deficiency identified in SOD ZY4714. The order letter stated that at a minimum, the provider would develop or review written procedures and staff training to address caregiver misconduct. The order letter stated the provider was to retroactively complete an investigation report of	{N 196}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 196}	Continued From page 8 the alleged incident of caregiver misconduct. The provider was to document staff training in personnel records and include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. On 02/01/2024, Surveyor reviewed department records for Rolling Meadows of Strum, licensed on 10/01/2021. Since initial licensure the facility has had 12 substantiated complaints, resulting in 38 deficiencies, and multiple recites issued. The following information was reviewed: LHMG11, dated 10/05/2021. Four deficiencies were identified. Two of 3 complaints were substantiated. 1. 83.12(4)(c) Reporting Incidents With Serious Injury 2. 83.31(2) Emergency Or Temporary Transfer 3. 83.32(3)(h) Rights Of Residents: Receive Medication 4. 83.47(1)(c) Safety Requirements: No Safe Evacuation ZY4711, dated 12/07/2021. Two deficiencies were identified. Two of 3 complaints were substantiated. 1. 83.32(3)(h) Rights Of Residents: Receive Medication 2. 83.32(3)(n) Rights Of Residents: Safe Environment J0MI11, dated 09/09/2022. One deficiency was identified. Two of 5	{N 196}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 196}	Continued From page 9 complaints were substantiated. 1. 83.32(3)(h) Rights Of Residents: Receive Medication ZY4712, dated 06/22/2022. Six deficiencies were identified. Three of 8 complaints were substantiated. There was one repeat violation (see SOD ZY4711, dated 12/07/2021). 1. 83.17(2)(a) Employees Screened For Communicable Disease 2. 83.32(3)(h) Rights Of Residents: Receive Medication 3. 83.38(1)(g) Health Monitoring 4. 83.45(1)(d) Hazards 5. 83.55(6)(b) Bath And Toilet Areas: Water Temperature 6. 50.065(2)(bm) Out Of State Background Checks ZY4713, dated 02/10/2023. One of 3 complaints was substantiated, and 7 deficiencies were identified. Three of 7 deficiencies were repeat violations (see SOD LHMG11, dated 10/05/2021, SOD ZY4711, dated 12/07/2021, SOD ZY4712, dated 06/22/2022, and SOD J0MI11, dated 09/09/2022). 1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect 2. 83.12(5)(a) Notification: Incident, Injury, Changes. 3. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 4. 83.32(3)(h) Rights Of Residents: Receive Medication	{N 196}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 196}	Continued From page 10 5. 83.32(3)(i) Rights Of Residents: Adequate Treatment 6. 83.55(6)(b) Bath And Toilet Areas: Water Temperature 7. 50.065(2)(bm) Out Of State Background Checks ZY4714, dated 07/28/2023. One complaint was substantiated, and 7 deficiencies were identified. Four of the 7 deficiencies were repeat violations (see SOD LHMG11, dated 10/05/2021, SOD ZY4711, dated 12/07/2021, SOD ZY4712, dated 06/22/2022, SOD J0MI11, dated 09/09/2022, and SOD ZY4713, dated 02/09/2023). 1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect 2. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 3. 83.14(2)(j) Not Permit A Condition Of Substantial Risk 4. 83.32(3)(h) Rights Of Residents: Receive Medication 5. 83.32(3)(n) Rights Of Residents: Safe Environment 6. 83.35(3)(a) Comprehensive Individualized Service Plan 7. 83.38(1)(a) Personal Care ZY4715, dated 02/23/2024. One complaint was substantiated, and 10 deficiencies were identified. Four of the 10 deficiencies were repeat violations (see SOD LHMG11, dated 10/05/2021, SOD ZY4713, dated 02/09/2023, SOD ZY4714, dated 07/28/2023). 1. 83.12(2)(a) Caregiver: Investigating Abuse	{N 196}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 196}	Continued From page 11 Neglect 2. 83.12(4)(c) Reporting Incidents With Serious Injury 3. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 4. 83.20(2)(a)-(d) Department-Approved Training Courses 5. 83.21(1)-(3) All Employee Training 6. 83.35(3)(a) Comprehensive Individualized Service Plan 7. 83.35(4) Resident Satisfaction Evaluation 8. 83.38(1)(k) Transportation 9. 83.40 Oxygen Storage 10. 