STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 000	Initial Comments On 08/21/2024-08/30/2024, Surveyor conducted a complaint investigation at Huntington Place Memory Care 2. Three deficiencies were identified. The complaint was substantiated. Census: 6	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report a serious injury resulting in emergency room treatment to the Department within 3 days. Resident 2 fractured his/her right wrist on 08/02/2024. Findings include: On 08/21/2024, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted on 06/21/2024 with diagnosis including dementia, depressive disorder, and anxiety. Resident 2 had a guardian to assist in decision making. Resident 2's ISP dated 06/21/2024 documented:	N 165		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 165	Continued From page 1 "Fall Risk" Staff will become familiar with my daily routine and will try to anticipate and meet my needs daily. I am at high risk for falls based on my fall assessment." Resident 2's progress notes documented: "08/02/2024: Resident was walking in the hall without [his/her] walker. Writer asked resident where [his/her] walker was and resident turned around to walk in [his/her] room and tripped over [his/her] feet falling backwards. Writer and other coworker went to resident and asked if [s/he] was okay. Resident complained about [his/her] head hurting and wrist hurting. Nurse told staff to call 911. Resident was taken to the hospital and poa was notified. 08/03/2024: SSM hospital called asking for information on resident (how [s/he] takes [his/her] meds, normal behaviors and how staff handles behaviors with resident). Nurse informed staff that resident's wrist is broken and in a splint. Resident has taken [his/her] splint off multiple times and [s/he] has made [his/her] wrist fracture worse than when [s/he] was admitted." Resident 2's hospital records dated 08/02/2024-08/05/2024 documented: "Patient presented to the ED today with complaints of unwitnessed fall. Patient current residing at [provider] . [S/he] was apparently trying to get [his/her] walker when [s/he] fell. [S/he] does complaint of right wrist pain and bilateral hip pain....ED evaluation today notable for right wrist x-ray with comminuted, dorsally displaced, and angulated fracture of the right distal radius extending into the radiocarpal joint. [S/he] was placed in a sling and was also given a splint....POA arrived and is concerned with patient returning to facility and attempting to remove [his/her] cast and controlling [his/her] pain. As a	N 165		

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	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 165	Continued From page 2 result patient was admitted." On 08/21/2024, Surveyor reviewed Department records, which indicated no self-reports were submitted regarding Resident 2's right wrist fracture. On 08/21/2024 at 3:00 PM, Surveyor interviewed Executive Director A and Nurse B. Nurse B reported s/he was responsible for submitting Resident 2's self-report but forgot. Nurse B stated s/he completed the form but must had gotten busy with something else and forgot to submit. Nurse B acknowledged Resident 2's serious injury required hospitalization and should had been reported to the Department.	N 165		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 431	Continued From page 3	N 431		

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 ensure 1 of 2 residents' health was monitored related to food and fluid intake.

Staff did not report significant deviations from normal food and fluid intake to Resident 1's medical team.

Findings include:

On 08/01/2024, the Department received a complaint alleging concerns related to a resident's significant weight loss.

On 08/21/2024, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 06/18/2024 with diagnosis including dementia, psychotic disturbance, mood disturbance, anxiety, and chronic kidney disease. Resident 1 had an activated healthcare power of attorney to assist in decision making. Resident 1 passed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 431	Continued From page 4	N 431		

away on 07/11/2024 while at the hospital.

Resident 1's pre-admission assessment dated 06/19/2024 documented:
"Last physician visit: 06/06/2024, most recent weight: 178.4 (dated 06/19/2024). Weight monitoring: 1x monthly. Nutrition: I need verbal cutes/reminder to attend meals; assist with menu selection; opening containers, packets, etc. I can eat independently or with set up only. Experienced Gradual Weight Change Over the Past 6 Months: "No." History of Dehydration: "No." Orientation and Behavior: Areas of declining/refusing care: "Refuses Medications." "

Resident 1's admission health exam dated 04/11/2024 documented:
"Pt spends a lot of time in bed just resting, does not toilet self anymore, does become aggressive at times with staff when they are trying to help [him/her] with ADL's ....Dementia due to general medical condition with behavioral disturbance. [His/her] dementia is quite advanced."

