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 09/03/2025

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 08/07/2025, Surveyors conducted x8 complaint investigation, verification visit, and x3 self-report review. Data collection continued through 09/03/2025. The deficiency identified in SOD ZY4716, dated 01/08/2025 was corrected. Eight of the 8 complaints were substantiated. Thirteen deficiencies were identified. Four of the 13 were repeat violations (see SOD ZY4712, dated 06/22/2022; ZY4713, dated 02/09/2023; ZY4714, dated 07/28/2023; ZY4715, dated 02/23/2024; and UWF11, dated 07/09/2024). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 21	{N 000}		
N 160	83.12(2)(c) Report to law enforcement and coroner Investigating and reporting abuse, neglect, or misappropriation of property. Other reporting. Filing a report under sub. (1) or (2) does not relieve the licensee or other person of any obligation to report an incident to any other authority, including law enforcement and the coroner. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure allegations of sexual assault between 4 of 4 residents (Resident 3 and Resident 4 and between Resident 5 and Resident	N 160		

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

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N 160	Continued From page 1 6) were reported to law enforcement. Findings include: On 05/06/2025, 05/13/2025, 05/15/2025, 05/19/2025, and 07/09/2025 the department received six complaints alleging concerns of sexual assault. The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025 at 9:45 AM, Surveyors requested any internal investigations since January 2025. Example 1 On 08/07/2025 at 11:00 AM, Surveyor reviewed an internal investigation conducted from 05/05/2025 to 05/07/2025 with allegations that Resident 4 sexually assaulted Resident 3 in a public bathroom on 05/04/2025. There was no documentation indicating law enforcement had been notified by the provider about the abuse allegations. On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E stated law enforcement showed up the next day on 05/05/2025 to investigate the abuse allegations. Director E stated s/he had not notified law enforcement about the abuse allegations and thought someone through the state had. On 08/19/2025 at 9:13 AM, Surveyor interviewed Police Officer (PO) O. PO O stated the Office of Caregiver Quality (OCQ) had reported the allegations of abuse between Resident 3 and	N 160		

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N 160	Continued From page 2	N 160		

Resident 4 to them.

On 08/20/2025 at 8:26 AM, Surveyor received an email from OCQ Investigator P confirming s/he had notified law enforcement on 05/05/2025 about the abuse allegations between Resident 3 and Resident 4. They had been notified through a third-party complaint.

On 08/18/2025 at 07:32 PM, Surveyor received an email from Administrative Assistant (AA) B. AA B stated s/he was unsure who notified law enforcement about the 05/04/2025 incident. AA B indicated s/he thought the caregiver involved in the incident had made the appropriate notifications.

Example 2

On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 5's record and an internal investigation. An internal investigation was conducted from 02/24/2025 to 02/28/2025 with allegations of staff finding Resident 5 and Resident 6 in the dining room alone with Resident 6 touching Resident 5 sexually in his/her groin area on 02/24/2025. Resident 5's record had an incident report dated 04/05/2025 that indicated Resident 6 was observed by staff with his/her hand inside Resident 5's shirt touching him/her sexually.

On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E stated s/he was unsure if law enforcement was involved in the documented incidents of sexual abuse between Resident 5 and Resident 6.

On 08/13/2025 at 3:02 PM, Surveyor interviewed Assistant Director (AD) K. AD K was unsure if law enforcement was involved in the documented

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N 160	Continued From page 3 incidents of sexual abuse between Resident 5 and Resident 6. On 08/18/2025 at 07:32 PM, Surveyor received an email from Administrative Assistant (AA) B. AA B stated s/he did not believe law enforcement was notified regarding the incidents on 02/24/2025 and 04/05/2025. On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, AA B, Director E, and AD K. AA B stated s/he did not know who reported the sexual assault incident on 05/04/2025 to the police, but an officer showed up the next day. AA B stated s/he did not report the incidents to the police. AA B stated moving forward they would update their policy and procedure to include police notification. The provider did not notify law enforcement about an allegation of sexual assault between Resident 3 and Resident 4 on 05/04/2025. The provider did not notify law enforcement about observed incidents of sexual abuse between Resident 5 and Resident 6 on 02/24/2025 and 04/05/2025. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 160		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident.	N 161		

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N 161	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate all injuries of unknown source for 1 of 1 resident (Resident 5). Staff documented multiple injuries in February 2025 and the provider did not investigate to determine a cause. Findings include: The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 10/29/2024 and had an activated Power of Attorney for Health Care (POAHC). Resident 5 had diagnoses that included dementia, schizoaffective disorder bipolar type, major depressive disorder, anxiety disorder, and Parkinson's disease. An ISP dated 12/02/2024, indicated Resident 5 required 24-hour supervision and total assistance. The ISP indicated Resident 5 required 2 staff to assist with Hoyer lift transfers into a Broda chair for ambulation. The ISP indicated Resident 5 had a history of dermatitis on his/her sacral area and refusing cares such as repositioning and incontinence care. The ISP indicated staff were to observe for skin changes and document, report, and initiate appropriate treatment. An internal investigation was conducted on 02/04/2025 with allegations of staff finding	N 161		

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N 161	Continued From page 5 Resident 6 in Resident 5's room with his/her hand on Resident 5's upper thigh while s/he was in bed. An internal investigation was conducted from 02/24/2025 to 02/28/2025 with allegations of staff finding Resident 5 and Resident 6 in the dining room alone with Resident 6 touching Resident 5 sexually in his/her groin area on 02/24/2025 at approximately 7:30 PM. The allegations go on to state Resident 6's pants were down to his/her knees. The investigation read in part, "Per incident report, it was indicated that residents [sic] incontinent product was moved and blanket displaced exposing [his/her] genital area." The investigation indicated both staff [Caregiver S] and [Caregiver U] were interviewed and had inconsistent statements. Resident 5's physician was asked to perform a visual exam when staff documented Resident 5 being reluctant to peri care. No concerns were identified with the exam. Staff observation notes dated 02/01/2025 to 02/28/2025 indicated the following: 02/01/2025 - "Shower was done this am [sic], changed dressing on bottom wound and found what appeared to look like a scratch near [groin] area." 02/09/2025 - "Upon getting resident ready for the day, writer and co-staff ...noticed that resident had a small bruise on top of [his/her] right hand." 02/14/2025 - "Upon changing resident writer and co-staff ...found 8 small/medium lacerations on upper left arm." 02/20/2025 - " ...noticed there's was some spots on right upper thigh in the back of thigh. rn [sic]	N 161		

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was notified and so was medpasser [sic]."

02/25/2025 - "writer noticed there was a bruise on this residents top of [his/her] left arm forearm area."

The abuse, misappropriation, and injuries of unknown sources policy and procedure read in part, "An injury should be classified as an injury of an unknown source when both of the following conditions are met:
1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident.
2. The injury is suspicious because of the extent of the injury, the location of the injury (the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at any particular point in time, or the incidence of injuries over time." The policy and procedure indicated injuries that met these conditions should be reported to management and investigated immediately.

On 08/07/2025 at 9:45 AM, Surveyors requested any internal investigations since January 2025. There were no internal investigations related to injuries of unknown origin received for Resident 5.

On 08/15/2025 at 7:08 AM, Surveyor received an email from Assistant Administrator (AA) B regarding if any investigations of unknown origin had been done for Resident 5 in February 2025. The email read in part, "No. bruise [sic] on forearm was from blood draw".

On 08/22/2025 at 3:09 PM, Surveyor received an email from Case Manager (CM) Q, which read in part regarding Resident 5, "I was also not notified

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N 161	Continued From page 7 of any of the bruises during my face-to-face visit on 02/20/2025." On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, AA B, Director E, and Assistant Director (AD) K. AA B stated s/he thought the bruise on top of Resident 5's hand was from a blood draw. AA B stated typically if staff report an injury of unknown origin, management would assess and investigate it. They would then put a note in the electronic medical record to "close the circle" and complete follow-up. AA B stated s/he did not know if investigations were done for Resident 5's documented skin injuries in February 2025 as there was nothing documented that they had followed-up.	N 161		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify 1 of 1 resident's (Resident 6) activated Power of Attorney for Health Care (POAHC) when Resident 6's risperidone dosage and frequency was increased due to behaviors.	N 169		

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N 169	Continued From page 8 This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4713, dated 02/09/2023. Findings include: On 07/09/2025, the Department received a complaint alleging a resident's legal representative was not updated with changes. The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 6's record. Resident 6 was admitted on 01/15/2025 and had an activated POAHC. Resident 6 had diagnoses that included dementia, history of deep vein thrombosis (DVT), diabetes mellitus type 2, peripheral vascular disease, venous stasis with lymphedema, and benign prostatic hyperplasia with history of urinary tract infections (UTIs). The Medication Administration Records (MARs) for April and May 2025 indicated Resident 6 was taking risperidone 0.25 mg tablet twice daily starting on 03/25/2025. On 05/19/2025 risperidone was increased to 0.5 mg three times daily and on 05/28/2025 risperidone was again increased to 1 mg three times daily. A pharmacy medication order dated 05/18/2025, indicated Resident 6 was prescribed risperidone 0.5 mg three times daily An order by Psych Nurse Practitioner Y dated 05/28/2025, indicated risperidone 0.5 mg three times daily was discontinued and risperidone 1	N 169		

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mg three times daily was started.

There was no documentation in the staff observation notes for Resident 6 regarding his/her dosage changes with risperidone or documented notification to POAHC W of those changes in May 2025. The May 2025 staff observation notes indicated the following behaviors prior to his/her risperidone dosage increases on 05/19/2025 and 05/28/2025:

05/11/2025 - Note indicated Resident 6 was up and down until 4:00 AM and stated s/he could not sleep.

05/17/2025 - Note indicated Resident 6 was yelling and urinated all over him/herself.

05/18/2025 - Note indicated Resident 6 had been yelling throughout the night and was being rude to staff during cares.

05/23/2025 - Note indicated Resident 6 did not sleep throughout the night and was yelling loudly.

05/28/2025 - Note indicated Resident 6 was yelling at staff in his/her room and had been incontinent. It took 4 staff to help Resident 6 stand due to him/her being unwilling to help staff. After breakfast, Resident 6 was hitting his/her nightstand with the bed remote.

On 05/28/2025 at 4:08 PM, Director E sent POAHC W an email with an attached medication list. The medication list displayed risperidone 0.5 mg three times daily, which started on 05/19/2025. The body of the email was blank and did not indicate there had been a change to the attached medication list for risperidone.

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A letter from POAHC W to Licensee A dated 06/23/2025, read in part, "In addition to everything else on June 10th, I was informed by the emergency department physician that the dosage for the medication Risperidone was 1.0 mg. The increase in the dosage was done without my authorization as [Resident 6's] Health Care Agent. The last authorized communication with [Director E] was via email on 3/23/25 that the Risperidone was being changed back to .25mg [sic] twice a day. The .50mg [sic] dosage caused [Resident 6] to be sleepy and lethargic."

