STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 12/09/2025, the bureau of assisted living southern regional office conducted a complaint investigation at Bascom Hall a CBRF located in Monona, WI. As a result of this survey, 2 violations of DHS chapter 83 were identified. The complaint was substantiated. Census: 26	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all of Resident 1's medication was administered as prescribed. On 10/07/2025, Med Passer C did not administer Resident 1's PRN morphine sulfate 15 mg tablet ordered to comfort end-of-life stage upon request. Family Member B reported s/he witnessed Resident 1 pass away "in a great deal of pain." On 10/08/2025, Nurse E investigated Family Member B's report of medication error. Nurse E concluded Med Passer C had not administered Resident 1's PRN morphine sulfate 15 mg tablet as prescribed.	N 352		

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
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 352	Continued From page 1 FINDINGS INCLUDE: On 11/13/2025, the Department received a complaint related to medication management at facility. On 12/09/2025, Surveyor arrived at facility for a complaint investigation. RECORD REVIEW: On 12/09/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 09/16/2025. Resident 1 had an activated power of attorney. On 12/09/2025, Surveyor reviewed Resident 1's investigation summary dated 10/08/2025. Nurse E documented Family Member B was upset that when s/he requested PRN morphine for Resident 1 due to difficulty breathing from Med Passer C. Med Passer C told them that it was too early for the morphine and Resident 1 would need to wait. Nurse E documented the following, "OUTCOME OF INVESTIGATION ...FINDINGS: The complaint was substaantited (sic.) for the resident not receiving a PRN dose of morphine ...CORRECTIVE ACTION: med passers were educated on the use of PRN medications and the use of PRN comfort medications to be given when needed between scheduled dose (sic.). Staff were also educated to reach out to the on-call nurse or hospice triage when there are questions about PRN administration." On 12/09/2025, Surveyor reviewed Resident 1's October 2025 medication administration record (MAR). Surveyor reviewed the following order, "MORPHINE SULFATE TAB 15MG (Morphine	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 352	Continued From page 2 Sulfate) TAKE ONE-HALF TABLET BY MOUTH EVERY 2 HOURS AS NEEDED FOR PAIN OR SHORTNESS OF BREATH (Indications for use Pain) (Diagnoses: ENCOUNTER FOR PALLIATIVE CARE (Z51.5))-start date 10/06/2025 0000." Zero, administrations of the PRN morphine sulfate were documented for 10/06/2025. On 10/07/2025 at 0157, Med Passer C documented a PRN dose as "UNKNOWN." On 12/09/2025, Surveyor reviewed Resident 1's hospice record: The hospice recorded documented the primary diagnosis as amyotrophic lateral sclerosis (ALS). 1.) On 10/04/2025 at 10:36 AM, Hospice Nurse F documented the following, " ...Writer spoke with [Med Passer D] who states pt refused MSIR (morphine sulfate immediate release) and Lorazepam this morning, discussed symptom management, disease progression, and medication for symptom management, disease progression and medication for symptom management. Pt agreeable to taking MSIR and Loraz (sic.) and states [s/he] has no memory of refusing any medications. Write spoke with [Med Passer D] about administering medications, [Med Passer D] stated medications cannot be administered after refusal, but [s/he] can administer PRNs, writer requested PRNs ...". 2.) On 10/07/2025 at 1:20 AM, Hospice Nurse G documented a call from Family Member B. Hospice Nurse G documented the following, "Narrative: [Family Member B] called to report that [s/he] is at bedside with [Resident 1] who is actively dying and is very uncomfortable, awake and moaning, calling out. Earlier [Hospice Nurse H] had been out to help make the patient more comfortable with new medication orders. Patient	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 352	Continued From page 3 was scheduled Morphine IR and lorazepam every 4 hours with morphine IR every 2 hours ...Per caller the facility staff is not giving the patient [his/her] PRN medications stating that it hasn't been long enough since the scheduled comfort medications had been given. [Family Member B] reports that this has been an ongoing issue with facility staff not wanting to give comfort medication to the patient. Writer states that the intention of the PRN medications is to be given in between the scheduled meds for additional comfort. Write states [s/he] will have a nurse contact the facility to speak with staff and find out why they are not giving medications and if needed a nurse visit will be arrange (sic.) ...". 3.) On 10/07/2025 at 1:42 AM, Hospice Nurse G documented a call from Family Member B. Hospice Nurse G documented the following, "Death Notification ...Writer offered condolences and stated that a visiting RN will be out as soon as possible ...Was the patient comfortable? No, [Family Member B] states [s/he] was in a great deal of pain ...Is there anything else we need to know about the death before the visit RN arrives? [Family Member B] upset with facility staff d/t lack of care provided ...". INTERVIEWS: On 12/09/2025 at 11:40 AM, Surveyor interviewed Med Passer C. Med Passer C verified s/he was the only staff passing medication the night Resident 1 passed away. Med Passer C reported s/he started his/her shift on 10/06/2025 at 10:00 PM. Med Passer C stated s/he was notified during shift report that Resident 1 was the in end-of-life stage. Med Passer C reported s/he had administered Resident 1's scheduled dose of morphine and lorazepam at approximately	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 352	Continued From page 4 midnight, and approximately an hour later Caregiver I reported Family Member B was requesting a PRN dose of morphine be administered. Med Passer C stated s/he didn't administer the PRN dose of morphine upon request because it wasn't available. Surveyor reviewed Resident 1's October 2025 MAR with Med Passer C. Med Passer C verified that a PRN order for morphine was available for administration at approximately 1:00 AM. Med Passer C could not explain why s/he had missed the PRN Morphine order the night Resident 1 passed away. Med Passer C stated Family Member B was very upset with him/her that night. Med Passer C stated Nurse E had told him/her s/he hadn't done anything wrong. On 12/09/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator A, Nurse E, Regional Nurse J and Regional Director K. Administrator A, Nurse E, Regional Nurse J and Regional Director K all acknowledged Resident 1 wasn't administered his/her PRN dose of morphine upon request. CROSS REFERENCE: N0385 DHS Chapter 83.35(2) Temporary Service Plan	N 352		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 385	Continued From page 5 provider did not ensure a temporary service plan was written to meet the immediate needs of the resident. On 12/09/2025, Surveyor reviewed Resident 1's temporary service plan. Resident 1's primary diagnosis of amyotrophic lateral sclerosis (ALS) and prescribed oxygen therapy were not documented in the temporary service plan. FINDINGS INCLUDE: On 11/13/2025, the Department received a complaint related to medication management at facility. On 12/09/2025, Surveyor arrived at facility for a complaint investigation. RECORD REVIEW: On 12/09/2025, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 09/16/2025. Resident 1 had an activated power of attorney. On 12/09/2024, Surveyor reviewed Resident 1's hospice record: 1.) On 08/25/2025, the following order was documented, "Oxygen maintenance: Blue/Black 5L Concentrator wipe vented areas on concentrator weekly and as needed. If patient begans (sic.) to use, check humidification cannister each visit and add water as needed." 2.) On 09/10/2025, Hospice Social Worker L documented the following, "[Resident 1] ...was admitted to [Name Of Hospice Provider] on 8/25/25 with ALS (amyotrophic lateral sclerosis)." 3.) On 09/10/2025, the durable medical equipment list included: Oxygen Concentrator	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 385	Continued From page 6	N 385		