Resident 1's individual service plan (ISP) dated 06/19/2024 documented:
"Dining/Eating/Drinking: I can eat independently or with set up only."

The ISP did not address Resident 1 refusing eating or drinking.

Resident 1's progress notes documented:
"06/22/24: ...Resident refused to come out of [his/her] room all of this am shift. [S/he] also refused both meals.
06/23/2024: ...Resident didn't want any lunch.
06/30/24: ....Resident has been offered snacks through the night but has refused.
07/04/24: ...Writer keeps reapproaching [him/her]

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	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 5	N 431		

and this last time writer gave [him/her] a drink and [s/he] sat up to drink it but then when staff went to sit [him/her] all the way up [s/he] pulled away from staff and laid back on the floor.
07/08/2024: [Legal Representative C] arrived to see [him/her] at 3pm. [S/he] noted several changes in both [his/her] appearance and [his/her] room that [s/he] was unaware of, such as [his/her] bed being repositioned....Have been given information in the past that communication between [Legal Representative C] and facility has been difficult to obtain. Stated to [Legal Representative C] that the lack of update in [his/her] conditions may be due to the broken office phone....[Legal Representative C] asked how [s/he] lost so much weight and explained that [s/he] had refused most of [his/her] meals, and that we cannot force-feed [him/her]. [Legal Representative C] contacted director of nursing and once that call concluded, [s/he] requested [s/he] be taken to emergency room.....Call placed to [Legal Representative C], regarding resident's status. [S/he] stated "[s/he] is not doing well, [s/he] is severely dehydrated and may be in kidney failure.""

Resident 1's hospital records dated 07/07/2024-07/09/2024 documented:
"Admitting diagnosis: Hypernatremia, CKD stage III, Severe Alzheimer's with aggressive behaviors, Severer sepsis, and elevated troponin.
Final Diagnosis: Dementia, elevated troponin presumably due to demand ischemia, hypernatremia, metabolic acidosis, hyperkalemia, AKI on CKD stage II, transient erythrocytosis, and severe protein calorie malnutrition.
Discharge Destination: SSM Hospice
...Reportedly has moved to the provider 10 days ago, has been agitated, not eating or drinking. Exam on day of discharge (135 lbs) ....By report

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	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 6	N 431		

from EMS, the patient has not been out of bed in almost a week, is much less responsive than usual ....[Legal Representative C] reports that the patient has been at the provider for about 10 days now and they have received very little communication from the memory care about [her/him]. [S/he] has been seen here several times for falls, but [s/he] was only told today about how [s/he] has not been eating. [S/he] went to visit [him/her] and found [him/her] with a very dry mouth, just lying in bed ....[Legal Representative C] reports the patient had previously been eating relatively well with 1:1 assistance as of about 2 weeks ago. [S/he] was taking meds crushed in puree. However, intake has declined in the past 2 weeks and [s/he] has had significant weight loss. Cause of death: Severe Sepsis due to bladder infection due to urinary retention due to prostatism."

On 08/21/2024 at 8:40 AM, Surveyor interviewed Memory Care Director D. Memory Care Director D stated Resident 1 was aggressive towards staff on a daily basis when staff attempted to change him/her and trying to offer food/fluids. Memory Care Director D stated s/he was off for a few weeks during Resident 1's short admission, but upon returning s/he did hear reports of him/her not eating or drinking. Memory Care Director D stated Resident 1 had weight loss due to his/her continued refusals.

On 08/21/2024 at 10:15 AM, Surveyor interviewed Nurse B. Nurse B stated Resident 1 would hardly eat/drink during admission. Nurse B reported staff attempted many times but Resident 1 would exhibit aggression towards them. Nurse B stated s/he tried to report concerns to Legal Representative C, but after s/he dropped off Resident 1, Legal Representative C did not

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 431	Continued From page 7	N 431		

answer the phone.

On 08/21/2024 at 11:10 AM, Surveyor interviewed Caregiver E. Caregiver E stated staff had a hard time getting Resident 1 to eat or drink due to his/her aggressive behaviors. Caregiver E stated Resident 1 would kick/hit staff when attempting to do cares or offer food/fluids.

