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	0020366	A. BUILDING: _____ B. WING _____	C 07/28/2025

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COPPERLEAF ASSISTED LIVING OF SCHOFIELD	1408 LILI LANE SCHOFIELD, WI 54476

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N 000	Initial Comments On 07/28/2025, Surveyor conducted a complaint investigation at Copperleaf Assisted Living of Schofield. The complaint was substantiated. Two deficiencies were identified. Census: 23	N 000		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there were sufficient numbers of employees on a 24-hour basis to meet the needs of all residents. Findings include: The provider is licensed to care for 25 residents in the client groups emotionally disturbed/mental illness, developmentally disabled, physically disabled, advanced aged, terminally ill, and irreversible dementia/Alzheimer's disease. On 07/28/2025 at 9:15 AM, Surveyor interviewed Director A. Director A stated staffing had been better the past few months. Director A stated the day and evening shifts usually had 2 caregivers with 1 support staff as a caregiver and cook. Director A stated the overnight shift only had 1 staff. Director A stated the other provider next door had 2 staff on the overnight shift and 1 staff	N 396		

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

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N 396	Continued From page 1 would float over if needed. On 07/28/2025 at 9:46 AM, Surveyor interviewed Resident 2. Resident 2 stated that approximately 3 times per week, s/he would have wait times of up to 1 hour for staff to take him/her to the bathroom. Resident 1 stated s/he would end up being incontinent due to the wait time. On 07/28/2025 at 10:24 AM, Surveyor interviewed Resident 3 and Family Member (FM) G. FM G stated that since his/her last hospitalization a couple weeks ago, Resident 3 required supervision with toileting. Resident 3 stated that sometimes s/he would take him/herself to the bathroom due to staff being too busy and/or s/he would have a long wait for staff to come. Resident 3 stated s/he was the overnight hours 3 to 4 times to use the bathroom. Resident 3 stated that sometimes staff would make comments when they came to toilet him/her, that s/he was not the only resident and to stop drinking water at night. Resident 3 stated the "other night" s/he wanted to go to bed at 9:30 AM and it was 10:30 PM before staff came to help him/her. On 07/28/2025 at 11:11 AM, Surveyor interviewed Caregiver H. Caregiver H stated they were frequently short staff and there was 1 staff on restrictions, which prevented him/her helping with resident cares. Caregiver H stated staff in the other building next door only come over to help if asked to. Caregiver H stated there were approximately 4 residents that could at times require assistance from 2 staff for transfers. On 07/28/2025 at 11:31 AM, Surveyor interviewed Caregiver E. Caregiver E stated s/he had been employed since March 2024 and was the day	N 396		

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shift team lead. Caregiver E stated that when staff "called in" (for absence) to work, it made the day shift more challenging. Caregiver E stated that sometimes a caregiver from another provider within the company would come to work at this provider. Caregiver E stated weekends were more "hectic" and staff had less support. Caregiver E stated that on the day shift, the busiest time was between 8:30 AM and 10:30 AM, and sometimes residents would have a longer wait time than usual, but no more than 10 to 15 minutes. Caregiver E explained this was not intentional, but staff could not be in 5 places at once. Caregiver E stated that some residents got frustrated with waiting for staff to come. Caregiver E stated staff had 2 pagers and there was a call light system staff had to shut off in the staff break room. Caregiver E stated that once a 2-staff assisted transfer was completed, the other staff would go help other residents. Caregiver E stated it was not ideal for residents to wait more than 15 minutes but it did occur on occasion. Caregiver E stated there was only 1 staff scheduled on the overnight shift and another staff that worked in the other building next door that would float over to help if needed. Caregiver E indicated there were approximately 4 residents that sometimes needed 2-staff assistance with transfers. Caregiver E stated Resident 1 did not get up on the overnight shift and Resident 2 was not listed as a 2-staff assist in his/her Individual Service Plan (ISP), but sometimes needed the extra help.