On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E stated Resident 6 had been having on and off behaviors of screaming and shouting at night disturbing his/her neighboring residents. Director E stated Psych Nurse Practitioner Y ordered the new doses of risperidone for Resident 6 when they notified him/her of the behavior changes. Director E stated s/he notified POAHC W about most of the risperidone dosage changes.

On 08/12/2025 at 5:12 PM, Surveyor received an email from POAHC W. The email indicated Resident 6 never recovered from the severity of the sepsis from a urinary tract infection and passed away on 08/05/2025. The email read in part, "If they had not increased the risperidone medication without my consent and paid attention to [his/her] symptoms the uti (urinary tract infection) [sic] could have been caught."

A fax from POAHC W dated 09/03/2025, read in part, "It was agreed with [Director E] to keep me informed of [Resident 6's] medications and to discuss any changes with me as the POA. Last conversation regarding medications was on the Zoom meeting on 4/3/2025 between [Director E],

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N 169	Continued From page 11 [Psych Nurse Practitioner Y], and myself. I was never contact [sic] regarding the increase of the Risperidone medication regarding the dates of 5/19/25 and 5/28/25. I did not learn of the increase until ER (emergency room) physician told me and I confirmed with a phone call with [Director E] both on June 8, 2025 ...I called [Director E] at 10:02am [sic] (on 05/10/2025) to verify the Risperidone medication dosage. [S/he] confirmed it was increase [sic] due to an 'outburst' that [Resident 6] had around 5/17/25 but [s/he] could not remember the exact date. I was extremely upset over this and told [sic] asked [him/her] why they did not notify me and did this without my consent. [S/he] replied that [s/he] called [Psych Nurse Practitioner Y] regarding the outburst and [s/he] did the medication order." On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, Administrative Assistant (AA) B, Director E, and Assistant Director (AD) K. Director E confirmed POAHC W always wanted to be notified about any changes or updates with Resident 6. Director E stated s/he would typically update POAHC W about any recommendations by Psych Nurse Practitioner Y. Director E was unsure if POAHC W was notified about every risperidone dosage change for Resident 6. The provider failed to notify Resident 6's POAHC when Resident 6 exhibited changes in his/her behaviors to warrant an increase in his/her risperidone medication on 05/19/2025 and 05/28/2025. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 169		

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N 170	Continued From page 12	N 170		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the CBRF (Community Based Residential Facility) immediately notified 1 of 1 resident's (Resident 3) representative when there was an allegation of physical, sexual or mental abuse, or neglect. Findings include: On 05/13/2025, the department received two complaints alleging resident legal representative was not notified about allegations of abuse. The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025 at 9:45 AM, Surveyors requested any internal investigations since January 2025. On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 3's record and an internal investigation. Resident 3 was admitted on 05/26/2023 and had an activated Power of Attorney for Health Care (POAHC). An internal investigation was conducted from 05/05/2025 to 05/07/2025 with allegations that Resident 4 sexually abused	N 170		

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(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 170	Continued From page 13 Resident 3 in a public bathroom on 05/04/2025. There was no documentation indicating Resident 3's POAHC was notified about the allegations. On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E indicated s/he reached out to POAHC M about the abuse allegations the next day in the afternoon on 05/05/2025 when POAHC came to the CBRF for a palliative care meeting. Director E stated the police showed up around the same time and started questioning about the abuse allegations. Director E stated POAHC M indicated s/he did not know about the abuse allegations and that prompted the conversation. On 08/13/2025 at 3:02 PM, Surveyor interviewed Assistant Director (AD) K. AD K confirmed POAHC M did not know about the abuse allegations prior him/her attending the palliative care meeting in the afternoon on 05/05/2025. On 08/19/2025 at 9:28 AM, Surveyor interviewed POAHC M. POAHC M stated s/he was not notified about the abuse allegations until the afternoon on 05/05/2025. POAHC M stated the conversation was prompted when s/he was approached by Director E who thought his/her earlier phone call to the facility was about the abuse allegations. POAHC M indicated to Director E that s/he did not know anything about the abuse allegations. Director E gave POAHC M minimal information as the investigation was still in progress. POAHC M indicated Director E had never called back to follow-up with him/her about the results of the abuse allegation investigation. POAHC M stated s/he was taken by surprise and upset when s/he found out about the abuse allegations in a round about way.	N 170		

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 09/03/2025

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ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

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N 170	Continued From page 14 On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, Administrative Assistant (AA) B, Director E, and AD K. AA B stated they thought Caregiver S, who was working that shift, had notified Resident 3's care team. AA B stated they found out that Caregiver S had not notified POAHC M and immediately the next day had notified him/her. POAHC M was not notified immediately when there were abuse allegations related to Resident 3. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 170		
N 196	83.14(2)(a) Licensee ensures facility complies with laws 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; ZY4714, dated 07/28/2023; ZY4715, dated 02/23/2024; and UWFF11, dated 07/09/2024. Findings include: The provider is licensed to care for 50 residents	N 196		

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N 196	Continued From page 15 in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025, Surveyors conducted an eight-complaint investigation, verification visit, and three self-report review at Rolling Meadows of Strum. On 08/07/2025, Surveyor reviewed department records for Rolling Meadows of Strum, licensed on 10/01/2021. Since initial licensure the facility has had 20 substantiated complaints, resulting in 51 deficiencies, and 16 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	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 16 J0MI11, dated 09/09/2022 One deficiency was identified. Two of 5 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	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 17 Complies With Laws 4. 83.32(3)(h) Rights Of Residents: Receive Medication 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	N 196		

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N 196	Continued From page 18 02/09/2023; and SOD ZY4714, dated 07/28/2023). 1. 83.12(2)(a) Caregiver: Investigating Abuse 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 ZY4716, dated 01/08/2025 One deficiency was identified, which was a repeat violation (see SOD ZY4715, dated 02/23/2024). 1. 83.47(2)(d) Fire Drills ZY4717, dated 09/03/2025 Eight complaints were substantiated, and 13 deficiencies were identified. Three of three self-reports reviewed had a deficiency identified. Four of the 13 deficiencies were repeat violations (see SOD ZY4712, dated 06/22/2022; SOD ZY4713, dated 02/09/2023; SOD ZY4714, dated 07/28/2023; SOD ZY4715, dated 02/23/2024; and SOD UWF11, dated 07/09/2024). 1. 83.12(2)(c) Report To Law Enforcement And Coroner 2. 83.12(3)(a) Investigate Injuries Of Unknown	N 196		

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N 196	Continued From page 19 Source 3. 83.12(5)(a) Notification: Incident, Injury, Changes 4. 83.12(5)(b) Notification: Abuse And Neglect Allegations 5. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 6. 83.35(1)(a) Pre-Admission And Ongoing Assessments 7. 83.35(3)(a) Comprehensive Individualized Service Plan 8. 83.35(3)(b) Service Plan Development: Parties Involved 9. 83.35(3)(c) Implement, Follow The Individual Service Plan 10. 83.35(3)(d) Service Plans Updated Annually Or On Changes 11. 83.38(1)(b) Supervision 12. 83.38(1)(g) Health Monitoring 13. 83.42(1) Resident Record Maintained On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, Administrative Assistant (AA) B, Director E, and Assistant Director (AD) K. Licensee A indicated s/he was at the CBRF 2 to 3 times per month and had meetings with management every Tuesday for updates. AA B stated s/he was always available via phone and physically at the CBRF minimally 4 to 6 days per month. AA B stated s/he oversees Director E and AD K making sure they follow-through and "complete the circle". Director E stated s/he was responsible for the clinical aspects of the CBRF and updating the care plans. Director E stated s/he was at the CBRF during daytime hours Monday through Friday. AD K stated s/he supported Director E with his/her tasks. AA B indicated they understood the concerns discussed and would work immediately to correct them.	N 196		

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N 196	Continued From page 20 The licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF when 8 of 8 complaints were substantiated and 13 deficiencies were identified. Cross Reference: N0160 DHS 83.12(2)(c) Report To Law Enforcement And Coroner N0161 DHS 83.12(3)(a) Investigate Injuries Of Unknown Source N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0170 DHS 83.12(5)(b) Notification: Abuse And Neglect Allegations N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0426 DHS 83.38(1)(b) Supervision N0431 DHS 83.38(1)(g) Health Monitoring N0454 DHS 83.42(1) Resident Record Maintained	N 196		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the	N 381		

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N 381	Continued From page 21 CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess 2 of 2 residents (Resident 4 and Resident 6) reviewed when they had a change in their needs, abilities, and/or physical and mental condition. Resident 4 and Resident 6 did not have an assessment completed after they exhibited sexual behaviors toward other residents. Findings include: On 05/06/2025, 05/13/2025, 05/15/2025, 05/19/2025, and 07/09/2025 the department received six complaints alleging concerns of sexual assault. The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025 at 9:45 AM, Surveyors requested any internal investigations since January 2025. Resident 4	N 381		

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N 381	Continued From page 22 On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 4's record and an internal investigation. Resident 4 was admitted on 03/27/2025 and had a guardian. Resident 4 had diagnoses that included dementia with moderate psychotic disturbance and major depressive disorder. A physician note dated 03/12/2025, indicated Resident 4 was brought to the emergency department (ED) after displaying both violent and sexually disruptive behaviors at his/her previous home requiring staff to involve law enforcement. The note indicated Resident 4 has had a cognitive decline in the past few years and was in the process of acquiring a guardian. A pre-admission assessment dated 03/21/2025, indicated Resident 4 was alert and orientated times 2 to person and place. The assessment indicated Resident 4 was unable to make good decisions. The assessment indicated there were no sexual concerns for Resident 4. An incident report dated 04/04/2025, indicated staff witnessed Resident 5 bend over trying to kiss Resident 4. An internal investigation was conducted from 05/05/2025 to 05/07/2025 with allegations that Resident 4 sexually assaulted Resident 3 in a public bathroom on 05/04/2025. The results of the investigation were inconclusive. A staff observation note dated 05/07/2025 indicated staff observed Resident 4 had his/her hands on Resident 3's face rubbing it in the hallway. An Individual Service Plan (ISP) dated 04/17/2025, indicated Resident 4 needed some	N 381		

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N 381	Continued From page 23	N 381		

supervision. The ISP indicated Resident 4 was independent with transfers and ambulation. The ISP indicated s/he had a history of inappropriately touching residents of the opposite sex. The ISP indicated interventions to prevent inappropriate sexual behaviors included staff keeping an eye on him/her and redirecting Resident 4 with other activities. The ISP read in part, "Staff to ensure a respectful and non-judgmental approach to the conversation. Validate the resident's concerns and feelings without judgement."

An ISP dated 06/13/2025, indicated no new interventions were put into place after the alleged incident on 05/04/2025.