On 08/21/2024 at 11:20 AM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 1 would not let staff change his/her depend. Caregiver F stated Resident 1 was lucky if s/he ate 1 meal per day due to his/her aggressive behaviors. Caregiver F stated behaviors and lack of nutrition were reported to management. Caregiver F stated weight loss in Resident 1 was evident due to his/her refusals to eat/drink. Caregiver F stated Resident 1 would take medications without issue. Surveyor asked if Resident 1 was prescribed any type of nutritional shake to supplement missing meals. Caregiver F stated "no, [s/he] did not."

On 08/21/2024 at 1:06 PM, Surveyor interviewed Legal Representative C. Legal Representative C denied s/he was contacted by the provider regarding Resident 1's continued refusals of eating/drinking. Legal Representative C stated s/he was contacted maybe 2x regarding falls Resident 1 had, but reiterated the provider did not report concerns with eating/drinking. Legal Representative C stated upon admission, the provider was made aware Resident 1 only had 1 functioning kidney and when going to the hospital on 7/7/24, Resident 1 was severely dehydrated and in acute kidney failure. Legal Representative C stated when visiting Resident 1 on 7/7/24, s/he was told the provider's phone system was down for several weeks. Legal Representative C noted the hospital stated Resident 1's kidney would

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	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 431	Continued From page 8 either respond to treatment or s/he would pass away. Legal Representative C reported concerns when Resident 1 admitted to the hospital on 7/7/24, s/he weighed 135 lbs. On 08/21/2024 at 3:00 PM, Surveyor interviewed Executive Director A and Nurse B. Surveyor asked if lack of nutrition concerns were reported to Resident 1's physician. Nurse B stated Resident 1 was going to see the in-house doctor in early July, but s/he went to the hospital prior to this appointment and did not return. Nurse B stated Resident 1 was seen by the last provider's in-house physician prior to admission. Nurse B stated the provider did not have a physician to report concerns to until Resident 1 was seen by their in-house physician. Surveyor expressed concern during Resident 1's admission (20 days) the above concerns were not reported to the admitting physician until Resident 1 could be assessed with the current provider's physician. Executive Director A and Nurse B confirmed the record did not indicate Resident 1's medical team or legal representative was notified about refusals of eating/drinking. Cross Reference: N0433 DHS 83.38(1)(i) Behavior Management	N 431		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 433	Continued From page 9	N 433		

services to manage resident ' s behaviors that may be harmful to themselves or others.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not provide services to manage residents' behaviors that may be harmful to themselves or others.

Resident 1's physical aggression behaviors and refusing cares were not being managed.

Resident 2's verbal and physical aggression behaviors were not being managed.

Findings include:

The provider is licensed to serve up to 8 nonambulatory residents within the client groups of irreversible dementia/Alzheimer's and advanced age.

On 08/21/2024-08/30/2024, Surveyor conducted a complaint investigation and identified the following:

Example 1 - Resident 1

Resident 1 was admitted to the facility on 06/18/2024 with diagnosis including dementia, psychotic disturbance, mood disturbance, anxiety, and chronic kidney disease. Resident 1 had an activated healthcare power of attorney to assist in decision making. Resident 1 passed away on 07/11/2024 while at the hospital.

Surveyor reviewed Resident 1's progress notes from 06/18/2024-07/07/2024 and observed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 433	Continued From page 10	N 433		

"06/19/2024: Resident is very aggressive with staff. It was reported by agency staff that resident without warning tried to punch staff in the face. Resident is incontinent and will not let staff go near [him/her] to change [his/her] depend.
06/20/2024: ...Writer looked in resident's bathroom and [s/he] has used the toilet but still appears wet with urine from what I can see. I almost had [him/her] convinced to let me change [his/her] depend but then [s/he] looked at me with an aggressive look and I decided to leave the room.
06/21/2024: Resident arrived back from the hospital at 12:40 am with police escort. When paramedics were assisting resident into [his/her] bed, resident tried to kick one of the paramedics and swore at [him/her].
06/23/2024: ...Resident was very resistive with the transfer. [S/he] would not let staff help [him/her] with anything else, [s/he] started trying to hit staff ....Resident didn't want any lunch. [S/he] just wanted to sleep. Resident refused to let staff change [him/her]. [S/he] started trying to kick and hit staff ....Res much more awake and aggressive at bedtime, when staff tried to assist resident, resident tried to kick and hit staff.
06/24/2024: Resident was very aggressive. Do not listen to staff. Resident was very aggressive during evening cares. [S/he] start kicking both staff with [his/her] legs and pinch staff.
06/25/2024: Resident was awake all night. Resident started wondering halls and trying to enter other people's rooms ...Resident tumbled and fell to the floor at 2am. Resident was not hurt. Staff called ED. Resident refused to allow staff to help [him/her] up. Resident got [him/herself] up and off the floor after about 5 minutes. Resident then continuously sat [him/herself] on the floor while trying to take apart the fire place ...Staff tried to help resident to [his/her] room and into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 433	Continued From page 11	N 433		