83.47(2)(d) Fire Drills On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee A and Licensee B during a survey exit conference. Licensee B stated Licensee C and B had now moved to Wisconsin in early 2023 to help get the facility in compliance. Surveyor asked about the caregiver misconduct policy and procedure and related staff training. Licensee B stated they had updated the caregiver misconduct policy and procedure, and conducted staff in-service on the topic. Surveyor had reviewed the caregiver misconduct policy and procedure on the day of survey. Surveyor expressed concerns about staff training and documentation concerns. Licensee B stated they were not aware multiple staff training documents did not have dates on them or the duration of training. Surveyor asked about the investigation report of the alleged incident of caregiver misconduct from SOD ZY4714. Licensee A stated they had done the retroactive investigation and submitted it to the office of caregiver quality (OCQ). Licensee A submitted a confirmation of the submission to OCQ. Licensee B and Licensee C acknowledged the above concerns and would be working toward compliance	{N 196}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 196}	Continued From page 12 immediately. The licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF when the special orders were not completed, and all deficiencies were not corrected. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse Neglect N0165 83.12(4)(c) Reporting Incidents With Serious Injury N0239 83.20(2)(a)-(d) Department-Approved Training Courses N0243 83.21(1)-(3) All Employee Training N0386 83.35(3)(a) Comprehensive Individualized Service Plan N0392 83.35(4) Resident Satisfaction Evaluation N0435 DHS 83.38(1)(k) Transportation N0444 83.40 Oxygen Storage N0525 83.47(2)(d) Fire Drills	{N 196}		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 239	Continued From page 13 starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on source interview and record review, the provider did not ensure 3 of 6 employees obtained all department approved training as required. Caregiver D, Caregiver F, and Caregiver H did not have training in fire safety within 90 days after starting employment. Caregiver D, Caregiver F, and Caregiver H did not have training in first aid and choking within 90 days after starting employment. Caregiver D, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties. Findings include: On 11/15/2023, the department received a complaint alleging staff were not fully trained. On 02/01/2024, Surveyor conducted a review of 6	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 239	Continued From page 14 employees to verify compliance with department approved training requirements. Surveyor requested training records from Director A for Caregiver D, Caregiver E, Caregiver F, Caregiver G, Caregiver H, and Maintenance Staff I. Fire Safety The record for Caregiver D, hired 11/18/2022, did not contain evidence of training or evidence of meeting an exemption for fire safety. The record for Caregiver F, hired 10/13/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. The record for Caregiver H, hired 07/31/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 02/01/2024, Surveyor verified Caregiver D, Caregiver F, and Caregiver H not on the Community-Based Care and Treatment training registry for fire safety. First Aid and Choking The record for Caregiver D, hired 11/18/2022, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. The record for Caregiver F, hired 10/13/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. The record for Caregiver H, hired 07/31/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 02/01/2024, Surveyor verified Caregiver D,	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 239	Continued From page 15 Caregiver F, and Caregiver H were not on the Community-Based Care and Treatment training registry for first aid and choking. Standard Precautions The record for Caregiver D, hired 11/18/2022, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 02/01/2024, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for standard precautions. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C about staff training concerns. Licensee B stated they were having a hard time getting staff scheduled with an instructor for the courses. Licensee B stated they had to "beg" the instructor to come after the day of survey and now approximately 95% of the staff have their department approved training completed. Licensee C stated Caregiver D was a certified nursing assistant (CNA) but was not sure if his/her license was currently active for an exemption to standard precautions training. Surveyor gave Licensee B and Licensee C an opportunity to submit any additional evidence of training by the end of the day. Surveyor received a couple of CNA course certificates for Caregiver D, dated back in 2000 and 2001. Surveyor looked up Caregiver D on the Wisconsin CNA registry, which indicated Caregiver D had a CNA license issued on 08/05/2006. The license had expired on 08/04/2008.	N 239		
N 243	83.21(1)-(3) All employee training.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 243	Continued From page 16 The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 243	Continued From page 17	N 243		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 5 caregivers reviewed obtained all training as required within 90 days after starting employment.

