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N 000	Initial Comments From 01/27/2026 to 01/29/2026, the bureau of assisted living southern regional office conducted a complaint investigation at Bascom Hall at CBRF located in Monona, WI. As a result of this survey, 1 violation of DHS Chapter 83 was issued. Complaint was substantiated. Census: 20	N 000		
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 observation, record review, and interview, the provider didn't arrange medication administration services adequate to meet Resident 1's needs. On 09/18/2025, Resident 1 was admitted to the facility. Resident 1 was on hospice services and diagnosed with but not limited to chronic pain prior to admission.	N 432		

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

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N 432	Continued From page 1 On 01/14/2026 at approximately 4:30 PM, Dean Of Nursing (DON) B and Hospice Nurse F assessed Resident 1's condition had declined and planned for his/her pain to be managed by adding the narcotic Morphine Sulfate (Sul) to his/her medication administration record (MAR). DON B explained to Hospice Nurse F provider's usual pharmacy wouldn't be able to fill a Morphine Sul script until the next day. Immediately following the assessment, Hospice provider faxed a telephone order (T.O) to add PRN (as needed) Morphine Sul Solution (Soln) 10mg Q2HR (every 2 hours) to provider and a local branch of Walgreen's pharmacy. Family Member G picked up the Morphine Sul Soln from Walgreen's and delivered it to facility staff who secured it in Assistant DON B's office. On 01/15/2026 at midnight, Doctor N's order for PRN Morphine Sul Soln 10mg Q2HR was transcribed to Resident 1's medication administration record (MAR) and physician order list. On 01/15/2026 at approximately 12:50 AM, Family Member G and Hospice Nurse K observed Resident 1 displaying increased signs of non-verbal pain and advocated for Resident 1 to receive his/her PRN Morphine Sul Soln 10mg. Med Passer on duty called DON B and it was decided Doctor N's T.O. for Morphine Sul wasn't valid, when Hospice Nurse K was notified s/he called Hospice Nurse E. Hospice Nurse E contacted provider's usual pharmacy to "push through" the PRN Morphine Sul Soln order. Hospice Nurse K contacted DON B and offered to prefill/cap single doses of Morphine Sul Soln for facility med passers to administer. DON B maintained the T.O. wasn't valid and refused to	N 432		

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have Hospice Nurse K pre-fill/cap syringes of morphine sulfate dispensed by Walgreen's pharmacy.

Instead, it was decided Family Member G would keep the bottle of Morphine Sulfate Soln on their person and administer doses to Resident 1 without documenting administrations on the MAR.

From 01/15/2026 at 1:37 AM, Family Member G administered PRN Morphine Sul Soln 10mg every 2-3 hours to treat Resident 1's terminal pain until approximately 5:00 PM. Provider then permitted Hospice Nurse F to draw up 10 pre-filled syringes of Morphine Sulf Soln 0.5ml/10mg doses from the Walgreen's bottle, secure the 10 doses in provider's medication cart, and waste the remainder of Morphine Sul Soln from the bottle with Family Member G.

On 01/16/2026 at approximately 9:30 AM, Family Member G and Hospice Nurse F returned to Resident 1's room and found him/her to be displaying increased signs of non-verbal pain. Hospice Nurse F reported to facility med passer Resident 1 was in pain and asked when s/he last received PRN Morphine Sul Soln. Med Passer showed Hospice Nurse F all 10 syringes of Morphine Sul Soln s/he had filled the day before remained in the medication cart, and verified facility staff hadn't administered any PRN Morphine Sul Soln to Resident 1.

Provider's usual pharmacy delivered Resident 1's PRN Morphine Sul Soln script on 01/16/2026. The first dose of PRN Morphine Sul Soln 10 mg administered by provider was at 10:07 AM.

From 01/16/2026 until Resident 1's passing on 01/18/2026, Family Member G hired a home

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health agency to spend the nights with Resident 1 to be sure his/her pain was adequately managed by provider's staff.

FINDINGS INCLUDE:

The facility provided care for the following client groups: irreversible dementia and Alzheimer's.

On 01/23/2026, the Department received a complaint about medication administration practices at facility.

On 01/27/2026, Surveyor arrived at the facility for a complaint investigation.