bed but resident refused all help and would not let staff touch [him/her]. Resident sat in lobby area and talked to [him/herself] for about an hour. While staff was cleaning, resident pulled [his/her] [expletive] out of [his/her] depend and began touching [him/herself] while watching staff. Staff then went into the charting room until [s/he] stopped behaving inappropriately.
06/26/2024: I was able to get one of residents shirt off before resident started trying to hit me. I have tried all the redirection tactics I can think of ....Residents pants are soaked in urine and [s/he] is sitting in every chair in common room ....Resident going into [fe/male] residents room and turning their lights off taking and moving their belongings. Writer trying to redirect resident out of rooms, [s/he] started calling me a "[expletive]" and charging me. So I let [him/her] chase me out of the [fe/male] room and shut the door. [His/her] clothes are soaked with urine and blood from what looks like a skin tear from [his/her] elbow. Residents pants are soaking wet and resident is refusing to allow staff to get near resident to even try to assist in any way. Resident at one point kept going into another residents room and taking their blanket off of them, then laid down on a matt next to the bed and would not get up ...Resident also at one point was crawling on the floor, and sitting on the floor all around the building. Resident is urinating on the floor around the building ...Resident is yelling cussing and trying to hit staff when they get close to resident. Resident has gotten blood and urine in every chair they have sat in tonight.
06/27/2024: Went into resident room at 4:45 AM to try and change [his/her] depend for the third time. Resident had urinated on the floor of [his/her] bedroom when writer bent down to clean it up, [s/he] got out of bed and started yelling racial slurs, and telling me to get out of [his/her]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

(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 433	Continued From page 12	N 433		

room.
06/30/2024: Resident was laying on the floor in front of [his/her] room when staff arrived. The previous shift reported that [s/he] had been laying on the floor for about 5 hours ...Resident has been soaked in urine all night but refuses help from staff to get changed into dry clothes. Resident refused and has been continuously aggressive toward staff telling staff to get away. At one point, staff attempted to get resident off the floor and resident grabbed staff's hand with both of [his/her] hands and attempted to break staff finger by bending the finger side ways ...Around 2am, resident got [him/herself] to [his/her] feet and attempted to charge toward staff ....Resident has been sleeping on the floor since yesterday after dinner until 8am this morning and refusing to let us get [him/her] dressed for the day.
07/01/2024: This writer contact [Executive Director A] regarding res put [him/herself] on the floor [s/he] is being very aggressive. Staff wanted to get res up off the floor. Res came out swinging and cussing at staff. Res is incont of urine this writer attempted to change res. Res started to kick at this writer.
07/02/2024: Resident was very aggressive during evening cares, [s/he] kicking staff with both legs and start biting staff also. Resident pinch staff on [his/her] stomach.
07/04/2024: Resident put [him/herself] on the floor around 120am. Writer went in to sit resident up and [s/he] started being aggressive.
07/05/2024: Resident had been on the floor in [his/her] bedroom through the night. Staff has attempted to offer resident off the floor multiple times through the night but resident had refused. Resident is also covered in urine but refused to allow staff to help [him/her] change ....Staff used hoyer to get [him/her] up and into [his/her] bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

(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 433	Continued From page 13	N 433		

Resident had bm. Resident was aggressive while staff changed and cleaned [him/her] up.
07/07/2024: Resident has been on the floor since pm shift. Resident being very resistive. Resident hit staff in the eye. At 5 am, resident was half asleep so staff got resident up with the hoyer machine. The whole time resident was hitting staff."