Caregiver F and Caregiver H did not have training in resident rights within 90 days after starting employment.

Caregiver F and Caregiver H did not have training in recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment.

Caregiver F and Caregiver H did not have training in required client groups within 90 days after starting employment.

Findings include:

On 11/15/2023, the department received a complaint alleging staff were not fully trained.

On 02/01/2024, Surveyor conducted a review of 5 caregivers to verify compliance with all employee training requirements. Surveyor requested training records from Director A, Caregiver D, Caregiver E, Caregiver F, Caregiver G, and Caregiver H.

Resident Rights

The record for Caregiver F, hired 10/13/2023, did not contain evidence of training or evidence of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 243	Continued From page 18 meeting an exemption for resident rights. The record for Caregiver H, hired 07/31/2023, contained a document titled, "Resident Rights." This document was signed by Caregiver H but did not have a date of completion. Caregiver H's record did not contain evidence of training or evidence of meeting an exemption for resident rights training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver F, hired 10/13/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behavior training. The record for Caregiver H, hired 07/31/2023, contained a training titled, "Responding to Challenging Situations." This document was signed by Caregiver H but did not have a date of completion. Caregiver H's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. Client Group The provider is licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's disease, terminally ill, physically disabled, and advanced age. The record for Caregiver F, hired 10/13/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver H, hired 07/31/2023, contained a training titled, "A Disease Process	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 243	Continued From page 19 Module: Understanding Alzheimer's Disease." This document was signed by Caregiver H but did not have a date of completion. Caregiver H's record did not contain evidence of training or evidence of meeting an exemption for client group training. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C about staff training concerns. Licensee B stated they were not aware the documents did not have dates on them. Licensee B stated they had the "Relias" training system, but since the beginning of 2023 staff started to have trouble accessing it. They were currently using "In The Know" caregiver training in-person in-services, and videos for training.	N 243		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 386}	Continued From page 20	{N 386}		

provider did not ensure Resident 4, Resident 9, and Resident 12 had an individual service plan (ISP) developed to identify their needs.

This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4714, dated 07/28/2023.

Resident 4's ISP did not accurately describe his/her personal cares and bathing needs.

Resident 9's ISP was not updated after a decision was made to stop alcohol intake and was only updated once, between 08/20/2023 through 10/24/2023, with fall interventions after 7 falls had occurred during that period.

Resident 12's ISP was not updated with frequency of oral hygiene and care of dentures.

Findings include:

On 02/01/2024 at 11:45 AM, Surveyors requested records for Resident 4, Resident 9, and Resident 12 to review.

Resident 4

On 02/01/2024 at 9:32 AM, Surveyor interviewed Resident 4. Resident 4 stated the consistency of his/her personal cares getting done with help of staff had improved since it was now scheduled the last few months. Resident 4 stated s/he had a bed bath and hair washing scheduled with staff assistance on Monday and Friday each week.