On 07/28/2025 at 12:07 AM, Surveyor interviewed Resident 1. Surveyor observed Resident 1 was still in bed and asked Resident 1 about it. Resident 1 stated s/he liked to sleep later in the morning but had wanted to get up 30 minutes ago and was waiting for staff. Resident 1 pressed his/her call button at 12:10 PM. Resident

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N 396	Continued From page 3 1 stated that usually, there were 2 staff to assist him/her but sometimes only 1 staff assisted him/her to go to bed. At 12:14 PM, Caregiver F peaked in Resident 1's room to see what s/he needed. Caregiver F left and returned at 12:16 PM with Caregiver H. At 12:18 PM, Administrator B arrived and offered assistance. Caregiver H left Resident 1's room to go back to the kitchen to help with lunch. At 12:20 PM, Director A arrived and also offered assistance. Surveyor observed Resident 1's pivot transfer with a gait belt and all 3 staff assisting. On 07/28/2025 at approximately 12:30 PM, Surveyor reviewed the staff schedule, lift policy and procedure, and records for Resident 1, Resident 2, Resident 3, and Resident 4. Resident 1 was admitted to the provider on 04/01/2016. Resident 1 had diagnoses that included cerebral infarction (stroke), type 1 and 2 diabetes mellitus, chronic kidney disease stage 4, anemia, ischemic cardiomyopathy, depression, and anxiety disorder. Resident 1's ISP, dated 07/10/2025, indicated Resident 1 required partial assistance with ambulating and required 1 staff to assist with a pivot transfer using a gait belt into his/her motorized wheelchair. The ISP indicated Resident 1 was a risk for falls due to his/her left sided weakness. The Resident Evacuation Assessment, dated 07/09/2025, indicated Resident 1 would be able to evacuate the building in an emergency after a "full transfer assistance from 2 staff members". Resident 2 was admitted to the provider on 08/07/2023. Resident 2 had diagnoses that included chronic myeloid leukemia, herniated nucleus pulposus, multi-level degenerative disc disease, frailty syndrome, pressure ulcer to heel	N 396		

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and buttock, congestive heart failure, atrial fibrillation, primary osteoarthritis, spondylosis with radiculopathy in the lumbar region, chronic kidney disease, and dysuria. Resident 2's ISP, with unknown date, indicated Resident 2 required full assistance from staff to ambulate and transfer using a sit-to-stand. The ISP read, in part, "[Resident 2] is able to evacuate facility in less than 4 minutes with total assistance from staff, only if they are already in their wheelchair. If resident is in bed, they are a point of rescue due to it taking two staff members, a mechanical lift and greater than 4 minutes to exit community."

Resident 4 was admitted to the provider on 03/01/2024. Resident 4 had diagnoses that included type 2 diabetes, depression, anxiety disorder, effusion of right shoulder, dorsalgia, repeated falls, weakness, and fracture of upper end of right humerus. Resident 4's ISP, with unknown date, indicated Resident 4 required full assistance from staff for ambulation. The ISP indicated Resident 4 could use a wheelchair and was unable to self-propel. The ISP read, in part, "Max (maximum) of 2 for transfers or use of sit to stand [sic] with increased weakness ...Resident is able to evacuate facility in less than 4 minutes with total assistance from staff, only if they are already in their wheelchair. If resident is in bed, they are a point of rescue due to it taking two staff members, a mechanical lift and greater than 4 minutes to exit community ...Resident is a Max of 2 assist out of bed and moves slowly."

Resident 5 was admitted to the provider on 11/07/2020. Resident 5 had diagnoses that included bilateral leg edema, diet-controlled type 2 diabetes mellitus, osteoporosis, bimalleolar ankle fracture, osteopenia, generalized epilepsy and paroxysmal dyskinesia syndrome, obesity,

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vascular dementia, anxiety disorder, and chronic heart failure. Resident 5's ISP, with unknown date, indicated Resident 5 required full assistance from staff to ambulate and used a wheelchair with staff assisting to push it where s/he needed to go. The ISP read, in part, "Resident is able to evacuate facility in less than 4 minutes with total assistance from staff, only if they are already in their wheelchair. If resident is in bed, they are a point of rescue due to it taking two staff members, a mechanical lift and greater than 4 minutes to exit community." The ISP indicated Resident 5 was a high risk for falls and used the mechanical lift at times for weakness. The Resident Evacuation Assessment, dated 07/17/2025, read, in part, "Resident is a POR (point of rescue) due to mechanical lift and refusals".

The Safe Resident Handling policy and procedure indicated residents who needed a total body lift required 2 staff for assistance. The policy and procedure indicated that if a resident were to fall and was not able to get up on their own, staff should use a total body lift to get the resident off the floor.

The staff schedule for March 2025 to current, noted that 2 staff were scheduled for each day and evening shift with a support staff for all or part of the shift. The schedule indicated typically there was only 1 staff scheduled to work on the overnight shift from 11:00 PM to 7:00 AM.