On 08/15/2025 at 7:08 AM, Surveyor received an email from Administrative Assistant (AA) B regarding if an assessment was done for Resident 4 regarding sexual consent since admission, which read in part, "None as no display of sexual behaviors or desires and understanding of assessments is for those that display desires or actions of sexual desires/behaviors/intimacy."

Resident 6

On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 6's record and an internal investigation.

Resident 6 was admitted on 01/15/2025 and had an activated Power of Attorney for Health Care (POAHC). Resident 6 had diagnoses that included dementia, depression, encephalopathy, benign prostatic hyperplasia, diabetes mellitus type 2, and venous stasis with lymphedema.

An incident report dated 02/04/2025 indicated Resident 6 was found in Resident 5's room with

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his/her hand on Resident 5's upper inner thigh.

An Intimacy and Sexual History Assessment was conducted by Director E on 02/04/2025. The assessment read in part, "As per [POAHC W, I don't know if [s/he] is seeking any relationship. I am okay if [s/he] does as long as it is consensual." Resident 6 refused to answer most of the assessment questions.

An ISP dated 02/13/2025, indicated Resident 6 needed some supervision. The ISP indicated Resident 6 transferred with standby or gait belt for safety and ambulated independently with a walker or wheelchair. The ISP indicated Resident 6 had been found in another resident's room with his/her hand on their upper inner thigh and it had also been noted s/he was putting his/her hand on his/her privates in common areas. The ISP indicated interventions included, "Staff to ensure a respectful and non-judgmental approach to the conversation. Validate the resident's concerns and feelings without judgment."

An internal investigation was conducted from 02/24/2025 to 02/28/2025 with allegations of staff finding Resident 5 and Resident 6 in the dining room alone with Resident 6 touching Resident 5 sexually on 02/24/2025.

Staff observation notes dated 01/01/2025 to 06/30/2025, indicated staff started documenting Resident 6 displaying sexual behaviors towards staff on 01/24/2025 when s/he grabbed a caregiver's bottom. On 02/01/2025 it was first documented Resident 6 displaying his/her privates in a common area to other residents. On 02/04/2025, it was first documented Resident 6 sexually touching another resident. On 03/06/2025, Resident 6 had a psychological

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evaluation for the sexual behaviors. On 04/05/2025, there was an additional incident with Resident 6 being found by staff with his/her hand in Resident 5's shirt touching him/her sexually.

An ISP updated on 06/09/2025, indicated there were no new interventions related to sexual behaviors and supervision.

Resident 6's most recent assessment was dated 02/04/2025. Resident 6's record did not contain any evidence of assessments completed for Resident 6 after either of the 2 sexual incidents with Resident 5 who did not consent on 02/24/2025 and 04/05/2025.

The resident relationships policy and procedure read in part, "Upon the initial discovery/knowledge of a relationship, the "Consent to Physical Sexual Expressions" assessment will be completed by the Administrator or Management Designee."

The sexual behavior policy and procedure read in part, "The policy should emphasize the importance of assessing a resident's capacity to consent to sexual activity."

On 09/03/2025, Surveyor received a fax from Guardian W, which indicated Resident 6 had never displayed sexual behaviors prior to his/her admission.

On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, Administrative Assistant (AA) B, Director E, and Assistant Director (AD) K. AA B stated it was their policy to assess residents for sexual consent only if and when the resident displayed sexual behaviors. AA B stated there were no sexual consent assessments done for Resident 4 and Resident 6.

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N 381	Continued From page 26 The provider did not assess Resident 4 and Resident 6 for their capacity to consent to sexual activity after they exhibited sexual behaviors toward other residents. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 381		
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 provider did not ensure 1 of 1 resident's (Resident 6) individual service plan (ISP) was comprehensive to resident's needs when the ISP did not identify services, frequency, approaches provided by the provider, or specify methods for delivering needed care, and identify who was responsible for delivering care for Resident 6's wound care.	N 386		

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N 386	Continued From page 27 This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4714, dated 07/28/2023; ZY4715, dated 02/23/2024; UWFF11, dated 07/09/2024. Findings include: On 07/09/2025, the Department received a complaint regarding resident care. The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 6's record. Resident 6 was admitted on 01/15/2025 and had an activated Power Attorney of Health Care (POAHC). Resident 6 had diagnoses that included dementia, history of deep vein thrombosis (DVT), diabetes mellitus type 2, peripheral vascular disease, venous stasis with lymphedema, and benign prostatic hyperplasia with history of urinary tract infections (UTIs). An Individual Service Plan (ISP) updated 02/13/2025, indicated Resident 6 had hyperpigmentation from venous stasis on his/her right leg and edema on both lower legs. An ISP updated 06/09/2025, indicated Resident 6 had a wound on his/her right leg and foot. The ISP indicated staff were to ensure Resident 6's socks and shoes were not soaked with urine due to incontinence. The ISP indicated staff were to monitor the wound for signs and symptoms of infection, apply foam to the affected area, and change as needed if soaked. The ISP indicated Resident 6 needed to have compression	N 386		

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stockings on during the day to prevent swelling and drainage. The ISP indicated Resident 6 would scratch and pick at the wound on his/her right leg. The ISP indicated Resident 6 was receiving home health services for wound care. The ISP indicated staff were to help Resident 6 with using his/her urinal to prevent leakage to support his/her wound healing.

The Medication Administration Records (MARs) from February to June 2025 indicated on February 02/27/2025 a foam dressing was first applied on Resident 6's right lower leg and changed every 3 days. The order for the foam dressing had an addition of changing it PRN (as needed) starting on 05/01/2025 and continued through 05/25/2025. The June 2025 MAR indicated the dressing order was changed on 06/09/2025 to: "cleanse [sic] wounds with wound cleanser, pat dry. apply [sic] zinc oxide to venous stasis ulcers on shin. Apply opticel AG (cut to fit). Apply blue pads (optilock) and abd to cover all wounds. Wrap with rolled gauze an [sic] secure with tape. change [sic] daily and PRN."

A staff observation note dated 05/09/2025, indicated home health admitted Resident 6 for wound care 3 days per week. The home health nurse ordered new dressings for the wound.

Surveyor requested wound care orders from Director A and reviewed the following:

A home health note dated 05/09/2025, indicated staff were to check Resident 6's dressing twice per day and change if it was soaked. The wound care orders were, "Cleanse wounds with wound cleanser, pat dry. Apply zinc oxide to venous stasis ulcers on skin. Apply optical Ag (cut to fit). Apply optilock (blue pads) and ABD to cover all

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wounds. Wrap with rolled gauze and secure with tape. Change daily and PRN."

A home health note dated 05/21/2025, read, "Due to minimal signs of improvement with the current wound care regimen, I am requesting revised wound care orders for the right leg as follows:
-Cleanse all wounds with normal saline and pat dry.
-Apply zinc oxide to all wound beds.
-Cover the wound on the right leg with Optilock and an ABD pad.
-Cover the wounds at the ankle with Optilock.
-Wrap leg with Kerlix and secure with tape.
-Apply an ACE wrap to the right leg.
-Change dressing every other day and as needed for increased drainage."

On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E stated Resident 6 developed a right leg wound and home health became involved. Director E stated Resident 6 required staff to change his/her wound dressings daily. Director E stated Resident 6 was incontinent and his/her urine would soak the wound dressings frequently.

On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, Administrative Assistant (AA) B, Director E, and Assistant Director (AD) K. AA B stated ISPs were updated and re-signed by the resident's care team if a resident had major changes. Licensee A stated Director E was responsible to update ISPs after any changes. Director E stated s/he was unsure if the ISPs were updated. Director E stated medication passers were responsible for resident wound dressing changes and monitoring.

The provider did not ensure Resident 6's

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N 386	Continued From page 30 individual service plan (ISP) was comprehensive to resident's needs when the ISP did not identify when Resident 6 was under home health for wound care services, the care Resident 6 received from home health services, and the frequency of those services. The ISP did not identify the wound dressing change orders, frequency of changes, and which staff were responsible for delivering Resident 6's wound care. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the	N 387		

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provider did not ensure 1 of 8 resident Individual Service Plans (ISPs) was signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and agreement with the plan.

Findings include:

On 08/07/2025, Surveyor reviewed Resident 2's record.

Resident 2's admission date was 07/07/2021. Resident 2's "Resident Information" document indicated Resident 2 had a power of attorney for healthcare (POAHC) and a guardian. Resident 2's ISP, dated 02/02/2025, only included a signature from POAHC J. The documentation did not appear to be updated to reflect whether Resident 2 had an activated POAHC or guardian. It was not typical to have both.

On 08/13/2025, at 10:01 AM, Surveyor emailed Guardian I. Surveyor asked Guardian I if s/he was given the opportunity to be involved in Resident 2's ISP development and if Guardian I was provided a copy of Resident 2's ISP.

On 08/14/2025, at 10:28 AM, Surveyor received an email from Guardian I. Guardian I stated, "I was appointed 1/31/25. I was not made aware, invited, or asked to be involved or sign the ISP completed on 2/2/25."

On 09/03/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A, Administrative Assistant (AA) B, Director E, and AD K. When asked if Resident 2's guardian was involved in the development of the ISP and provided a copy of the ISP, AA B stated s/he was not sure when Resident 2's guardian was appointed but the

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N 387	Continued From page 32 guardian requested a bunch of documentation for Resident 2. Director E stated s/he was not sure if the guardian received the ISP but s/he did receive documentation. The provider did not ensure Resident 2's ISP was signed by the resident's guardian. Resident 2 previously had an activated POAHC but was appointed a guardian on 01/31/2025. The guardian was not involved in the development of the plan and given a copy for review.	N 387		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure staff implemented 2 of 8 resident (Resident 1's and Resident 2's) individual service plan (ISP) as written. Findings include: Example 1 On 05/19/2025, the department received a self-report from the provider indicating Resident 1 eloped from the facility on 05/18/2025. Resident 1 was observed outside of a grocery store. On 06/04/2025, the department received a self-report from the provider indicating Resident 1 eloped from the facility on 06/04/2025. Resident 1 went to a grocery store and it was determined s/he had purchased alcohol. The report stated, in part, " [Resident 1] has a diagnosis of Alcohol	N 388		

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abuse with unspecified alcohol-induced disorder ...Staff retrieved resident from store and returned to facility. In person check was done and found [Resident 1] had purchased alcohol. Alcohol was not yet opened and removed from resident ..."

On 08/07/2025, at 11:49 AM, Surveyor requested records for Resident 1 from Administrative Assistant (AA) B.

Resident 1 was admitted on 01/02/2024 and had a guardian. Resident 1 had multiple diagnoses including unspecified dementia and alcohol abuse with unspecified alcohol-induced disorder. Resident 1's face sheet identified him/her as protectively placed and an elopement risk.