Resident 4 was admitted to the facility on 09/29/2021 and was his/her own decision maker. Resident 4 had diagnoses that included morbid obesity, nephrolithiasis, hydronephrosis, congenital factor 5 deficiency, and prediabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 386}	Continued From page 21 Resident 4's ISP, dated 01/26/2024, was inconsistent, indicating under personal cares for AM and HS (at bedtime) Resident 4 required 1 staff to assist and at the same time stating Resident 4 was independent with personal cares. The ISP did not indicate what personal cares Resident 4 needed assistance with, stating, "NARRATIVE OF CARES NEEDED". In the category of bathing , it indicated Resident 4 needed hands-on assistance from 1 staff. The ISP stated, "[Resident 4] does not take showers or baths. [S/he] does a bed bath in [his/her] bathroom daily. [S/he] does need some assistance from staff and will ask for help." The ISP indicated Resident 4 was scheduled weekly on Tuesday and Friday to receive assistance from staff with bathing. The ISP did not mention anything about washing Resident 4's hair. The ISP, under the category of toileting, indicated Resident 4 was independent. Surveyor reviewed staff observation notes, dated 11/01/2023 through 02/11/2024, which indicated the following cares were performed with staff assistance for Resident 4: -toileting/peri care -washing face -brushing teeth -washing of body -washing hair -changing clothes -applying astringent powder. Resident 9 Resident 9 was admitted on 03/26/2022 and had an activated power of attorney (POA). Resident 9 had diagnoses that included anemia, thrombocytopenia, moderate protein-calorie	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 386}	Continued From page 22	{N 386}		

malnutrition, hypocalcemia, hyponatremia, hypokalemia, dementia without behavioral disturbance, alcohol dependence, chronic pain, adult failure to thrive, fracture of second lumbar vertebrae, and chronic kidney disease.

The ISP, dated 08/14/2023, read, in part, under alcohol intake monitoring category, "As per [POA L], they are allowing [him/her] to have or take [his/her] liqour [sic] Windsor even if MD (medical doctor) recommends lowering and MD doesn't want to sign any orders for alcohol. Per [POA L and family member], [s/he] can have liqour [sic] as [s/he] chooses. Intervention: All alcohol beverages will be monitored and obtained via [POA L]. Liquor should be purchased by [POA L] and family ONLY. NO staff and res (resident) will not [sic] be going to nearby grocery to buy alcohol with the staff ..." The ISP indicated Resident 9 used a walker independently to ambulate to the bathroom. The ISP indicated Resident 9 had a history of falls and was a moderate fall risk. The ISP read, in part, "Identified concerns posing risk to fall and interventions: Makes [sic] sure res is using [his/her] pendant. Floor to be free with [sic] clutter. Check res [sic] from time to time."

A staff observation note, dated 08/16/2023, read, in part, "[POA L] stated that [s/he] wanted to change the CarePlan [sic] of [his/her] alcohol consumption and [s/he] would like to follow the MD's recommendation that [s/he] cannot have alcohol, and no one will purchase [his/her] alcohol [sic] even the staff. As per [POA L], as of now [s/he] has zero alcohol, no whiskey."