OBSERVATION:

On 01/27/2026 at 10:15 AM, Surveyor interviewed Med Passer H. Med Passer H stated s/he had gotten to know Resident 1 and his/her family well. Med Passer H spoke about Resident 1's family thanking them for their care of him/her. Med Passer H described Resident 1's decline in condition as the end of his/her life as "rapid." Med Passer H reported s/he had administered Morphine to Resident 1 at the end of his/her life. Med Passer H stated s/he was not the first staff member to administer his/her Morphine, and that a family member followed by a different facility staff had administered the Morphine prior. Med Passer H stated s/he remembered Family Member G was upset because the order for Morphine from the hospice wouldn't get filled at pharmacy quickly enough, but it was remedied by a different order instructing the facility to give the Morphine hourly. Med Passer H reported facility had given him/her training on how to administer liquid Morphine and identify signs of non-verbal pain. Med Passer H reported when s/he was

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giving Resident 1 his/her Morphine for the first time Med Passer H noticed Resident 1 breathing fast and loudly. Med Passer H reported the Morphine s/he had administered to Resident 1 had been effective in calming his/her breathing. Med Passer H stated s/he had heard from other staff about how Resident 1's family had been fearful Resident 1's pain wasn't controlled at the beginning of his/her decline. Med Passer H recalled being told that Family Member G had somehow obtained a bottle of liquid Morphine from Walgreens, but facility staff couldn't administer because it wasn't in Resident 1's medication administration record (MAR). So, it was decided the family would administer the Morphine to Resident 1 until facility was able to administer it. Med Passer H opened the facility medication cart and narcotic lock box for Surveyor. Surveyor observed a brown pharmacy bag, the order on the prescription label documented the order for Morphine Sulfate 0.5ml oral syringes to be administered Q4HR, with dispensed date of 01/15/2026 (Picture 1). Surveyor counted 43 oral syringes remaining in the brown bag and reviewed narcotic count record which documented 43 oral syringes (Picture 3). Surveyor observed a second brown pharmacy bag of Morphine Sulfate 0.5 ml oral syringes to be administered Q2HR, with dispensed date of 01/15/2026 (Picture 2). Surveyor counted 7 oral syringes remained in the brown bag (Picture 5) and reviewed the narcotic count record which documented 7 oral syringes (Picture 4).

RECORD REVIEW:

On 01/27/2026, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to facility on 09/18/2025. Resident 1 had an

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activated power of attorney. Resident 1 was diagnosed with but not limited to: anxiety disorder, pain, depression, and generalized abdominal pain.

On 01/27/2025, Surveyor reviewed Resident 1's admission agreement signed by Family Member G on 09/18/2025. Under the subsection titled, "Uses or Disclosures of Your Health Information," the following was documented, " ...Organized Health Care Arrangement. An organized health care arrangement is a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. We participate in organized health care arrangements with nursing homes, hospice, or home health agencies in connection with the services we furnish ..." Under the subsection about assessments and individualized services plans (ISP) the following was documented, "MEDICATION PROGRAM: Medication assistance will be given in compliance with DHS 83.37. All Resident Assistants will be trained to assist with medications. A Registered Nurse will oversee the entire program ..." Under the subsection titled, "Staffing Pattern," the following was documented, " ...A RN is on call and available 24 hours/day, 7 days/week ..."

On 01/27/2026, Surveyor reviewed Resident 1's ISP. The ISP was signed by Family Member G and DON B on 09/19/2025. Under the subsection titled, "MEDICATIONS," the following was documented, " ...ASSIST: I am unable to self administer medications. Staff assist with administering medication, reordering medications, and processing new prescriptions." Under the subsection titled, "HOSPICE CARE/PALLIATIVE CARE," the following was documented, "Staff work cooperatively with my

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hospice team to ensure my spiritual, emotional, intellectual, physical and social needs are met." Under the subsection titled, "ACUTE/CHRONIC (specify) PAIN R/T," the following was documented, " ...REPORT: to nurse and side effects of pain medication ..."