Resident 1's ISP, dated 10/11/2024, indicated s/he required 24/7 supervision. Under a "General Health/Chronic Illness" section, it read, in part, "Resident has been readmitted to the facility coming from the hospital due to a fall and ethanol poisoning. Resident's guardian has authorized the facility to make sure that resident's purchases outside the facility is monitored for any alcoholic products and be confiscated and related to the guardian." The ISP identified Resident 1 as a "Fall Risk 3 - High Risk." Under a section titled, "Risk - Harm to Self," it read, in part, "1. Thorough check to the resident after shopping including bag and [his/her] pockets as per guardian. 2. Keeping [his/her] cigarettes and lighter at the nurse station and giving [him/her] only 2-3 cig (cigarette) per smoke to prevent bringing cigarettes to [his/her] room for safety purposes. 3. To monitor what [s/he] brings back to the facility including foods and must be kept the the [sic] pantry fridge because [s/he] ferment something as per guardian." Under a section titled, "Behavior - Eating things that are inedible,"

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N 388	Continued From page 34 it read, in part, "[Resident 1] has a history of eating things that are inedible [sic] staff should be monitoring [him/her] that [s/he's] not doing this behavior for [his/her] safety." Under a section titled, "Grocery," it read, in part, "[Resident 1] needs to go to nearby grocery store accompanied by staff to buy [his/her] essential [sic]. Intervention: staff to ensure that they will follow res (resident) during shopping as to ensure the items that [s/he] will buy will be safe for [him/her]. Staff observation notes included the following: 05/20/2025: "Writer and staff [Caregiver F] went to look through residents' room and found ibuprofen in a bag. Lysol, shampoo and lotions. Items were removed from residents [sic] room. Writer spoke with resident about having those items in [his/her] room and that they were removed ..." On 05/25/2025: "Writer and staff searched residents' room. There were 2 bottles of vodka that were found in residents' room. Tylenol, and cigarettes. Guardian was notified." 06/10/2025: " ...did a room search while [Resident 1] was out smoking [sic] staff [sic] found small paper med (medication) cups in [Resident 1's] room with hand sanitizer and hand soup [sic] in them." 07/21/2025: "Staff couldn't find residents [sic] cigarettes [sic] after asking [sic] resident did admit to having [his/her] cigarettes in [his/her] room. When staff come [sic] into shift this morning NOC (overnight) staff had reported they smelled cigarette smoke upon asking resident, resident did admit to smoking in [his/her] room." 07/21/2025: "Staff did a room search [sic] 2 cigarettes and a bottle of shampoo were found. Resident stated [s/he] can not remember where [s/he] put the rest of [his/her] cigarettes."	N 388		

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N 388	Continued From page 35 On 08/13/2025, at 3:00 PM, Surveyor interviewed Assistant Director (AD) K via phone. AD K stated staff should go with Resident 1 to the store and staff watch him/her closely. AD K stated if staff turned their back, Resident 1 would take a bottle of vodka and put it in his/her sweatshirt. AD K stated when Resident 1 arrived back to the facility, staff checked his/her belongings. AD K stated Resident 1 sometimes made it back to his/her room with items but staff would find the items quickly. Example 2 On 08/07/2025, at 11:49 AM, Surveyor requested records for Resident 2 from Administrative Assistant (AA) B. Resident 2 was admitted on 07/07/2021 and had multiple diagnoses including a seizure disorder. A staff observation note, dated 07/01/2025, read, in part, "[Resident 2] had asked if [s/he] could go outside and enjoy the weather...About 8:00 pm I let a resident out to smoke. I saw an empty wheelchair sitting on the other side of the doorway. I asked the resident that was out there whom it belonged to and [s/he] said [Resident 2.] I looked down the sidewalk and saw [him/her] walking towards or from up town, I couldn't tell. I got ahold of [Caregiver H] and [s/he] grabbed [his/her] chair and ran after [him/her] and brought [him/her] back." Resident 2's Individual Service Plan (ISP,) dated 02/02/2025, included a section titled, "Fall Risk 3 - High Risk" it read, in part, "Res (Resident) has unsteady gait and risk for fall. Active measures in place: [Medical Provider] ordered [him/her] to use	N 388		

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N 388	Continued From page 36 a wheelchair to help prevent any future falls due to [him/her] having an unsteady gait ...Reorient resident the use of [his/her] wheelchair at all times." The provider failed to implement Resident 1's and Resident 2's ISP as written. Resident 1 eloped from the facility and visited the grocery store unattended by staff. Staff found alcohol, cigarettes, and other items in Resident 1's room that should have been confiscated or stored in a different location. Resident 2 was outside unattended by staff and walked away from the building, leaving his/her wheelchair behind. Resident 2 was to use his/her wheelchair at all times as ordered by his/her physician. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 388		
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.	N 389		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 4 of 4 resident's (Resident 3, Resident 4, Resident 5, and Resident 6) individual service plans (ISPs) were updated to include new interventions related to supervision, sexual behaviors, and fall risk.

Findings include:

On 05/06/2025, 05/13/2025, 05/15/2025, 05/19/2025, and 07/09/2025 the department received six complaints alleging concerns of sexual assault. On 05/13/2025, the department received a complaint regarding resident falls.

The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill.

On 08/07/2025 at 9:45 AM, Surveyors requested any internal investigations since January 2025.

Example 1

On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 3's and Resident 4's records and an internal investigation. An internal investigation was conducted from 05/05/2025 to 05/07/2025 with allegations that Resident 4 sexually assaulted Resident 3 in a public bathroom on 05/04/2025. The results of the investigation were inconclusive.

Resident 3

Resident 3 was admitted 05/26/2023 and had an activated Power of Attorney for Health Care (POAHC). Resident 3 had diagnoses that

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included dementia, peripheral vascular disease, collapsed vertebra in the thoracic region, osteoporosis, history of right humerus fracture, and low back pain.

Incident reports indicated s/he had approximately 5 documented falls (3 unwitnessed) from 01/09/2025 to 06/15/2025. For the fall on 02/07/2025, it was documented Resident 3 had sustained an injury to the back of his/her head and was medically evaluated.

An ISP last dated 08/08/2024, indicated Resident 3 had a fall on 07/01/2024 and his/her ambulation was declining. The ISP indicated Resident 3 was able to independently transfer and ambulate with a walker. The ISP indicated staff were to supervise Resident 3 when s/he was ambulating. The ISP indicated Resident 3 was an elopement risk and staff were to always know his/her whereabouts keeping him/her out of other resident's rooms and away from exits. The ISP indicated staff should redirect Resident 3 when s/he became agitated and reorient him/her as needed.

An assessment dated 08/28/2024, indicated Resident 3 had an unwitnessed fall on 08/28/2024 and was started on a scheduled toileting program as an intervention. The assessment indicated Resident 3 was a high risk for falls.

Resident 3's ISP was not updated since 08/08/2024 after allegations of a sexual assault on 05/04/2025 and after 5 falls between 01/09/2025 to 06/15/2025. An updated ISP did not describe changes to supervision and/or new interventions to prevent further incidents and falls from occurring again. An updated ISP did not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 39 indicate if Resident 3 was on a scheduled toileting program. Resident 4 Resident 4 was admitted on 03/27/2025 and had a guardian. Resident 4 had diagnoses that included dementia with moderate psychotic disturbance and major depressive disorder. An Individual Service Plan (ISP) dated 04/17/2025, indicated Resident 4 needed some supervision. The ISP indicated Resident 4 was independent with transfers and ambulation. The ISP indicated s/he had a history of inappropriately touching residents of the opposite sex. The ISP indicated interventions to prevent inappropriate sexual behaviors included staff keeping an eye on him/her and redirecting Resident 4 with other activities. The ISP read in part, "Staff to ensure a respectful and non-judgmental approach to the conversation. Validate the resident's concerns and feelings without judgement." An ISP dated 06/13/2025, indicated no new interventions were put into place after the alleged sexual assault incident on 05/04/2025. Example 2 On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 5's and Resident 6's records and an internal investigation. An internal investigation was conducted from 02/24/2025 to 02/28/2025 with allegations of staff finding Resident 5 and Resident 6 in the dining room alone with Resident 6 touching Resident 5 sexually on 02/24/2025. Resident 5's record had an incident report dated 04/05/2025 that indicated Resident 6 was observed by staff with his/her hand inside	N 389		

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N 389	Continued From page 40 Resident 5's shirt touching him/her sexually. Resident 5 Resident 5 was admitted on 10/29/2024 and had an activated POAHC. Resident 5 had diagnoses that included dementia, schizoaffective disorder bipolar type, major depressive disorder, anxiety disorder, and Parkinson's disease. An ISP dated 12/02/2024, indicated Resident 5 required 24-hour supervision. The ISP indicated Resident 5 required 2 staff to assist with Hoyer lift transfers into a Broda chair for ambulation. The ISP did not address further detail about Resident 5's supervision needs. An ISP was updated on 08/18/2025, indicated Resident 5's supervision needs were still not addressed in further detail. On 08/22/2025 at 3:09 PM, Surveyor received an email from Case Manager (CM) Q, which read in part regarding expectations of supervision for Resident 5 after the incident on 02/24/2025, "Interventions consisted of staff increasing supervision and moving the members to a different room ...my expectations consisted of 24-hour supervision to prevent similar incidents occurring and to ensure that all the members needs are met. However, I do not have any concerns about the member being near the nurses [sic] station for supervision." Resident 5's ISP was not updated after observed sexual incidents with another resident on 02/24/2025 and 04/05/2025. The ISP did not describe changes to supervision and/or new interventions to prevent further incidents.	N 389		

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Resident 6

Resident 6 was admitted on 01/15/2025 and had an activated POAHC. Resident 6 had diagnoses that included dementia, depression, encephalopathy, benign prostatic hyperplasia, diabetes mellitus type 2, and venous stasis with lymphedema.

An ISP dated 02/13/2025, indicated Resident 6 needed some supervision. The ISP indicated Resident 6 transferred with standby or gait belt for safety and ambulated independently with a walker or wheelchair. The ISP indicated Resident 6 had been found in another resident's room with his/her hand on their upper inner thigh and it had also been noted s/he was putting his/her hand on his/her private are in common areas. The ISP indicated interventions included, "Staff to ensure a respectful and non-judgmental approach to the conversation. Validate the resident's concerns and feelings without judgment."

Incident reports indicated s/he had approximately 7 documented falls (7 unwitnessed) from 01/19/2025 to 05/20/2025. Resident 6 did sustain mild skin injuries from a couple of the falls, but none of the falls required him/her to be medically evaluated.

An ISP updated on 06/09/2025, indicated Resident 6 was to use a sit to stand for transfers. There were no new interventions related to sexual behaviors and supervision. The ISP did not address Resident 6's fall risk or interventions to prevent falls.