Per medical notes, Resident 9 was hospitalized and then in a skilled nursing facility for short-term rehabilitation from 08/20/2023 to 09/14/2023, for a stroke which resulted in right-sided hemiplegia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 386}	Continued From page 23 and significant dysarthria. A 30-day discharge notice, dated 08/20/2023, indicated Resident 9 had continuous medical issues and needed more medical care than could be provided. The notice indicated Resident 9 was being discharged due to changes in condition that the provider was unable to provide care for. The anticipated discharge date was 08/31/2023. Surveyor reviewed fall incident reports, dated 08/20/2023 through 10/24/2023, and discovered there were 7 falls during this period. One fall was documented on 08/20/2023. Resident 9 was not in the facility from 08/20/2023 to 09/14/2023, so the other 6 falls occurred on 09/17/2023 to 10/24/2023. An ISP, dated 09/15/2023, read, in part, under alcohol intake monitoring category, "NO MORE ALCOHOL AT THIS TIME AS PER POA." The ISP was not updated for approximately 1 month with the change in Resident 9's alcohol intake. The ISP indicated Resident 9 needed 1 to 2 staff with a gait belt for ambulation and transfers. Resident 9 was on a 2-hour toileting schedule. Resident 9 was considered a high fall risk and the ISP read, in part, "Active measures in place: make sure pendant is working and in place. Floors to be free from clutter. Check res [sic] from time to time." The ISP was not updated with new fall interventions after each of the 7 falls, from 08/20/2023 through 10/24/2023. On 02/16/2024 at 11:56 AM, Surveyor interviewed POA L. POA L stated s/he agreed Resident 9's care towards the end of his/her stay at the facility was more than the provider could handle. POA L stated Resident 9 was having multiple falls and now, at his/her new facility, since 12/06/2023,	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 386}	Continued From page 24 s/he has not had one fall. Resident 12 On 02/01/2024 at 12:13 PM, Surveyor interviewed Caregiver K. Caregiver K stated interventions to prevent choking for Resident 12 included s/he was not to eat alone, s/he should not have hard candy, s/he needed his/her meat was to be cut up, and s/he should not have snacks in his/her room. Caregiver K stated staff were to monitor and cue Resident 12 to chew his/her food slowly and before speaking to prevent choking. Resident 12 was admitted on 07/07/2021 and had an activated power of attorney (POA). Resident 12 had diagnoses that included seizure disorder, depression, and anxiety. An ISP, dated 07/03/2023, indicated Resident 12 had a mechanical soft diet with ground meat. The ISP read, in part, "Independent with eating, resident will pocket food. Staff to monitor and give reminders to chew and swallow food." The ISP indicated Resident 12 was a choking risk. Under the personal cares category, the ISP indicated Resident 12 had dentures and needed set up and cueing. The ISP indicated Resident 12 had confusion and poor safety awareness. The ISP did not address Resident 12's transportation needs. A staff observation note, dated 09/19/2023, read, in part, "Writer asked [POA N] if res will be having new dentures and [s/he] stated that MD told [him/her] that [s/he] doesn't need new dentures because it fits [him/her] well and the reason why it looks like it doesn't fit well because of the food that is on the denture ...the MD is aware that	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 386}	Continued From page 25	{N 386}		

[s/he] is pocketing food and MD saw the foods in [his/her] buccal area. MD's [sic] ordered 'Res must remove dentures during the night, clean dentures after eating and clean inside of [his/her] mouth to avoid having fungal infections. Please help resident with oral hygiene." Another staff observation note for this date, read, in part, "[Resident 12] has some kind of infection in [his/her] mouth due to [him/her] not washing or soaking [his/her] dentures."

The care history for Resident 12, dated 09/01/2023 through 10/31/2023, indicated personal care at bedtime for oral hygiene was started on 09/29/2023.

A self-report, dated 01/02/2024, indicated Resident 12 had a fall on 12/02/2023. The incident report indicated Resident 12 had been taken to the emergency room (ER) earlier in the day due to a choking incident. Resident 12 had returned in the early morning of 12/03/2023 from the ER and was left unattended in the parking lot of the facility by the transportation driver. Resident 12 had a fall in the parking lot.

A medical note, dated 12/03/2023, indicated Resident 12 was diagnosed with a fracture of the right ulna styloid process and head injury. Resident 12 was sent back to the facility with a cock-up Velcro splint for his/her wrist and told to keep it on except for showering.