On 01/27/2026, Surveyor reviewed Resident 1's facility physician order list:
1.)"OXYCODONE TAB 5MG (Oxycodone HCL) TAKE 1 TABLET BY MOUTH TWICE DAILY FOR SHORTNESS OF BREATH OF PAIN(Indications for use: Pain) ...Electronically Transmitted from Pharmacy ...Order Date 11/06/2025 ...Start Date 12/25/2025 ...End Date ...01/18/2026."

2.) "MORPHINE SUL SOL 100/5ML (Morphine Sulfate) TAKE 0.5ML (10MG) BY MOUTH EVERY 2 HOURS AS NEEDED FOR SHORTNESS OF BREATH/PAIN ...Electronically Transmitted from Pharmacy ...Order Date 01/14/2026 ...Start Date 01/15/2026 ...End Date 01/16/2026"

3.) "MORPHINE SUL SOL 100/5ML (Morphine Sulfate) TAKE 0.5ML (10MG) BY MOUTH EVERY 4 HOURS AS NEEDED FOR SHORTNESS OF BREATH/PAIN ...Electronically Transmitted from Pharmacy ...Order Date 01/15/2026 ...Start Date 01/16/2026 ...End Date 01/20/2026"

4.) "Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 ml by mouth every 1 hours for restlessness ...Prescriber Written ...Order Date 01/17/2026 ...Start Date 01/17/2026." An end date was not documented with this order.

On 01/27/2026 at 10:00 AM, Surveyor requested from DON C all January 2026 orders for Resident

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N 432	Continued From page 7 1's medication orders received by facility: 1.) On 01/27/2026 at approximately 11:00 AM, DON C provided Surveyor with medication orders sent to facility in January 2026. Surveyor reviewed a telephone order from hospice provider. The order date and time was 01/14/2026 at 5:48 PM. Under the order description the following was documented, " ...VERBAL ORDER OBTAINED ...MORPHINE 20MG/ML GIVE 0.5ML EVERY 2 HOURS AS NEED FOR SHORTNESS OR PAIN ...Order Read Back to Physician/Agent of Physician?: Y ..." At the bottom of the order was Hospice RN F and Hospice RN E signatures. On 01/27/2026, Surveyor reviewed Resident 1's January 2026 MAR. Surveyor reviewed the following orders: 1.) "MORPHINE SUL SOL 100/5ML (Morphine Sulfate) TAKE 0.5ML BY MOUTH EVERY 2 HOURS AS NEEDED FOR PAIN/SHORTNESS OF BREATH (Indications for use: Pain) ...-Start Date-01/15/2026 0000 (midnight) ...-D/C Date-01/20/2026 0723 (7:23 AM) ..." The following doses were documented as follows: - 01/16/2026 at 10:07 AM -effective - 01/16/2026 at 2:52 PM - ineffective - 01/17/2026 at 1:02 AM - effective - 01/17/2026 at 4:14 PM - effective - 01/17/2026 at 6:15 PM - effective 2.) "MORPHINE SUL SOL 100/5ML (Morphine Sulfate) TAKE 0.5ML BY MOUTH EVERY 4 HOURS AS NEEDED FOR PAIN/SHORTNESS OF BREATH (Indications for use: Pain) ...-Start Date- 01/16/2026 0000 ... -D/C Date-01/27/2026 2010 (8:10 PM) ..." - From 01/16/2026 at midnight until 8:00 AM, Staff documented a "4" which on the MAR chart code means, "Med not available."	N 432		

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- From 01/16/2026 at noon until 01/17/2026 at 8:00 PM, the morphine sulfate solution was documented as administered for each 4-hour interval, equaling 9 doses.

3.) "Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 ml by mouth every 1 hours for restlessness ... -Start Date- 01/17/2026 2100 (9:00 PM) ... D/D Date 01/20/2026 1037 ..."
-From 01/18/2026 at midnight until 2:00 PM, the morphine sulfate solution was documented as administered for each 1-hour interval, equaling 15 doses.

On 01/27/2026, Surveyor reviewed a grievance filed by Family Member G on 01/23/2026. The grievance documented the following, " ...Concerning medications: [Family Member G] contacted the writer by phone regarding concerns that the resident's medications were not administered in a timely manner during [his/her] transition ...Summary conclusion: The findings indicated that hospice did provide facility with valid doctor's order in a timely manner. Orders were then received by facility and medications were administered ..."