Resident 1's individual service plan (ISP) dated 06/19/2024 documented:
"Under the toileting section: I am independent and manage my continence needs.

I am/have the potential to be verbally/physically aggressive or to demonstrate behaviors. Agitation, anger, or aggression. If I show signs of agitation, my caregivers will intervene before escalation: remain calm, take a deep centering breath, stand out of reach of me, listen and respond with empathy, guide me away from source of distress, calmly engage me in conversation. If my response is aggressive, they will calmly walk away, ask other residents o leave the area, ensure that I and other residents and team members are safe, and immediately report the situation to nurse, discuss other approaches and approach late."

Resident 1's hospital records dated 07/07/2024-07/09/2024 documented:
"Admitting diagnosis: Hypernatremia, CKD stage III, Severe Alzheimer's with aggressive behaviors, Severer sepsis, and elevated troponin.
Final Diagnosis: Dementia, elevated troponin presumably due to demand ischemia, hypernatremia, metabolic acidosis, hyperkalemia, AKI on CKD stage II, transient erythrocytosis, and severe protein calorie malnutrition.
Cause of death: Severe Sepsis due to bladder

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	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

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HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 433	Continued From page 14	N 433		

infection due to urinary retention due to prostatism."

On 08/21/2024 at 10:15 AM, Surveyor interviewed Nurse B. Nurse B confirmed Resident 1 had daily aggressive behaviors and was refusing cares such as toileting. Nurse B stated Resident 1 was sent to the emergency room 2x following falls but was sent right back due to behaviors. Nurse B stated Resident 1's ISP did include interventions but after Resident 1 admitted the severity of his/her physical aggression and refusals of care were not reported accurately from his/her former provider. Nurse B stated the provider attempted to get Resident 1 seen by a geri-psych unit but was unsuccessful.

On 08/21/2024 at 11:10 AM, Surveyor interviewed Caregiver E. Caregiver E acknowledged Resident 1 had daily aggression such as kicking, punching staff, and calling staff racial slurs. Caregiver E stated upon returning from the hospital after a fall, Resident 1 was observed kicking the paramedics. Caregiver E stated Resident 1 had charged after him/her a few times when trying to redirect his/her behaviors. Caregiver E noted s/he felt like staff lacked interventions to safely manage Resident 1's behaviors.

On 08/21/2024 at 11:20 AM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 1 would not let staff change his/her soiled depends. Caregiver F stated Resident 1 was very aggressive towards staff. Caregiver F stated s/he picked up a 3rd shift and observed Resident 1 upon returning from the hospital kicking the cops.

On 08/21/2024 at 3:00 PM, Surveyor interviewed Executive Director A and Nurse B. Nurse B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

(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 433	Continued From page 15	N 433		

reported Resident 1's former provider did not communicate the severity of his/her behaviors prior to admission. Surveyor expressed concern after early interventions identified on Resident 1's ISP were unsuccessful in managing Resident 1's behaviors, a more thorough plan should have been completed. Nurse B acknowledged Resident 1's behaviors were severe, and an updated plan should have been completed to keep him/herself and staff safe.

Example 2: Resident 2

On 08/21/2024 at 10:00 AM, Surveyor interviewed Memory Care Director D. Memory Care Director D stated Resident 2 is another resident who exhibits daily behaviors. Memory Care Director D stated Resident 2 requires a 1:1 staff 24/7 due to behaviors.

Resident 2 was admitted on 06/21/2024 with diagnosis including dementia, depressive disorder, and anxiety. Resident 2 had a guardian to assist in decision making.

Surveyor reviewed Resident 2's progress notes from 07/02/2024-08/20/2024 and observed the following:
"07/02/2024: Res having an outburst yelling and screaming at staff and at res. Lashing out at staff with [his/her] walker.
07/03/2024: [S/he] was starting to cry around 2 and kept doing it still like 8pm ... [S/he] pulled the fire alarm as well tonight.
07/08/2024: At 630, res began wailing and screaming.
07/09/2024: Res was given PRN around 1:00am for pain and agitation. PRN's did not seem to work and resident has been up and down all night screaming and crying.