On 02/16/2024 at 11:30 AM, Surveyor interviewed Case Manager (CM) O. CM O stated Resident 12 cannot go to appointments by him/herself due to cognition and s/he was a wander risk. CM O stated POA N usually went to Resident 12's appointments but was not always able to go. CM O stated that for the 12/03/2023 fall incident, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 386}	Continued From page 26 transportation company did not know Resident 12 was supposed to be accompanied into the facility and staff were unaware Resident 12 had fallen outside. An ISP, updated 01/24/2024, indicated Resident 12 should be observed while eating and staff were to give reminders to chew and swallow food. The ISP did not address Resident 12's ordered oral hygiene protocol, transportation needs, supervision to medical appointments, right arm splint, and wander risk. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee B stated Director A and Licensee B were responsible for updating resident ISPs. Licensee B confirmed they would update an ISP with a change in condition. Licensee B stated they were starting to educate AD J with the role of updating resident ISPs and would have more detail within them moving forward. Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury N0426 DHS 83.38(1)(b) Supervision	{N 386}		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department.	N 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 392	Continued From page 27 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident and their legal decision maker had the opportunity to complete a department approved evaluation of the resident's satisfaction of the provider's services. Findings include: On 02/01/2024 at approximately 1:00 PM, Surveyor reviewed Resident 1's and Resident 2's records for satisfaction surveys and was unable to find any. Resident 1 had been a resident at the facility since 10/20/2021 and Resident 2 had been a resident at the facility since 09/09/2021. On 02/08/2024 at 5:00 PM, Surveyor requested via email, satisfaction surveys for Resident 1 and Resident 2. On 02/11/2024 at 12:28 AM, Surveyor received a satisfaction survey for Resident 1, dated 02/09/2024, and did not receive a satisfaction survey for Resident 2. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C. Licensee B stated Resident 1 had not had any additional satisfaction surveys since admission. When Surveyor asked why, Licensee B stated they did not know satisfaction surveys needed to be completed with residents annually until Surveyor had asked for them during the survey.	N 392		
N 435	83.38(1)(k) Transportation. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 435	Continued From page 28 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: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for medical transportation to meet Resident 12's needs. Resident 12 had an unwitnessed fall in the parking lot of the facility on 12/03/2023, after returning from the emergency room (ER) via taxi. Findings include: The facility is licensed to serve up to 19 residents in the following client groups: physically disabled, terminally ill, advanced aged, and irreversible dementia/Alzheimer's disease. On 02/01/2024 at 10:07 AM, Surveyor interviewed Assistant Director (AD) J. AD J indicated Resident 12 had 2 falls in the past few months. One of the falls was in the provider parking lot upon his/her return from the ER on 12/03/2023.	N 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 435	Continued From page 29 On 02/01/2024, Surveyor reviewed Resident 12's record. Resident 12 was admitted on 07/07/2021 and had an activated power of attorney (POA). Resident 12 had diagnoses that included seizure disorder, depression, and anxiety. An incident report, dated 12/02/2024, indicated Resident 12 had a choking incident at 5:45 PM and was taken to be medically evaluated. The report read, in part, "At around 8:30 pm [hospital] called and said [s/he] would be coming back to facility tonight. They were arranging a ride back for [him/her], not sure what time [s/he] will be back." An incident report, dated 12/03/2023, read, in part, "[Resident 12] was coming back from the ER and when the transportation company came to drop [him/her] [sic] [Resident 12] reported to staff that [s/he] had fallen later on [sic] not right away. Sunday 12/4 Med passer ...reported to this staff that [Resident 12] was complaining about [his/her] hand hurting. [S/he] told [him/her] that [s/he] had fallen when coming back from the ER. [S/he] didn't tell staff when it happened." A self-report, dated 01/02/2024, indicated Resident 12 had a fall on 12/02/2023. The incident report indicated Resident 12 had been taken to the hospital earlier in the day due to a choking incident. It read, in part, "They called the facility to say [s/he] was going to be returning that night. The taxi service that the ER used [company name] picked [him/her] up and when dropping [him/her] off, apparently they dropped [him/her] and left to walk in by [him/herself]. Staff were unaware that [s/he] even got dropped off. Another employee called the facility to say [s/he] was	N 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 435	Continued From page 30	N 435		

outside. They had stopped to help [him/her] because [s/he] was apparently on the ground. According to [Resident 12] [s/he] had slipped when [s/he] was coming in and hurt [his/her] wrist. [POA N] was ok with [him/her] being evaluated in urgent care. [S/he] came back w/ (with) a hairline fracture. The next day [s/he] was complaining about [his/her] other wrist hurting so was seen again. They said [s/he] had a sprained wrist. [S/he] came back with a splint on it. [S/he] is to be following up with orthopedics."