Resident 6's ISP was not updated after observed sexual incidents with another resident on 02/24/2025 and 04/05/2025. The ISP did not

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N 389	Continued From page 42 describe changes to supervision and/or new interventions to prevent further incidents from occurring again. The ISP was not updated after 7 falls between 01/19/2025 to 05/20/2025 with new interventions to prevent further falls. The fall prevention policy and procedure overview indicated the administrator or designee would revise the resident's ISP following the incident to initiate intervention that may prevent a fall from reoccurring. The resident relationships policy and procedure read in part, "The Administrator or Management Designee will update the Individual Service Plan (ISP) regarding the relationship and ability to consent per the "Consent to Physical Expressions" assessment...The resident's service plan should include interventions that balance their right to associate with protecting them from abusive or exploitative sexual contact." On 08/13/2025 at 3:02 PM, Surveyor interviewed Assistant Director (AD) K. AD K stated interventions put in place for Resident 5's safety after the sexual assault incident on 02/24/2025 included after meals Resident 5 was brought out to the front entrance by the nurse's station. AD K stated staff were there all the time to keep Resident 5 in line of sight. AD K stated an intervention put in place after the sexual behavior incident on 04/05/2025 between Resident 5 and Resident 6 was to keep the two residents separated in the dining room and staff were to keep their eyes on both residents when in the same room together. AD K stated interventions after the alleged sexual assault incident between Resident 3 and Resident 4 included staff monitoring both residents.	N 389		

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N 389	Continued From page 43 On 08/20/2025 at 9:49 AM, Surveyor interviewed Guardian V. Guardian V stated interventions put in place for Resident 4 after the 02/24/2025 sexual assault incident on 02/24/2025 included Resident 4 being in staff's line of sight for a time and frequent checks. On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, Administrative Assistant (AA) B, Director E, and AD K. AA B stated ISPs were updated and re-signed by the resident's care team if a resident had major changes. AA B stated after a resident fall; they tried to implement new interventions. Licensee A stated staff would be educated on the new interventions, and Director E was responsible to update ISPs after an incident. AA B stated staff would also receive a pop-up notification on their electronic medical record notifying them about any new interventions. Director E stated s/he was unsure if the ISPs were updated after each incident and fall. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 389		
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.	N 426		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not provide supervision appropriate to meet the needs of 7 of 8 residents.

Resident 1, Resident 2, and Resident 8 eloped from the Community-Based Residential Facility (CBRF).

Resident 4 had allegations of an incident of sexual assault against Resident 3.

Resident 6 had 3 documented observations by staff of non-consensual sexual behavior towards Resident 5.

Findings include:

The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill.

On 07/08/2025, the department received a complaint regarding resident supervision.

Example 1

On 05/19/2025, the department received a self-report from the provider indicating Resident 1 eloped from the facility on 05/18/2025. The report stated, in part, "[Resident 1] asked to go out to smoke as per [his/her] norm at 10am [sic]. Shortly after [s/he] went out to smoke [sic] staff were notified by off duty staff that resident was seen outside at the grocery store. [Resident 1] is self ambulatory [sic] with assisstive [sic] device and

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has a diagnosis of unspecified dementia."

On 06/04/2025, the department received a self-report from the provider indicating Resident 1 eloped from the facility on 06/04/2025. The report stated, in part, "[Resident 1] was allowed to go out on patio to smoke as per [his/her] usual. [Resident 1] proceeded to utilize sidewalk to go to store approximately two blocks away. Staff member immediately retrieved resident and brought [him/her] back to facility..."

On 08/07/2025, at 11:49 AM, Surveyor requested records for Resident 1 from Administrative Assistant (AA) B.

Resident 1 was admitted on 01/02/2024 and had a guardian. Resident 1 had multiple diagnoses including unspecified dementia and alcohol abuse with unspecified alcohol-induced disorder. Resident 1's face sheet identified him/her as protectively placed and an elopement risk. Resident 1's Individual Service Plan (ISP,) dated 10/11/2024, indicated s/he required 24/7 supervision. Under a "Grocery" section of the ISP, it stated Resident 1 needed to be accompanied by staff to the grocery store.

At approximately 12:00 PM, Surveyor interviewed Caregiver C. When asked about Resident 1's elopements, Caregiver C stated the staff trusted Resident 1 when Resident 1 first moved to the facility. Caregiver C stated Resident 1 was not an elopement risk when s/he first arrived, and staff were shocked after Resident 1's first elopement. When asked if any interventions were put into place after Resident 1's first elopement, Caregiver C stated s/he thought staff were with Resident 1 outside for a period of time. Caregiver C stated Resident 1 desperately wanted staff to

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trust him/her and that was why it happened a second time.

At approximately 12:30 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 was always let out by his/herself to smoke until s/he went to the store. When asked if any interventions were put into place after Resident 1's first elopement, Caregiver D stated s/he was not sure. Caregiver D stated the current expectation was for staff to sit outside with Resident 1.

At approximately 3:00 PM, Surveyor interviewed Director E. Director E stated Resident 1 was allowed to go out on the patio on his/her own and went to the grocery store without staff. Director E stated Resident 1 was an elopement risk prior to Resident 1's first elopement. Director E stated after the first elopement, staff talked with Resident 1 and Resident 1 promised s/he would not elope again. Staff would check on Resident 1 from time to time.

Example 2

On 08/07/2025, at approximately 10:20 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he used to smoke outside in front of the building and staff left him/her out front sometimes.

At 11:49 AM, Surveyor requested records for Resident 2 from AA B.

Resident 2 was admitted on 07/07/2021 and his/her "Resident Information" sheet identified a power of attorney for healthcare (POAHC) and guardian. It indicated the POAHC was activated. Under the "Guardian" section, it read, "NO."

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N 426	Continued From page 47 Under the "Protective Placement" section, it read, "Yes." Resident 2 had multiple diagnoses including a seizure disorder. Resident 2's ISP, dated 02/02/2025, under the "Supervision" section, read, "Needs some supervision." Under the "Resident has advanced directives" section, "Yes (Not Activated)" was selected. There appeared to be some inconsistencies related to the advanced directives. A staff observation note, dated 07/01/2025, read, in part, "[Resident 2] had asked if [s/he] could go outside and enjoy the weather...I thought this was okay. I had though [sic] the [sic] would hangout front withtheothersor [sic] "pace" the sidewalk out front of the facility. About 8:00 pm I let a resident out to smoke. I saw an empty wheelchair sitting on the other side of the doorway. I asked the resident that was out there whom it belonged to and [s/he] said [Resident 2.] I looked down the sidewalk and saw [him/her] walking towards or from up town, I couldn't tell. I got ahold of [Caregiver H] and [s/he] grabbed [his/her] chair and ran after [him/her] and brought [him/her] back." At approximately 12:30 PM, Surveyor interviewed Caregiver D. When asked about any elopements involving Resident 2, Caregiver D stated s/he read a report that Resident 2 was outside and walking towards town. Caregiver D stated s/he was not sure if Resident 2 was supposed to be alone. At approximately 3:00 PM, Surveyor interviewed Director E. When asked about any elopements involving Resident 2, Director E stated Resident 2 was always supervised if s/he requested to go outside. Director E stated the staff who let Resident 2 outside was Caregiver G and s/he	N 426		

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N 426	Continued From page 48 was a new staff. Director E stated Resident 2 was a known elopement risk prior to the incident. At approximately 3:10 PM, Surveyor interviewed Caregiver H. Caregiver H stated s/he was working with Caregiver G on the day of Resident 2's elopement. Caregiver H stated Caregiver G let Resident 2 outside and then went to help other residents. Caregiver H stated Caregiver G went to check on Resident 2 and realized Resident 2 was all the way down at the bank. On 08/12/2025, at 8:54 AM, Surveyor emailed Guardian I and requested information pertaining to Resident 2's guardianship and supervision expectations. At 10:09 AM, Surveyor received an email from Guardian I. Guardian I attached Resident 2's letters of guardianship and protective placement orders. Guardian I stated within the email Resident 2's guardianship was effective 01/31/2025 and protective placement was initiated in 2006. Guardian I also attached Resident 2's member care plan completed by Resident 2's manage care organization (MCO) with a start date of 05/14/2025. Guardian I stated, "I also circled where it states [s/he] needs 24/7 supervision and is an elopement/wandering risk. Also that [s/he] needs supervision when outside of the facility." Example 3 On 08/12/2025, the department received a self-report from the provider indicating Resident 8 eloped from the facility on 08/12/2025. The report indicated Resident 8 got downstairs to the basement of the building by the staff elevator and walked out the side of the basement stairwell.	N 426		

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Resident 8 would not be redirected by Cook R and left the CBRF. Cook R notified staff and Assistant Director (AD) K found Resident 8 sitting on a neighbor's front porch. Resident 8 was returned to the CBRF with no injuries. The self-report indicated Resident 8 would be on more frequent checks and an additional padlock was placed on the staff elevator buttons to ensure no residents could slip their fingers in.

On 08/15/2025, at 07:40 AM, Surveyor requested records for Resident 8 from AA B.

On 08/15/2025 at 8:50 AM, Surveyor received Resident 8' s record and reviewed them. Resident 8 was admitted on 06/18/2025 and had a guardian. Resident 8 had diagnoses that included altered mental status, post-concussion syndrome, traumatic brain injury, chronic kidney disease, diabetes mellitus type 2, osteomyelitis, medication noncompliance, and agitation.

An incident report dated 08/12/2025, indicated Resident 8 was able to push his/her fingers through the padlock on the elevator to go downstairs in his/her wheelchair. Resident 8 went out the side door in the basement stairwell leaving his/her wheelchair behind. Resident 8 was found behind the building on the neighbor's front porch by staff.

The ISP dated 07/14/2025, indicated Resident 8 needed some supervision and was a high risk for falls.

The ISP updated 08/15/2025, indicated Resident 8 had a wandering behavior and staff were to know his/her whereabouts keeping him/her out of other resident's rooms and away from the exits. The ISP indicated Resident 8 was an elopement

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risk verbalizing s/he wanted to go home. Resident 8 would try to open the CBRF entrance door and ask staff to let him/her out. Staff were to check on Resident 8 frequently.

Staff observation notes indicated the following:
08/01/2025 - Resident 8 was agitated and trying to leave the facility, tried pulling the fire alarm, pushing buttons on the exit panel, and blocking the entrance from a visitor.
08/12/2025 - After eloping, Resident 8 made comment to staff saying s/he planned to try and escape during the night shift since 'there will only be two people and it will be dark so no one can find me'.

Example 4

On 08/07/2025 at 9:45 AM, Surveyors requested any internal investigations since January 2025.

On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 3's and Resident 4's records and an internal investigation.

Resident 3 was admitted 05/26/2023 and had a POAHC. Resident 3 had diagnoses that included dementia, peripheral vascular disease, collapsed vertebra in the thoracic region, osteoporosis, history of right humerus fracture, and low back pain. An ISP last dated 08/08/2024, indicated Resident 3 was able to independently transfer and ambulate with a walker. The ISP indicated staff were to supervise Resident 3 when s/he was ambulating. The ISP indicated Resident 3 was an elopement risk and staff were to always know his/her whereabouts keeping him/her out of other resident's rooms and away from exits. The ISP indicated staff should redirect Resident 3 when s/he became agitated and reorient him/her as

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needed.

