STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 03/05/2025, the bureau of assisted living southern regional office conducted a standard and complaint investigation at 1st Health LLC 2 a CBRF located in Monroe, WI. As a result of this survey, 6 violations of DHS Chapter 83 were identified. Complaint was unsubstantiated. Census: 7	N 000		
N 189	83.13(3)(b) Post house rules, resident rights, grievances The CBRF shall post all of the following: House rules, resident rights and grievance procedures as required under s. DHS 83.32(2) (b). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the following was posted: house rules, resident rights, and grievance procedure. FINDINGS INCLUDE: On 03/05/2025, Surveyor arrived at facility for a standard survey. On 03/05/2025, Surveyor toured the facility. Surveyor could not locate the house rules, resident rights, and/or grievance procedure posted in a common area of the facility. On 03/05/2025 at 11:00 AM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged the facility did not have the house rules, resident rights, and	N 189		

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
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 189	Continued From page 1 grievance procedure posted in a common area of the facility. CROSS REFERENCE: N0191 DHS Chapter 83.13(3)(d) Posting Activity Schedule CROSS REFERENCE: N0450 DHS Chapter 83.41(2)(c) Nutrition: Menus	N 189		
N 191	83.13(3)(d) Posting activity schedule. The CBRF shall post all of the following: Activity schedule as required under s. DHS 83.38(1)(c). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an activity schedule was posted. FINDINGS INCLUDE: On 03/05/2025, Surveyor toured the facility. Surveyor could not find an activity schedule posted in a common area of the facility. On 03/05/2025 at 8:10 AM, Surveyor interviewed Caregiver B and asked where the activity schedule was posted. Caregiver B reported staff complete activities with residents. However, s/he was not aware of an activity schedule posted for residents to review. On 03/05/2025 at 11:00 AM, Surveyor discussed the above concern with Administrator A. Administrator A reported the facility had leisure time activities available to residents throughout the week. Administrator A reported some residents preferred one-on-one time to talk to staff. Administrator A acknowledged a monthly	N 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 191	Continued From page 2 schedule of daily activities hadn't been posted in a resident common area. CROSS REFERENCE: N0189 DHS Chapter 83.13(3)(b) Post House Rules, Resident Rights, Grievances CROSS REFERENCE: N0450 DHS Chapter 83.41(2)(c) Nutrition: Menus	N 191		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation of medication administration at the time of medication administration, the person administering the medication or treatment documented in the resident record the name, dosage, date, and time of medication taken or treatments performed and initialed the medication administration record (MAR). From 02/01/2025 to 02/28/2025, 30 doses of	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 415	Continued From page 3	N 415		

Resident 1 and Resident 2's prescription medications were not documented on their February 2025 MARs.

FINDINGS INCLUDE:

The provider was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's.

On 03/05/2025, Surveyor arrived at facility for a standard survey.

EXAMPLE 1: Resident 1

On 03/05/2025 at 11:18 AM, Surveyor emailed Licensee C requesting Resident 1's face sheet and February 2025 medication administration record (MAR).

On 03/07/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 08/26/2023. Resident was diagnosed with but not limited to: glaucoma.

