STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015688	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUNG HOUSE	4141 SAVANNAH DRIVE DE FOREST, WI 53532

(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 From 10/15/2025 to 10/16/2025, Surveyor conducted a standard survey at Young House, a CBRF in DeForest. Two deficiencies were identified. Census: 8	N 000		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 2 residents reviewed had the rationale for use and a detailed description of behaviors which indicated the need for administration of a PRN Psychotropic included	N 408		

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
	0015688	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUNG HOUSE	4141 SAVANNAH DRIVE DE FOREST, WI 53532

(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 408	Continued From page 1 in their ISP. Resident 1's use of Quetiapine Fumarate PRN was not included in his/her ISP. Findings include: On 10/15/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility with diagnoses including dementia and down syndrome. Resident 1's physician orders included Quetiapine Fumarate 50 mg (Start Date: 09/05/2025) - Take twice daily as needed for aggressive behavior or 30 minutes before cares. Resident 1's medication administration record (MAR), dated 09/01/2025 to 10/15/2025, documented 22 administrations of Quetiapine Fumarate PRN. Resident 1's ISP, dated 05/19/2025, and behavioral support plan (BSP), dated 03/14/2025, did not include the use of Quetiapine Fumarate PRN. On 10/15/2025 at approximately 10:45 a.m., Surveyor reviewed concern with Assistant Administrator A that Resident 1's ISP did not include the rationale for use and a detailed description of behaviors which indicated the need for administration of Quetiapine Fumarate PRN. Assistant Administrator A reviewed Resident 1's ISP and BSP and confirmed Surveyor's observation.	N 408		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015688	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUNG HOUSE	4141 SAVANNAH DRIVE DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 431	Continued From page 2	N 431		

the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not monitor the health of 1 of 3 residents reviewed and document changes in the record. Resident 1's vitals were not taken and recorded as ordered or care planned.

Findings include:

On 10/15/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility with diagnoses including dementia and down syndrome. Resident 1's record identified the following concerns:

Furosemide:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015688	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUNG HOUSE	4141 SAVANNAH DRIVE DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 431	Continued From page 3 Resident 1's physician orders included Furosemide 20 mg (Start Date: 09/24/2025) - Take 1 tablet daily; hold for weight loss >2 lbs/day. Resident 1's record did not document a daily weight 10/10/2025 through 10/13/2025, yet Furosemide 20 mg was documented as administered each of the 4 days. On 10/15/2025 at approximately 10:45 a.m., Surveyor reviewed concern with Assistant Administrator A that Resident 1's weight was not recorded daily as ordered with his/her Furosemide. Assistant Administrator A stated the hold parameter regarding the 2 lb weight gain may have been the provider's "add on" to the order, not the physician's order. On 10/16/2025 at 10:45 a.m., Surveyor interviewed Pharmacist B with the provider's facility. Pharmacist B stated the 09/24/2025 Furosemide order did include the order to hold if weight loss of >2 lbs. occurred within a day. Pharmacist B stated the pharmacy received an order on 10/15/2025, the day of Surveyor's visit, to remove the hold parameter. Vitals: Resident 1's MAR, dated 09/01/2025 to 10/15/2025, documented to record and document Resident 1's vitals daily (Start Date: 01/16/2025); notify management of any readings outside of baseline or a temperature above 99 or a pulse ox below 90. Resident 1's ISP, dated 09/19/2025, documented daily vitals. Resident 1's MAR did not include daily vitals on 09/01/2025, 09/06/2025, 09/07/2025, 09/13/2025, 09/14/2025, 09/17/2025, 09/18/2025, 09/20/2025, 09/21/2025, 09/23/2025, 09/25/2025, 09/28/2025, 09/29/2025,	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015688	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUNG HOUSE	4141 SAVANNAH DRIVE DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 431	Continued From page 4 10/04/2025, 10/05/2025, 10/07/2025, and 10/11/2025 - 10/13/2025. On 10/15/2025 at approximately 10:45 a.m., Surveyor reviewed concern with Assistant Administrator A that Resident 1's vitals were not taken and recorded daily as indicated on his/her MAR. Assistant Administrator A stated daily vitals were not ordered by a physician, but rather a preference of the facility.	N 431		