Resident 4 was admitted on 03/27/2025 and had a guardian. Resident 4 had diagnoses that included dementia with moderate psychotic disturbance and major depressive disorder. An ISP dated 04/17/2025, indicated Resident 4 needed some supervision. The ISP indicated Resident 4 was independent with transfers and ambulation. The ISP indicated s/he had a history of inappropriately touching residents of the opposite sex. The ISP indicated interventions to prevent inappropriate sexual behaviors included staff keeping an eye on him/her and redirecting Resident 4 with other activities. Neither resident was assessed for ability to consent before or after the incident.

An incident report dated 04/04/2025, indicated staff witnessed Resident 4 bend over trying to kiss Resident 3.

An internal investigation was conducted from 05/05/2025 to 05/07/2025 with allegations that Resident 4 sexually assaulted Resident 3 in a public bathroom on 05/04/2025. The investigation read in part, "[Caregiver S] stated [s/he] and [Caregiver T] found [Resident 4] and [Resident 3] in the bathroom together. [Caregiver S] indicated that [him/her] [sic] and [Caregiver T] entered bathroom together right after [Resident 4] left it and found [Resident 3] in bathroom without incontinent product or pants on. In notes [Caregiver S] indicates resident was holding [his/her] [...] area with tears coming out of [his/her] eyes, they immediately took resident to [his/her] room ...[Resident 4] had asked to use restroom in common area, which [s/he] did. [Caregiver S] indicated door was unlocked so [Resident 4] just entered; [Caregiver T] indicated

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[Caregiver S] had to unlock door for [him/her] to get in. Staff heard fumbling of the door handle, asked [Resident 4] if [s/he] needed help, [s/he] stated no and exited bathroom a few minutes later and returned to dining room. [Resident 3] had been self ambulating [sic] in the facility with and without [his/her] wheelchair. [Caregiver T] heard water running in restroom about 15 mins [sic] after [Resident 4] had exited and found [Resident 3] in restroom alone at the sink with water on, [his/her] pants draped over toilet and incontinent product in garbage. Per [Caregiver T] (who found resident in bathroom) resident did not appear to be in any distress." Per the investigation, [Caregiver S's] and [Caregiver T's] accounts of the incident were inconsistent. The investigation's conclusion indicated the reported incident was determined to be inconclusive/unfounded. The investigation indicated staff were to continue monitor Resident 3 and Resident 4 knowing their whereabouts. Staff were to check public restrooms prior to and after resident usage. Also, additional education with staff regarding documentation and incidents considered criminal in nature between residents. Per the investigation, police were also investigating the incident.

A staff observation note dated 05/07/2025 indicated staff observed Resident 4 had his/her hands on Resident 3's face rubbing it in the hallway.

On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E stated the alleged sexual assault incident on 05/04/2025 occurred on a weekend and s/he was not present. Director E stated s/he was notified by staff after dinner about the incident on 05/04/2025 and came the next day to start an investigation. Director E confirmed

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the investigation was inconclusive with both staff giving different statements. Director E stated staff were to keep an eye on both resident's whereabouts and check on them if they were not in the common areas. Director E stated the public bathrooms were typically locked to monitor residents.

On 08/13/2025 at 3:02 PM, Surveyors interviewed Assistant Director (AD) K. AD K stated they did not know what happened, if anything, between Resident 3 and Resident 4 on 05/04/2025. AD K stated Resident 3 showed no signs of fear towards Resident 4 after the incident on 05/04/2025.

Example 5

On 08/07/2025 at 9:45 AM, Surveyors requested any internal investigations since January 2025.

On 08/07/2025 at 11:00 AM, Surveyor reviewed Resident 5's and Resident 6's records and two internal investigations.

Resident 5 was admitted on 10/29/2024 and had a POAHC. Resident 5 had diagnoses that included dementia, schizoaffective disorder bipolar type, major depressive disorder, anxiety disorder, and Parkinson's disease. An ISP dated 12/02/2024, indicated Resident 5 required 24-hour supervision. The ISP dated 12/02/2024, indicated Resident 5 required 2 staff to assist with Hoyer lift transfers into a Broda chair for ambulation.

Resident 6 was admitted on 01/15/2025 and had a POAHC. Resident 6 had diagnoses that included dementia, depression, encephalopathy, and benign prostatic hyperplasia. An ISP dated

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N 426	Continued From page 54 02/13/2025, indicated Resident 6 needed some supervision. The ISP indicated Resident 6 transferred with standby or a gait belt for safety and ambulated independently with a walker or wheelchair. The ISP indicated interventions for sexual behaviors included, "Staff to ensure a respectful and non-judgmental approach to the conversation. Validate the resident's concerns and feelings without judgment." An ISP updated on 06/09/2025, indicated there were no new interventions related to sexual behaviors and supervision. An internal investigation was conducted on 02/04/2025 with allegations of staff finding Resident 6 in Resident 5's room with his/her hand on Resident 5's upper thigh while s/he was in bed that same day. Resident 6's room was located right across the hallway from Resident 5's room. Resident 5 was assessed, and it was determined Resident 5's undergarments were still intact with no obvious signs of displacement. Staff were directed to assist Resident 6 to his/her proper room and redirect if s/he attempted to enter another resident's room. An internal investigation was conducted from 02/24/2025 to 02/28/2025 with allegations of staff finding Resident 5 and Resident 6 in the dining room alone with Resident 6 touching Resident 5 in a sexual manner on 02/24/2025 at approximately 7:30 PM. The investigation read in part, "Per incident report, it was indicated that residents [sic] incontinent product was moved and blanket displaced exposing [his/her] genital area and that [Resident 6] had [his/her] fingers inside of [Resident 5]". The investigation indicated both staff [Caregiver S] and [Caregiver U] were interviewed and had inconsistent statements. Resident 5's physician was asked to perform a	N 426		

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visual exam when staff documented Resident 5 being reluctant to peri care. No concerns were identified with the exam. Due to this incident, Resident 5 was moved to a different room on the other side of the building. Staff were educated on supervision changes for both residents with Resident 5 being in visual sight of staff during waking hours and always knowing Resident 6's whereabouts. Resident 6 had been referred for a psych evaluation and possible medication changes.

Resident 5's record had an incident report dated 04/05/2025 that indicated Resident 6 was observed by staff with his/her hand inside Resident 5's shirt touching him/her sexually on 04/05/2025 at 9:45 AM. Upon staff approaching, Resident 6 removed his/her hand from Resident 5's shirt and stated, "Don't worry I'm not touching [him/her]." Resident 5 was removed from the dining room and placed by front entrance across from the nurse's station.

On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E stated the investigation was also inconclusive with staff giving different statements. Director E stated s/he did not believe Resident 6 had caused Resident 5 any trauma on 02/24/2025 due to Resident 5's legs being contracted and hard to open. Director E stated s/he observed Resident 6 had long fingernails and there would have been evidence. Director E stated they had a physician examine Resident 5 the next day and there were no signs of trauma either.

On 08/13/2025 at 3:02 PM, Surveyors interviewed AD K. AD K stated Resident 5 was now removed from the dining room after eating and placed where staff can keep a visual of him/her. Staff

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were to keep Resident 5 and Resident 6 separated in the dining room and eyes on both residents when in the same room together. AD K stated in general supervision could be challenging at times and staff do the best they can.

On 08/19/2025 at 9:13 AM, Surveyor interviewed Police Officer (PO) O. PO O stated s/he had concerns with resident supervision at the CBRF. PO O stated s/he had seen 2 staff in front of the building smoking at the same time and residents would be unattended smoking in front of the building at night when PO O drove by. PO O stated s/he had not had any elopement calls, but lots of calls related to resident falls resulting in injury.

On 08/19/2025 at 9:28 PM, Surveyor interviewed POAHC M. POAHC M stated s/he had concerns with Resident 3 having frequent falls at the CBRF. POAHC M stated Resident 3 had approximately 6 to 12 falls last year and seemed to have an emergency room (ER) visit once per month. POAHC M stated s/he visited Resident 3 once or twice per month. POAHC M stated on one visit, s/he was unable to find Resident 3 and found him/her over on the newly remodeled side of the CBRF by him/herself. POAHC M stated the staff working had no idea s/he was over there.

On 08/19/2025 at 10:20 AM, Surveyor interviewed Adult Protective Services (APS) Worker X. APS Worker X stated s/he had been at the CBRF multiple times in the past couple months and has had multiple resident family members calling upset with their loved one's care. APS Worker X stated there were concerns of resident supervision due to a lot of unwitnessed falls. APS Worker X stated s/he did not feel the CBRF was staffed appropriately to

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N 426	Continued From page 57 meet the resident's supervision needs on all shifts. On 08/20/2025 at 9:11 AM, Surveyor interviewed Family Member (FM) N. FM N stated s/he lived across from the CBRF and frequently observed employees out in their cars smoking. FM N stated one employee was out in their car for 4 hours and now staff hide in the back of the CBRF to smoke. FM N stated sometimes s/he only observed one staff vehicle at the CBRF. FM N stated when s/he visits Resident 3, it can take up to 15 minutes to find his/her wheelchair and it was something s/he should always have. FM N stated the CBRF had 5 to 6 elopements last year and s/he had to tell staff where 2 of the residents went. One resident was found 5 blocks away. On 08/20/2025, Surveyor reviewed the department file for the CBRF. The CBRF file indicated in 2024 and 2025 there were approximately 5 reported elopements. The CBRF file indicated in 2024 and 2025 there were a total of approximately 25 resident falls reported to the department requiring hospitalization and/or ER treatment. On 08/22/2025 at 3:09 PM, Surveyor received an email from Case Manager (CM) Q, which read in part regarding Resident 5, "On 2/28/2025, I was notified that the member had a room change, due to another resident touching [his/her] inner thigh. I was not informed of possible penetration ....I was not notified of the incident on 04/05/2025 ....Interventions consisted of staff increasing supervision and moving the members to a different room. Due to [Resident 5's cognition limitation, the member is unable to participate in depth conversations and can barely communicate most of [his/her] needs ...my expectations	N 426		

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consisted of 24-hour supervision to prevent similar incidents occurring and to ensure that all the members needs are met. However, I do not have any concerns about the member being near the nurses [sic] station for supervision."

On 09/03/2025 at 5:37 PM, Surveyor received a fax from POAHC W. POAHC W indicated s/he had observed concerns when visiting Resident 6 such as residents left unattended/unsupervised in the dining room for hours and residents that smoked and some that didn't were allowed to go outside unsupervised.

The missing resident policy and procedure read in part, "The Executive Director, or [his/her] Designee, must:
-Assess the resident for further elopement risk.
-Implement elopement risk interventions.
-Provide direction to caregiving staff via an incident report and/or the resident's service plan."

The sexual behavior policy and procedure read in part, "The [provider] has a responsibility to ensure the safety and well-being of all residents, and this includes protecting them from harm, including sexual abuse or harassment."

