STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009432	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELLURIAN TRANSITIONAL HOUSING	300 FEMRITE DR MADISON, 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 03/26/2025, The Bureau of Assisted Living, Southern Regional Office conducted a standard survey at Tellurian Transitional Housing, a CBRF located in Madison, WI. Three deficiencies were identified. One deficiency was a repeat deficiency. See Statement of Deficiency (SOD), 9DTJ11 dated, 05/18/2021 and SOD 9DTJ12, dated 09/22/2021. Census: 16	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 caregivers reviewed, were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Caregiver A and Caregiver B were not screened for clinically apparent communicable disease,	N 220		

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
	0009432	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELLURIAN TRANSITIONAL HOUSING	300 FEMRITE DR MADISON, 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 220	Continued From page 1 including tuberculosis, within 90 days before the start of employment. This is a repeat deficiency. See Statement of Deficiency (SOD), 9DTJ11 dated, 05/18/2021 and SOD 9DTJ12, dated 09/22/2021. Findings include: On 03/25/2025 at approximately 8:30 a.m., Surveyor requested an employee roster and records from Director of Human Resources C. Director of Human Resources provided records that did not include tuberculosis tests for Caregiver A and Caregiver B. At approximately 11:45 a.m., Surveyor Interviewed Director of Human Resources C regarding the missing tuberculosis tests. Director of Human Resources C stated those records could be in another area and s/he would email the tuberculosis tests. Surveyor requested that records, including staff screened for clinically apparent communicable disease, including tuberculosis be sent over by 12:00 p.m. on 03/26/2025. On 03/26/2025 at 9:19 a.m., Surveyor received an email from Director of Human Resources C. Director of Human Resources C indicated in the email that the facility was unable to locate a tuberculosis test for Caregiver A and Caregiver B.	N 220		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009432	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELLURIAN TRANSITIONAL HOUSING	300 FEMRITE DR MADISON, 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 243	Continued From page 2 rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009432	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELLURIAN TRANSITIONAL HOUSING	300 FEMRITE DR MADISON, 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 243	Continued From page 3	N 243		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 2 of 2 employees reviewed had completed training in resident rights, client group or challenging behaviors. Caregiver A and Caregiver B did not obtain all trainings required within 90 days after starting employment.

Findings include:

On 03/25/2025 at approximately 8:30 a.m., Surveyor requested an employee roster and employee records from Director of Human Resources C to verify compliance with all employee training requirements. Director of Human Resources C provided training records indicated below:

Resident Rights

The record for Caregiver A, hired 04/08/2024, contained evidence of training in resident rights, dated 12/09/2024, approximately 5 months after the 90-day requirement.

The record for Caregiver B, hired 08/05/2024, contained evidence of training for resident rights, dated 03/03/2025, approximately 5 months after the 90-day requirement.

Recognizing, Preventing, Managing and Responding to Challenging Behaviors

The record for Caregiver A, hired 04/08/2024, contained evidence of training in challenging behaviors, dated 10/20/2024, approximately 3 months after the 90-day requirement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009432	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELLURIAN TRANSITIONAL HOUSING	300 FEMRITE DR MADISON, 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 243	Continued From page 4 The record for Caregiver B, hired 08/05/2024, contained evidence of training in challenging behaviors, dated 01/12/2025, approximately 2 months after the 90-day requirement. Client Group The record for Caregiver A, hired 04/08/2024, contained evidence of training in client groups, dated 10/22/2024, approximately 3 months after the 90-day requirement. The record for Caregiver B, hired 08/05/2024, contained evidence of training in client groups, dated 03/03/2025, approximately 5 months after the 90-day requirement. On 03/25/2025 at approximately 12:00 p.m., Surveyor interviewed Director of Human Resources C. Director of Human Resources C confirmed that Caregiver A and Caregiver B had completed the training in resident rights, client group and challenging behaviors. Director of Human Resources C did confirm that the trainings were not obtained within the required 90 days after starting employment.	N 243		
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	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009432	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELLURIAN TRANSITIONAL HOUSING	300 FEMRITE DR MADISON, 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 408	Continued From page 5	N 408		

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 record review and interview, the provider did not include the rationale for use and description of the behaviors which indicate the need for administration in the Individual Service Plan (ISP) of 1 of 1 residents reviewed receiving psychotropic medications as needed. The rational for administration of Lorazepam 1 mg and a description of Resident 1's behaviors was not included in Resident 1's ISP.

Findings include:

On 03/25/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 11/19/2024 with a diagnosis of schizophrenia. Resident 1's physician order included Lorazepam 1mg - Give 1 tablet oral, every 6 hours as needed for schizophrenia.

Surveyor reviewed Resident 1's ISP, dated 01/06/2025. The ISP did not include the rationale for use and description of behaviors that would warrant administration of Resident 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009432	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELLURIAN TRANSITIONAL HOUSING	300 FEMRITE DR MADISON, 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 408	Continued From page 6 Lorazepam. The Mental health/AODA category of Resident 1's ISP documented, "Report any changes in mental health, remain sober and attend related appointments as needed" but did not give a description of the behaviors or list Resident 1's use of Lorazepam 1 mg as needed. Surveyor reviewed Resident 1's Medication Administration Record (MAR). The MAR indicated Resident 1's Lorazepam as needed was administered on 11/29/2024, 02/12/2025 and 03/09/2025. The MAR did not include a detailed description of behaviors that would warrant administration of Resident 1's Lorazepam. On 03/25/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 1's ISP with Program Supervisor D. Surveyor discussed concern that Resident 1's ISP did not include the rationale for use and description of the behaviors which indicate the need for administration of Resident 1's Lorazepam. Program Supervisor D stated that s/he would check in with the team clinician and see if the rationale of use or behavior description was documented on other paperwork. At approximately 11:45 a.m., Surveyor interviewed Director of Community Housing E. Director of Community Housing E confirmed that the rational for use and behavior description for the Lorazepam 1 mg was not documented in the ISP. Director of Housing E stated that "it will be added to the ISP by the end of the day."	N 408		