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	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

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HUNTINGTON PLACE MEMORY CARE 2	3840 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 433	Continued From page 16 07/13/2024: Resident has been in out of bed moving from chair to chair in the lobby resident is complaining of leg pain. Resident is also very agitated and started yelling at staff and throwing walker around. Resident asked another resident for a tissue while sitting in the lobby the resident told [him/her] that they did not have one when staff told [him/her] they would get [him/her] a tissue resident turned to the side and started blowing snot and spitting on the floor. Resident then began to scream at the top of [his/her] lungs ...Resident spent another hour in the lobby screaming and crying and being rude to other residents. 07/18/2024: ...Resident started screaming and crying on the top of [his/her] lungs. 07/21/2024: After end of 7/20 PM shift [Executive Director A] requested one of the 2nd shift employees to walk over to AL to assist [him/her] in attempting to calm resident down from a state of agitation and destruction and occasional attempts to hit or kick both of us ...Combined efforts from both of us unsuccessful in soothing resident, and police were called. Uncertain whether resident was escorted to [his/her] room in ½ or taken by police. 07/22/2024: Resident and staff were outside when it was time to come in, staff tried helping resident up when trying to help , resident grabbed staff's keys and whipped them at staff. Resident began screaming. Resident also told staff [s/he] was [expletive]. Staff tried to redirect resident and resident just began screaming and yelling. 07/23/2024: Resident came out to the lobby area around 11pm crying stating someone poisoned [him/her] and that [s/he] needed the staff to reverse it ....Resident was sitting in the common area, there was another resident sitting in the common area, when [Resident 2] threw an entire cup of apple juice at resident. [Resident 2] also	N 433		

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 433	Continued From page 17	N 433		

rammed [his/her] walker into same resident.
07/25/2024: Staff gave resident a prn due to resident having screaming outbreaks 3x since 2pm.
08/01/2024: Staff witness resident was spitting and punching another resident in the face and started screaming out of control."

Resident 2's ISP dated 06/21/2024 documented: "I am/have the potential to be verbally/physically aggressive or to demonstrate behaviors. Custom Interventions: My care team will approach me calmly, gently and speak to me as the progressional, intelligent psychotherapist I was in my professional life.
I have cognitive impairment. I may frequently have socially inappropriate behaviors (i.e. yelling, verbally inappropriate, physically inappropriate."

Resident 2's hospital records dated 06/08/2024 (prior to admission) documented:
"..advanced Alzheimer's dementia with agitation activated POA, who resides at [former provider]....presents on a chapter 55 after facility refused to take back after attacking other residents. [S/he] reportedly been having increasing behaviors. Today [s/he] was attacking other residents with [his/her] cane."

On 08/21/2024 at 11:10 AM, Surveyor interviewed Caregiver E. Caregiver E stated Resident 2 had daily behaviors of screaming and some physical aggression. Surveyor asked if Resident 2's ISP contained strategies to safely manage his/her behaviors. Caregiver E stated "no."

On 08/21/2024 at 3:00 PM, Surveyor interviewed Executive Director A and Nurse B. Executive Director A reported at the end of July, Resident 2 attended a funeral and upon returning to the

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	0014095	A. BUILDING: _____ B. WING _____	C 08/30/2024

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N 433	Continued From page 18 facility, Resident 2's family member returned him/her to the provider's assisted living building instead of memory care. Executive Director A stated Resident 2 refused to return to memory care and sat him/herself at the reception desk at the front of assisted living. Executive Director A stated it took calling law enforcement to get Resident 2 to return to the provider's memory care building. Nurse B acknowledged Resident 2's behaviors prior to his/her wrist fracture were hard to manage. Nurse B stated since Resident 2's wrist fracture, his/her behaviors had been minimal. Nurse B reported Resident 2's family had hired a 1:1 caregiver 24/7 to assist in managing Resident 2's behaviors. Nurse B stated the 1:1 caregiver was hired privately and would be in the picture until Resident 2's wrist heals. Surveyor expressed concern Resident 2's ISP did not identify the 1:1 caregiver and other interventions were not trialed to mitigate Resident 2's behaviors. Cross Reference: N0431 DHS 83.38(1)(g) Health Monitoring	N 433		