On 07/28/2025 at approximately 2:45 PM, Surveyor interviewed Director A, Administrator B, Regional Director of Operations (RDOO) C, and Director D. Administrator B stated in response to the one staff having restrictions, that they still always had 2 other staff on the schedule with the

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N 396	Continued From page 6 staff on restrictions as support staff. Director D stated the float staff in the other building would only come over to help in an emergency when there was only 1 staff on the overnight shift. Director D stated s/he lived only minutes away and would come in to help if needed as well. There were not sufficient numbers of employees on the overnight shift to meet the needs of all residents, with 4 residents requiring 2-staff assistance with transfers and only 1 staff at the provider.	N 396		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure Resident 1 was provided with medication administration appropriate to the resident's needs. Findings include: The provider is licensed to care for 25 residents in the client groups emotionally disturbed/mental	N 432		

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N 432	Continued From page 7 illness, developmentally disabled, physically disabled, advanced aged, terminally ill, and irreversible dementia/Alzheimer's disease. On 07/28/2025 at approximately 12:10 PM, Surveyor was interviewing Resident 1 in his/her room and observed a paper medication cup sitting on his/her bedside table with multiple medications in it. Surveyor asked Resident 1 about the medications. Resident 1 stated Caregiver E brought the medications around 7:00 AM that morning and s/he planned to still take them. At 12:20 PM, Director A, Administrator B, and Caregiver F arrived to help Resident 1 out of the bed for the day. Staff were in the room for approximately 15 to 20 minutes and got Resident 1 up in his/her motorized chair. Before leaving his/her room, Surveyor observed Resident 1 pick up his/her medication cup and bring it to his/her mouth as if s/he was going to take them, then set them back down on the bedside table. Resident 1 left his/her room without taking his/her medications to go to the dining room. On 07/28/2025 at 12:58 PM, Surveyor interviewed Caregiver E. Caregiver E stated s/he took Resident 1's medications into his/her room this morning when s/he gave Resident 1 his/her insulin. Caregiver E stated s/he observed Resident 1 grab his/her drink and thought Resident 1 was going to take his/her medications. Caregiver E stated s/he left Resident 1's room before confirming that Resident 1 took them. Caregiver E confessed s/he was not supposed to leave the medications with the resident but observed the resident take them. Surveyor explained the medications were still at Resident 1's bedside table and Caregiver E stated s/he was not aware of that. Surveyor observed Caregiver E go to Resident 1's room to retrieve	N 432		

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N 432	Continued From page 8 the medications. At approximately 1:30 PM, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 04/01/2016. Resident 1 had diagnoses that included cerebral infarction (stroke), type 1 and 2 diabetes mellitus, chronic kidney disease stage 4, anemia, hyperlipidemia, hypokalemia, ischemic cardiomyopathy, gastroesophageal reflux disease, depression, and anxiety disorder. Resident 1's Individual Service Plan (ISP), dated 07/10/2025, indicated the provider managed Resident 1's medications. The ISP read, in part, "[Resident 1] often refused [his/her] morning medications due to [him/her] not waking up until the early afternoon." The ISP indicated Resident 1 was on a blood thinner. Resident 1's Medication Administration Record (MAR) for July 2025 indicated Caregiver E charted s/he administered the following oral medications to Resident 1 at 9:00 AM on 07/28/2025: - Aspirin 81 mg for heart attack prevention - Escitalopram 20 mg for depression - Ezetimibe 10 mg for hypercholesterolemia - Metropolol Succinate ER 25 mg for ischemic cardiomyopathy - Vitamin D3 2,000 IU for vitamin deficiency - Potassium chloride 10 mEq for hypokalemia - Ferrous sulfate 325 mg for iron supplement - Calcium citrate 200 mg for calcium replacement - Famotidine 20 mg for GERD - Eliquis 5 mg (blood thinner). On 07/28/2025 at approximately 2:45 PM, Surveyor interviewed Director A, Administrator B, Regional Director of Operations (RDOO) C, and Director D. Surveyor asked if Caregiver E had	N 432		

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N 432	Continued From page 9 informed them about the medication concern for Resident 1. Director A stated that Caregiver E had let them know and the expectation was for staff to watch residents take their medications and not leave them at the bedside. Director A stated the medication would be destroyed, would follow-up with Resident 1's physician, and document the medication error.	N 432		