On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, AA B, Director E, and AD K. AA B stated Resident 1 was not allowed to go outside anymore unless staff was with him/her. AD K stated the elevator Resident 8 exited the building from was in the newer remodeled side of the building. AD K stated Resident 8 got his/her finger into the locked part of the elevator and was able to get in the elevator to the basement of the building. AD K stated Cook R immediately notified them of Resident 8's whereabouts. AD K stated they put another lock on the elevator to make

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N 426	Continued From page 59 sure no one could get their fingers in there. Licensee A stated they were addressing Resident 4's behaviors and continuing to monitor Resident 3. Licensee A confirmed Resident 3's care team was looking for a different placement for him/her. AA B stated they always made sure Resident 5 was kept in visual sight. Licensee A stated they were working on their new employee orientation related to resident supervision and making sure resident ISPs were updated. AA B stated staff ratio was typically 1 staff to 7 or 8 residents. AA B indicated there were 3 to 4 staff on the day and evening shifts including support staff. Cross Reference N0160 DHS 83.12(2)(c) Report To Law Enforcement And Coroner N0170 DHS 83.12(5)(b) Notification: Abuse And Neglect Allegations N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 426		
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.	N 431		

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N 431	Continued From page 60 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 record review and interview, the provider did not monitor 1 of 1 resident's (Resident 6) health when it failed to document and monitor Resident 6's skin breakdown on his/her lower right extremity. This is a repeat deficiency. See SOD ZY4712, dated 06/22/2022 and UWFF11, dated 07/09/2024. Findings: On 07/09/2025, the Department received a complaint regarding resident care. The provider is licensed to care for 50 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 08/07/2025 at 11:00 AM, Surveyor reviewed	N 431		

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Resident 6's record. Resident 6 was admitted on 01/15/2025 and had an activated Power Attorney of Health Care (POAHC). Resident 6 had diagnoses that included dementia, history of deep vein thrombosis (DVT), diabetes mellitus type 2, peripheral vascular disease, venous stasis with lymphedema, and benign prostatic hyperplasia with history of urinary tract infections (UTIs).

A pre-admission assessment dated 01/10/2025, indicated Resident 6 wore compression stockings and needed assistance with applying leg pumps for wounds. A skin breakdown assessment within the pre-admission assessment indicated Resident 6 had risk factors of incontinence and poor oral intake.

An Individual Service Plan (ISP) updated 02/13/2025, indicated Resident 6 needed some assistance with self-care and minimum assistance with activities of daily living (ADLs). The ISP indicated Resident 6 transferred with standby assist or gait belt for safety and ambulated independently with a walker or wheelchair. The ISP indicated Resident 6 had hyperpigmentation from venous stasis on his/her right leg and edema on both lower extremities. The ISP indicated Resident 6 used leg pumps 2 times per day for lymphedema. The ISP indicated Resident 6 was on an anticoagulation medication. The ISP indicated Resident 6 was on a 2-hour toileting schedule.

An ISP updated 06/09/2025, indicated Resident 6 had a wound on his/her right leg and foot. The ISP indicated staff were to ensure Resident 6's socks and shoes were not soaked with urine due to incontinence. The ISP indicated staff were to monitor the wound for signs and symptoms of infection, apply foam to the affected area, and

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change as needed if soaked. The ISP indicated Resident 6 needed to have compression stockings on during the day to prevent swelling and drainage. The ISP indicated Resident 6 would scratch and pick at the wound on his/her right leg. The ISP indicated Resident 6 was receiving home health services for wound care. The ISP indicated staff were to help Resident 6 with using his/her urinal to prevent leakage to support his/her wound healing.

Staff observation notes dated 01/01/2025 to 06/30/2025, indicated the following:

01/28/2025 - Resident 6 had swelling in right leg and scabs from scratching. Compression stockings were ordered.

2/21/2025 - Director E noticed a wound that was scabbing and measured approximately 1x1 centimeters on Resident 6's lower extremity. Director E charted Resident 6 confirmed s/he had been picking the wound and notified Resident 6's physician.

03/20/2025 - Assistant Director (AD) K charted s/he changed a border foam dressing on Resident 6's lower right ankle/foot.

04/10/2025 - AD K charted Resident 6's legs were hurting and red. AD K notified Resident 6's physician.

04/14/2025 - AD K charted Resident 6's legs were swollen, and red. Resident 6 was sent to the emergency room (ER) to be evaluated. Resident 6 came back, and it was documented arthritis was potentially causing the leg pain.

04/22/2025 - AD K charted Resident 6 went to

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urgent care (UC) for the wound on his/her outer right leg. AD K came back with doxycycline ordered for his/her legs.

04/25/2025 - Director E charted Resident 6's wound dressing was changed due to his/her incontinence. The wound was assessed and Resident 6's physician was notified with a wound referral requested.

04/27/2025 - AD K charted the wound dressing was changed on his/her right foot and outer leg.

05/01/2025 - Director E charted home health was requested for wound care and a new order for wound dressing changes to be as needed (PRN) was made.

05/09/2025 - Home health admitted Resident 6 for wound care 3 days per week. The home health nurse ordered new dressings for the wound.

05/17/2025 - Staff charted Resident 6 now had 2 open sores on his/her lower leg and open sore on his/her foot. The note read in part, "[POACH W] wants us to notify the home health nurse to not use plastic seal or tape on [Resident 6's] leg."

05/18/2025 - Staff charted Resident 6's wounds had a large amount of drainage and was sent to the ER to be medically evaluated. Resident 6 was diagnosed with cellulitis of his/her lower leg and prescribed 2 new medications.

05/19/2025 - The home health nurse came to change Resident 6's dressing and educated staff on how to change them.

05/21/2025 - Home health discontinued Resident

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N 431	Continued From page 64 6 using his/her leg pumps due to the amount of drainage from his/her wounds. 05/28/2025 - Home health visits changed to twice per day and provider inquired about the wound clinic referral. The note read in part, " ...the order was sent May 1st and [s/he] stated that [s/he] will send again the order." 05/30/2025 - Occupational therapy would be following with Resident 6 and home health received the referral for wound clinic. 06/03/2025 - Staff charted the dressing was changed due to it being saturated. 06/09/2025 - AD K charted Resident 6's dressing was changed twice on day shift and AD K reached out to home health to come assess the wound. Home health came to assess the wound and change the dressing. The Medication Administration Records (MARs) for February to June 2025 indicated on February 02/27/2025 a foam dressing was first applied on Resident 6's right lower leg and changed every 3 days. The order for the foam dressing had an addition of changing it PRN. Staff started the first dressing change for this order on 05/01/2025 through 05/25/2025. There was only 1 charting for the dressing change being done PRN on 05/11/2025. The June 2025 MAR indicated the dressing order was changed on 06/09/2025 to: "cleanse [sic] wounds with wound cleanser, pat dry. apply [sic] zinc oxide to venous stasis ulcers on shin. Apply opticel AG (cut to fit). Apply blue pads (optilock) and abd [sic] to cover all wounds. Wrap with rolled gauze an [sic] secure with tape. change [sic] daily and PRN." Staff did not chart under this new order in the MAR as Resident 6	N 431		

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N 431	Continued From page 65 was hospitalized on 06/10/2025. The Task Administration Record (TAR) for May and June 2025, indicated staff did not chart on personal cares 4 times in May 2025. The TAR indicated staff did not chart Resident 6 was showered on 05/15/2025, 05/19/2025, and 05/29/2025. It was charted Resident 6 refused to be showered on 05/05/2025. The TAR indicated staff did not chart Resident 6 was toileted every 2 hours 16 times in May 2025. On 06/08/2025, staff did not chart if personal cares were completed in the AM or PM, which included oral car, dressing, and hygiene. The TAR indicated Resident 6 refused a shower on 06/05/2025. On 06/08/2025 at 6:00 PM and 8:00 PM and on 06/09/2025 at 4:00 AM staff did not chart if toileting was completed. The TAR indicated staff were to ensure Resident 6's socks and shoes were not soaked with urine due to his/her incontinence; staff were to check the wound for signs and symptoms of infection, and change the dressing as needed if soaked. Staff did not start charting this was done twice per day until 06/04/2025. The TAR did not have staff charting for tubi grips on during the day and off at night to prevent further swelling and drainage until 06/10/2025. A home health skilled nursing note dated 05/07/2025, indicated Resident 6 was admitted to home health. The note indicated Resident 6 was incontinent of urine and his/her lower extremities would be soaked from urine constantly due to Resident 6 missing the urinal. Initial wound care orders included cleansing the wound with normal saline and applying medihoney. The wound was to be covered with an ABD pad, wrapped, and covered with kerlix. A Tegaderm drape was to be	N 431		

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placed to protect the wound from urine incontinence.

A home health order dated 05/09/2025, indicated staff were to check Resident 6's dressing twice per day and change if it was soaked. The wound care orders were, "Cleanse wounds with wound cleanser, pat dry. Apply zinc oxide to venous stasis ulcers on skin. Apply optical Ag (cut to fit). Apply optilock (blue pads) and ABD to cover all wounds. Wrap with rolled gauze and secure with tape. Change daily and PRN."

A home health order dated 05/21/2025, read, "Due to minimal signs of improvement with the current wound care regimen, I am requesting revised wound care orders for the right leg as follows:
-Cleanse all wounds with normal saline and pat dry.
-Apply zinc oxide to all wound beds.
-Cover the wound on the right leg with Optilock and an ABD pad.
-Cover the wounds at the ankle with Optilock.
-Wrap leg with Kerlix and secure with tape.
-Apply an ACE wrap to the right leg.
-Change dressing every other day and as needed for increased drainage."