and oxygen tanks.
4.) On 10/04/2025 at 8:21 AM, Hospice Nurse M documented a phone call from Family Member B, " ... [Resident 1] was struggling to breathe and isn't able to use [his/her] call light ...Director talked to staff, they were in pt's room as pt did press [his/her] call light. They elevated the HOB. They reported [s/he] doesn't have oxygen there and are requesting a nurse visit. Writer inquired if they tried any other interventions such as administering inhaler or morphine. [Caregiver N] was not sure. Writer also noted oxygen is on pt DME list so believed it should be there, but if not we can also try using a fan directed towards pt face ...". (Source: The Mayo Clinic Website, Amyotrophic Lateral Sclerosis, 1998-2025, https://www.mayoclinic.org/diseases-conditions/amyotrophic-lateral-sclerosis/symptoms-causes/syc-20354022 (retrieval date - December 10, 2025).)

The Mayo Clinic website defines ALS as, "Amyotrophic lateral sclerosis (a-my-o-TROE-fik LAT-ur-ul skluh-ROE-sis), known as ALS, is a nervous system disease that affects nerve cells in the brain and spinal cord. ALS causes loss of muscle control. The disease gets worse over time ...ALS often begins with muscle twitching and weakness in an arm or leg, trouble swallowing or slurred speech. Eventually ALS affects control of the muscles needed to move, speak, eat and breathe. There is no cure for this fatal disease."

On 12/09/2025, Surveyor reviewed Resident 1's temporary service plan. The diagnoses listed in Resident 1's temporary service plan were as follows: encounter for palliative care, weakness, obesity, carpal tunnel syndrome, major depressive disorder, hypothyroidism, solitary pulmonary nodule, essential hypertension,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014202	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASCOM HALL	111 OWEN RD MONONA, WI 53716

(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 385	Continued From page 7 osteoarthritis of the shoulder and hyperlipidemia. Resident 1's order for PRN (as needed) oxygen therapy wasn't documented. On 12/09/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator A, Nurse E, Regional Nurse J and Regional Director K. Administrator A, Nurse E, Regional Nurse J and Regional Director K acknowledged ALS was Resident 1's primary diagnosis and a disease which causes progressive disability until death. Administrator A, Nurse E, Regional Nurse J and Regional Director K acknowledged Resident 1's ISP didn't document Resident 1's primary diagnosis of ALS and related complications. CROSS REFERENCE: N0352 DHS Chapter 83.32(3)(h) Rights Of Residents: Receive Medications	N 385		