According to the National Weather Service, on 12/02/2023, the weather from La Crosse, WI Regional Airport, the temperature was a high of 36 degrees Fahrenheit (F) and low of 18 degrees F. On 12/03/2023, the temperature was a high of 36 degrees F and low of 32 degrees F, with 1 inch of new snow fall. (Source: National Weather Service website, https://www.weather.gov/wrh/Climate?wfo=arx (retrieval date - 03/08/2024).)

An ISP, dated 07/03/2023, indicated Resident 12 ambulated independently and had a history of falls. Resident 12 had confusion and poor safety awareness. The ISP listed Resident 12 as both a moderate and high risk for falls. The ISP read, in part, "In general resident steady on feet, resident does walk slow, and drags [his/her] feet ...Resident also drags feet when walking." The ISP did not address Resident 12's transportation needs and required supervision.

A medical note, dated 12/03/2023, indicated Resident 12 was diagnosed with a fracture of the right ulna styloid process and head injury. The note read, in part, "Patient had a fallen 2 days ago while [s/he] was outside. [S/he] would [sic] fallen backwards onto the cement. [S/he] hit the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 435	Continued From page 31	N 435		

left side of [his/her] head and injured [his/her] right wrist ...[S/he] was seen in the emergency department last night because of a choking episode. [S/he] was discharged home. [S/he] states that [s/he] had symptoms last night but did not report them because they were not severe."

A medical note, dated 12/04/2023, indicated Resident 12 was seen for a sprained left wrist from his/her fall on 12/03/2024.

Staff observations notes indicated the following:

12/02/2023 at 3:30 PM - "At around 8:30 pm [hospital] called and said [s/he] would be coming back to facility tonight. They were arranging a ride back for [him/her], not sure what time [s/he] will be back."

12/03/2023 at 6:00 AM - "Writer ...came in at 6 am [sic] for [him/her] morning shift and [Resident 12] was walking down the hall stating that [s/he] had broken [his/her] wrist. I asked [him/her] what happened [sic] [s/he] stated that last night after [s/he] got dropped off from being at the hospital [sic] [s/he] fell in front of the building but [she] did not notify staff. I observed [Resident 12] and notice [sic] that [his/her] right wrist had a reddish bruise on it and through out [sic] the day it was getting a little bit more swollen."

12/03/2023 at 1:45 PM - "When the taxi driver dropped [him/her] off 12/2/23, the taxi driver just left [Resident 12] outside and didn't [sic] inform us [s/he] was standing outside so [s/he] was outside by [him/herself]."

The service agreement, dated 0707/2021, read in part under transportation and appointments, "Resident's family/Resident's Representative is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 435	Continued From page 32	N 435		

encouraged to arrange for transportation and to accompany Resident to Resident's medical and nonmedical appointments. Provider does not arrange for staff transport or accompany Resident, but may make arrangements for transportation through a qualified third party."

On 02/16/2024 at 11:30 AM, Surveyor interviewed Case Manager (CM) O. CM O stated Resident 12 cannot go to appointments by him/herself due to cognition and s/he was a wander risk. CM O stated POA N usually went to Resident 12's appointments but was not always able to go. CM O stated that for the 12/03/2023 fall incident, the transportation company did not know Resident 12 was supposed to be accompanied into the facility and staff were unaware Resident 12 had fallen outside.

On 02/16/2024 at 1:36 PM, Surveyor interviewed POA N. POA N was aware of the fall on 12/03/2023 and stated the transportation company dropped Resident 12 off at the facility and left before Resident 12 was inside. Resident 12 slipped and fell. Staff found Resident 12 on the sidewalk and did not know how long s/he was there.