A home health skilled nursing note dated 05/21/2025, read in part, "I am reaching out regarding [Resident 6], whose wounds have shown minimal progress and present as complex in nature. Given the current status, I would like to recommend a referral to the [Wound Clinic] for further assessment and management ...A referral to wound care may help facilitate a more specialized treatment plan and appropriate orders." The note indicated home health was not notified about Resident 6's recent ER visit for

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N 431	Continued From page 67 his/her wounds. A home health skilled nursing note dated 05/28/2025, read in part, "Staff states that they plan on checking the status of patients dressing two times per day and changing if it is saturated." A home health skilled nursing note dated 05/30/2025, read in part, "Patient did not have dressing on right lower extremity and only ace wrap was present. Spoke with [AD K] about importance of making sure dressing changes are completed and wounds remain covered to prevent infection. Per staff, they have had to change the dressing more frequently due to increase drainage/weeping. Orders signed for patient to get lymphedema therapy from lymphedema certified therapist and referral sent for a patient to be seen in ...wound clinic." A home health occupational therapy note dated 06/04/2025, read in part, "RN has been completing wound cares for approximately 3 to 4 weeks with limited improvement and would like to try lymphedema treatments to assist with wound healing ...Upon approaching patient, noted that socks and bottom of pants were soaked through from wounds, weeping and dressing being soaked. Follow up with staff indicates that they rely on home care RN (registered nurse) to complete wound changes, however, upon examining care plan and most recent upgrades, staff at facility are supposed to be changing wound dressings anytime they are noted to be soaked through and RN has reduced [his/her] frequency to two times per week ...Care plan updated for toileting program to assist with decreasing wound exposure to urine incontinence ...Significant concerns for wounds becoming infected and injuries."	N 431		

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N 431	Continued From page 68 A home health skilled nursing note dated 06/05/2025, read in part, "Patient fatigued throughout skilled nursing visit and some agitation present. Dressing and tubi grips completely soaked. Spoke with occupational therapist who stated that staff told [him/her] that they have not been changing dressing. Spoke with [AD K], who states staff has been performing dressing changes often due to weeping. Reinforced importance of changing dressing if it is soaked to help prevent further skin breakdown and applying tubi grips in the morning and taking off at nighttime. Requesting new wound care orders to have dressing changed daily and PRN for increased drainage ...Wounds have not shown much progress with healing." The visit note indicated wound clinic referral was made. A home health occupational therapy note dated 06/09/2025, indicated home health had significant concerns with Resident 6's urinary incontinence. The note indicated there was extensive discussion with the provider on a 1-to-2-hour toileting program to prevent urine from soaking clothing, compression bandages, and wound beds. The note indicated home health recommended Resident 6's lower extremities be elevated throughout the day. The home health note indicated there was concern with provider following through with the toileting program. A home health skilled nursing note dated 06/09/2025, indicated Resident 6 had a venous stasis ulcer on his/her right lateral foot heel, right leg calf, right medial leg, and an abrasion on his/her right medial leg ankle. The note read in part, " ...very fatigued throughout the skilled nursing visit ...The old dressings were removed and noted to be saturated with drainage ...a	N 431		

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two-hour toileting routine has been implemented ...Concerns were noted regarding staff compliance with the toileting schedule and dressing changes. These concerns were shared with the patient's POA, who also expressed dissatisfaction with the current level of care and is actively exploring alternative facilities that may better meet the patient's needs. Writer reinforced expectations with staff and discussed the matter with [Director E] to address ongoing compliance concerns.

An ER note dated 06/10/2025, indicated Resident 6 presented to the ER for generalized weakness and being less responsive than normal. The ER note indicated Resident 6 was incontinent of urine and saturated upon arrival. Resident 6's differential diagnoses included hypothermia, bradycardia, adrenal insufficiency, myxedema coma, hypothyroidism, urosepsis, urinary tract infection, and pyelonephritis. Resident 6 required an intensive care unit admission (ICU) and had final diagnoses of sepsis, urinary tract infection, change in mental status, and septic shock.

On 08/07/2025 at 1:48 PM, Surveyor interviewed Director E. Director E stated Resident 6 had a lot of comorbidities and fragile skin on his/her lower extremities. Director E stated once Resident 6's leg wound opened they got home health involved. Director E stated staff were changing Resident 6's leg wound dressing daily. Director E indicated Resident 6 was incontinent and would drip using his/her urinal. This caused Resident 6 to be soaked frequently.

On 08/13/2025 at 3:02 PM, Surveyor interviewed AD K. AD K staff were doing Resident 6's wound dressing changes 3 to 4 times per shift due to the amount of drainage. AD K stated staff had

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enough supplies and support with wound care for Resident 6.

On 08/15/2025 at 2:07 PM, Surveyor interviewed Home Health Nurse (HHN) Z. HHN Z stated Resident 6 had incontinence upon arrival to a visit 1 or 2 times, but s/he was unsure how saturated the wound was. HHN Z stated Resident 6 had a urinal at bedside but would spill it at times. HHN Z stated during his/her visits with Resident 6, s/he had concerns with staff following through with the 2-hour toileting schedule.

An email from POAHC W on 08/12/2025 at 5:12 PM, indicated Resident 6 had passed away on 08/05/2025 due to not recovering from the severity of his/her sepsis.

A fax from POAHC W on 09/03/2025 at 5:36 PM, indicated Resident 6 did not have any open wounds on his/her legs prior to admission. POAHC W indicated s/he received the most communication from home health regarding Resident 6's leg wounds. The fax read in part, "Not really any discussions regarding interventions to prevent the wound from getting wet/soiled. [Director E] and staff mainly just informed me that it was happening. [Home Health] stressed the importance of changing the dressing whenever it was wet. [Home Health] and I had several discussions regarding [his/her] instructions to [Director E] and the staff the importance of changing the dressing so the wound would heal. [S/He] stated that [s/he] didn't think they were doing it on a regular basis ...Specific dates [Resident 6] was soled [sic]. We noticed almost immediately after [his/her] catheter was removed on 1/28/25 but didn't document right away and probably missed a few but the dates are: 2/7, 2/23, 3/9, 3/26, 3/29, 4/12,

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4/16, 4/20 Easter, 5/7, 5/8, 5/12, 5/13, 5/17, 6/8. [His/Her] room frequently smelled of urine ...The last time I visited [Resident 6] was at around 4:00pm [sic] on Sunday, June 8, 2025. When I arrived, [s/he] was sleeping in [his/her] wheelchair in the dining room. [His/Her] shirt and [his/her] pants were smeared with food. [S/He] was sleeping so heavy that it took a few minutes to wake [him/her]. [S/He] was also completely soaked with urine. I called a CNA (certified nursing assistant) over and asked how long [s/he] had been sleeping in the dining room. [S/He] did not know but offer up that [s/he's] been pretty sleepy since [s/he] started about a week prior. I told [him/her] to get [him/her] changed." POAHC W indicated when Resident 6 was brought back to the dining room after being changed, staff also changed his/her wound dressing.

On 09/03/2025 at 1:00 PM, Surveyors interviewed Licensee A, Administrative Assistant (AA) B, Director E, and AD K. Director E stated they had implemented home health orders for Resident 6's wounds and educated staff. Director E stated staff that were trained to pass medications, were responsible for changing Resident 6's wound dressings. Director E stated management was responsible for putting in the new orders. Director E stated s/he was not aware of any concerns with Resident 6's wounds not healing. AA B, Director E, and AD K reiterated staff were changing Resident 6's wound dressings multiple times per shift.

Resident 6 had no skin breakdown upon admission on 01/15/2025, but was assessed to be a high risk for skin breakdown and a prevention protocol was not initiated. On 02/21/2025, it was initially noted Resident 6 had a 1x1 centimeter scabbed wound. Nothing was

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N 431	Continued From page 72 documented until 03/20/2025, when a foam dressing was applied to Resident 6's right lower extremity. Again, nothing was documented until 04/10/2025 when staff wrote Resident 6's lower extremities were red and hurting. Resident 6 was not admitted to home health until 05/07/2025. Resident 6's ISP was not updated to reflect Resident 6's skin breakdown and incontinence until 06/09/2025. Resident 6's MAR did not reflect the wound dressing order changes from 05/07/2025 to 06/09/2025. There was only 1 charting for the dressing change being done PRN on 05/11/2025 during that time. The May and June 2025 TAR indicated Resident 6's personal cares, toileting, and showering were not documented as completed consistently by staff. On 05/09/2025, home health ordered staff to check on Resident 6's dressing twice per day and change it if soaked. Staff did not start charting this was done twice per day until 06/04/2025 in the TAR. Home health notes expressed concerns with the provider's compliance regarding Resident 6's wound dressing changes and toileting schedule. Resident 6 passed away on 08/05/2025. Cross Reference N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 431		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b)	N 454		

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N 454	Continued From page 73 Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of	N 454		

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N 454	Continued From page 74 any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 8 resident records were maintained. Resident 7 had a cardiology procedure completed on 05/28/2025. The provider could not locate the written orders from Resident 7's medical provider that detailed directives to hold certain medications prior to the procedure. Findings include: On 06/04/2025, the department received a complaint alleging the provider was not following physician's orders. On 08/07/2025, at approximately 10:30 AM, Surveyor interviewed Resident 7. Resident 7 stated s/he obtained written orders from his/her	N 454		

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medical provider regarding medication changes for his/her upcoming medical procedure. Resident 7 stated s/he received medications when the medications should have been held. Resident 7 stated s/he had asked Assistant Director (AD) K and Director E multiple times about the orders to ensure s/he was receiving the correct medications. Resident 7 stated s/he gave AD K and Director E the written orders from the medical provider, but they could not find the document.

At approximately 2:15 PM, Surveyor interviewed Director E. When asked how staff received notification of changes after Resident 7's appointments, Director E stated Resident 7 would provide updates to staff. Director E stated Resident 7 reported s/he gave the orders to staff.

On 08/12/2025, Surveyor emailed Administrative Assistant (AA) B and inquired about the directives regarding Resident 7's medications prior to his/her medical procedure. Surveyor requested a copy of the written orders from the medical provider.

On 08/13/2025, at 9:54 AM, Surveyor received an email from AA B that stated, "Unable to locate written pre op orders."

At 3:00 PM, Surveyor interviewed AD K via phone. When asked about Resident 7's medical procedure, AD K stated the information s/he received came from Director E. AD K stated Director E gave the direction to put medications on hold. When asked how these medication guidelines were communicated, AD K stated it was through word of mouth. When asked if AD K received any written orders from Resident 7, AD K stated s/he did not receive any orders but

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maybe Director E did. When asked what may have happened to the orders, AD K advised to ask Director E. When asked what medications were to be held prior to Resident 7's procedure, AD K stated the Mounjaro medication and possibly one other medication. AD K stated Resident 7's Jardiance might have been held. AD K stated s/he was looking at Resident 7's medication list but was not sure about the Jardiance medication. AD K acknowledged seeing a "MAP" entered on the medication administration record (MAR) on the day of Resident 7's procedure and on the evening prior. AD K stated s/he was not sure what that meant.

On 08/19/2025, at 9:50 AM, Surveyor interviewed Primary Care Nurse (PCN) L. PCP L stated s/he was able to review medication instructions written by Resident 7's cardiology team. The instructions indicated Resident 7 should not take vitamins or supplements the morning of the procedure. It stated to hold Mounjaro medication 7 days prior and to hold Metformin the evening before and the morning of the procedure. PCN L stated Resident 7 had called the office and asked for medication clarification. PCN L stated clarification was provided to Caregiver D via phone. PCN L stated s/he did see in the notes that Jardiance was to be held the morning of procedure.

On 09/03/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A, Administrative Assistant (AA) B, Director E, and AD K. When asked if written orders related to what medications were to be held prior to Resident 7's procedure were found, Director E stated they were not able to find the orders. Director E stated there was an order to resume the Mounjaro medication. When asked if anyone determined what "MAP" meant on Resident 1's MAR, AA B

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 09/03/2025

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 454	Continued From page 77 stated that was something they were trying to figure out. AA B stated they did not have anyone working with the provider with that code. When asked if Resident 1 received the medications on days where that code was entered, AA B stated it was hard to tell.	N 454		