On 03/07/2025, Surveyor reviewed Resident 1's February 2025 MAR. The following dosages of medication were not documented as administered or refused:
1.) 02/01/2025-8:00PM- Brimonidine-Timolol 0.2%-0.5% eye drops
2.) 02/11/2025-8:00AM- Brimonidine-Timolol 0.2%-0.5% eye drops
3.) 02/03/2025 - 8:00PM - Melatonin 10 MG ER Tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 415	Continued From page 4 4.) 02/04/2025 - 8:00PM - Melatonin 10 MG ER Tablet 5.) 02/05/2025 - 8:00PM - Melatonin 10 MG ER Tablet 6.) 02/06/2025 - 8:00PM - Melatonin 10 MG ER Tablet 7.) 02/10/2025 - 8:00PM - Melatonin 10 MG ER Tablet 8.) 02/15/2025 - 8:00PM - Melatonin 10 MG ER Tablet 9.) 02/16/2025 - 8:00PM - Melatonin 10 MG ER Tablet 10.) 02/17/2025 - 8:00PM - Melatonin 10 MG ER Tablet 11.) 02/18/2025 - 8:00PM - Melatonin 10 MG ER Tablet 12.) 02/03/2025 -8:00 PM - Latanoprost 0.005% eye drops 13.) 02/15/2025 -8:00 PM - Latanoprost 0.005% eye drops 14.) 02/16/2025 -8:00 PM - Latanoprost 0.005% eye drops 15.) 02/17/2025 -8:00 PM - Latanoprost 0.005% eye drops 16.) 02/18/2025 -8:00 PM - Latanoprost 0.005% eye drops 17.) 02/12/2025 - 8:00 AM - Dorzolamide HCL 2% eye drops 18.) 02/04/2025 - 8:00 PM - Dorzolamide HCL 2% eye drops 19.) 02/05/2025 - 8:00 PM - Dorzolamide HCL 2% eye drops 20.) 02/06/2025 - 8:00 PM - Dorzolamide HCL 2% eye drops 21.) 02/10/2025 - 8:00 PM - Dorzolamide HCL 2% eye drops EXAMPLE 2: Resident 2 On 03/07/2025, Surveyor reviewed Resident 2's	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 415	Continued From page 5 facility record. Resident 2 was admitted to the facility on 07/20/2024. Resident 2 was diagnosed with but not limited to: anxiety. On 03/07/2025, Surveyor reviewed Resident 2's February 2025 MAR. The following dosages of medication were not documented as administered or refused: 1.) 02/05/2025- 8:00 PM - Mirtazapine 7.5 mg tablet 2.) 02/20/2025- 8:00 PM - Mirtazapine 7.5 mg tablet 3.) 02/25/2025- 8:00 PM - Mirtazapine 7.5 mg tablet 4.) 02/05/2025 - 8:00 PM - Carvedilol 3.125 mg tablet 5.) 02/20/2025 - 8:00 PM - Carvedilol 3.125 mg tablet 6.) 02/25/2025 - 8:00 PM - Carvedilol 3.125 mg tablet 7.) 02/05/2025 - 8:00 PM - Melatonin 3 mg tablet 8.) 02/20/2025 - 8:00 PM - Melatonin 3 mg tablet 9.) 02/25/2025 - 8:00 PM - Melatonin 3 mg tablet INTERVIEW: On 03/07/2025 at 2:00 PM, Surveyor interviewed Licensee C about the documentation concern. Licensee C confirmed Resident 1 and Resident 2's February 2025 MARs did not contain complete documentation of medication administration as evidenced by 30 blank entries and acknowledged understanding and importance of the requirement.	N 415		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 450	Continued From page 6 food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure weekly written menus were made available to residents. FINDINGS INCLUDE: On 03/05/2025, Surveyor toured the facility. Surveyor did not observe a weekly written menu posted in a common area of the facility. On 03/05/2025 at 8:10 AM, Surveyor interviewed Caregiver B and asked where the weekly menu was posted. Caregiver B reported the weekly menu was kept in the kitchen for staff to follow. Caregiver B stated s/he did not know if there was a weekly menu available to residents. Caregiver B showed Surveyor that staff write the daily menu on a dining area chalk board for residents to review. On 03/05/2025 at 11:00 AM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged facility did not have a written weekly menu easily available to residents. CROSS REFERENCE: N0189 DHS Chapter 83.13(3)(b) Post House Rules, Resident Rights, Grievances CROSS REFERENCE: N0191 DHS Chapter 83.13(3)(d) Posting Activity Schedule	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF used dryer vent tubing that was of ridged material with a fire rating exceeds the temperature rating of the dryer. FINDINGS INCLUDE: On 03/05/2025, Surveyor arrived at facility for a standard survey. On 03/05/2025, Surveyor observed the dryer vent tubing attached to the CBRF dryer was made of 'flexible' material (Picture 1). On 03/05/2025 at 8:45 AM, Surveyor and Administrator A went into the facility laundry room. Administrator A acknowledged the dryer vent tubing was made out of an 'accordion style' flexible material. CROSS REFERENCE: N0525 DHS Chapter 83.47(2)(d) Fire Drills	N 488		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 525	Continued From page 8	N 525		

employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure fire evacuation drills were conducted at least quarterly with both employees and residents.

FINDINGS INCLUDE:

Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's.

On 03/05/2025, Surveyor arrived at facility for a standard survey.

On 03/05/2025 at 11:18 AM, Surveyor sent Licensee C an email requesting all 2024 fire drills

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020009	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC 2	316 3RD AVE MONROE, WI 53566

(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 525	Continued From page 9 and severe weather drills. On 03/05/2025 at 4:08 PM, Surveyor received and email from Licensee C. The email did not contain documentation of 2024 fire drills. On 03/07/2025 at 2:00 PM, Surveyor discussed the above concern with Licensee C. Licensee C acknowledged s/he did not have documentation of quarterly fire drills completed during the calendar year of 2024 from when the facility was first licensed. Surveyor explained the requirement for quarterly fire drills. CROSS REFERENCE: N0488 DHS Chapter 83.44(1)(c) Clothes Dryers Enclosed And Vented	N 525		