On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C. Licensee B state the ER had a taxi service bring Resident 12 back to the facility and the driver left Resident 12 in the parking lot. Licensee B stated staff were not aware Resident 12 had returned. Licensee C recently stated s/he had contacted the ER to work out a way for them to contact staff when a resident was coming back to the facility. Licensee B stated it had been 20 minutes or so when Resident 12 was discovered outside but did not know the exact time s/he was dropped off by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 435	Continued From page 33 taxi or the time staff found him/her. Licensee B stated they just implemented having staff accompany residents to appointments if needed. The provider did not provide adequate transportation to meet the needs of Resident 12 when s/he was returning from the ER on 12/03/2023, early in the morning, and had a fall in the facility's parking lot after the taxi service the ER arranged dropped Resident 12 off without staff being aware. Staff were called ahead of time notifying them of Resident 12's return. Staff were unaware of Resident 12's return and how long Resident 12 had been on the sidewalk after his/her fall. Resident 12 was medically evaluated later in the day on 12/03/2024 and diagnosed with a right wrist fracture and head injury. Resident 12 was medically evaluated the next day on 12/04/2023 and diagnosed with a sprained left wrist. Due to the freezing temperatures on that date, during the timeframe of the fall there was an even greater potential of outcome for Resident 12. Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury	N 435		
N 444	83.40 Oxygen storage. Oxygen storage. Oxygen storage shall be in an area that is well ventilated and safe from environmental hazards, tampering, or the chance of accidental damage to the valve stem. If oxygen cylinders are in use, oxygen cylinders shall be secured in an upright position. If stored upright, cylinders must be secured. If stored horizontally, cylinders shall be on a level surface where they will remain stationary.	N 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 444	Continued From page 34 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure oxygen was secured when stored upright in a resident room. Findings include: On 02/01/2024 at 12:45 PM, Surveyor observed 3 large oxygen tanks stored in the upright position inside Resident 11's entrance door along the wall where frequent traffic of staff coming in and out of his/her room would occur. Surveyor observed 2 of the oxygen tanks secured, one in a metal frame and one in a portable wheeled carrier. One of the tanks was set on the ground. Surveyor observed the tank was partially full and attempted to move the tank. Surveyor observed the tank was being held to the wall by Velcro but was easily pulled away from the wall. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C. Licensee B stated this issue had already been addressed and Resident 11's family was called to bring in another portable carrier. Licensee C confirmed all the oxygen tanks were secured now and they were looking for a more secure area to store them.	N 444		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 525	Continued From page 35	N 525		

evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not conduct quarterly fire drills in 2023.

Findings include:

The provider is licensed to serve up to 19 residents in the following client groups: advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's.

On 02/01/2024, Surveyor reviewed the provider's documentation of quarterly fire drills for 2023. There were documented fire/emergency drills for 02/05/2023, 06/28/2023, 09/13/2023, and 11/11/2023. The fire/emergency drill on 06/28/2023 did not indicate a time it was conducted. The fire drill documentation did not include the facility's total evacuation time, the individual resident evacuation times, and the type of assistance each resident needed for evacuation. The documentation did not indicate at least one fire evacuation drill was held annually that simulates the conditions during usual sleeping hours. The documentation also had fire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 525	Continued From page 36 and emergency drills both marked. Surveyor was unable to distinguish if a fire or emergency drill was conducted. The provider was missing 2 fire and/or emergency drills for 2023. At 10:45 AM, Surveyor interviewed Caregiver E. Caregiver E stated s/he had worked at the facility for about 2 years. Caregiver E stated a tornado drill had been done a couple times but could not recall fire drills where staff took residents outside of the building. On 02/23/2024 at 2:00 PM, Surveyor interviewed Licensee B and Licensee C about fire drill documentation concerns. Licensee B stated they conducted one of the fire drills at 5:35 AM and considered that their fire drill to simulate the conditions during usual sleeping hours. Surveyor asked about the multiple different drills marked on the same form. Licensee B indicated multiple drills were done on the same day and moving forward they would have separate forms for the drills and would include all required information.	N 525		