On 01/27/2026, Surveyor reviewed Resident 1's Observation Notes:
1.) On 01/14/2026 at 4:00 PM, DON B documented the following, "Writer spoke with [Hospice Nurse F] at the facility for [Name Of Hospice Provider]. [S/He] stated that the resident is not doing well. [S/he] wishes to change [his/her] comfort medications. Writer stated that [s/he] needs to be the provide (sic.) call out pharmacy and not fax orders as it is right around the cut off time and if they are faxed, they may not be processed until tomorrow and then they wouldn't arrive until the following day. [Hospice Nurse F]

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N 432	Continued From page 9 state [s/he] understood." 2.) On 01/15/2026 at 12:50 AM, DON B documented the following, " ... Received call from facility - NOC med passer. Resident is actively dying. Hospice nurse also present. [Name Of Hospice Provider] Previously had sent a Morphine script to a local pharmacy, and [Family Member G] picked it up and gave it to a Med passer on the PM shift. Facility currently has no order for the Morphine. Morphine was placed in DON locked cabinet. When writer received the call at 0050 (12:50 AM) by the NOC Med passer and hospice nurse writer explained to both that we currently do not have an order and that the Hospice nurse would have to administer the medication. Writer had NOC Med passer retrieve the morphine and provide it to the hospice nurse. Hospice nurse also wanted to draw up liquid morphine to leave at the facility. Writer informed the Hospice nurse that the facility does not have any orders for liquid morphine and that [s/he] cannot leave it behind. Writer stated that if [s/he] needs it then [s/he] needs to administer it. It was decided that [Family Member G] can administer the morphine tablets and that (sic.) [s/he] had picked up earlier and [s/he] is aware that they are to be given every two hours ... had [Family Member G] signed (sic.) a piece of paper stating that [s/he] has the morphine and will administer it until heritage receives orders ..." 3.) On 01/15/2026 at 7:20 AM, DON B documented the following, "LATE ENTRY ...Writer knocked on Resident 1's door to provide an update to [Family Member G]. Resident is lying in bed with eyes closed. Arms were moving slowly, did not appear to be in any distress or experiencing any terminal agitation. [Family Member G] asked to step out of the room to the	N 432		

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N 432	Continued From page 10 hallway where we had a brief conversation where write informed the family member that writer will reach out to hospice ..." 4.) On 01/15/2026 at 7:50 AM, DON B documented the following, "Writer received scripts from [Name Of Hospice Provider]. They are not valid. They are T.O. (telephone order) on their end. Writer called [Name Of Hospice Provider] and they stated the Case Manager will be coming out at 0800 (8:00 AM) ..." On 01/27/2026, Surveyor reviewed facility policy number I.C.10 titled, "MEDICATION ADMINISTRATION," and documented the following in the procedure, " ...5. Resident medication orders are stored in the electronic medical recorded and administration documentation is completed in the Electronic Medication Administration Record (EMAR) ...6. All medications are securely stored in the medication cart and will be labeled appropriately. Controlled substances will be double locked ...17. Medications will be administered at the scheduled time per physician orders and per EMAR ... 21. New orders and prescription refills will be completed within a timely manner. Written orders for every medication will be maintained in the resident record." On 01/27/2026, Surveyor reviewed Resident 1's Comprehensive Assessment documented by DON B on 01/15/2026 at 9:00 AM. DON B documented under the subsection titled, "PAIN MANAGEMENT...Action: I prefer to have pain controlled by: Morphine...Action: REPORT: verbal/non-verbal indicators of pain such as: crying, moaning, grimacing, holding affected area, increased restlessness, irritability, agitation, taking rapid short breaths, etc. report to nurse."	N 432		

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N 432	Continued From page 11 Under the subsection titled, "Communication...3. Best description of speech pattern/clarity...No speech..." On 01/28/2026 at 1:25 PM, Surveyor received an email from Resident 1's home health provider. The email contained home health agency caregiver observation notes from 01/16/2026 until 01/18/2026. On 01/28/2026, Surveyor reviewed an email sent from DON C at 3:18 PM. Surveyor reviewed the following attachments: 1.) A file titled, "Family Member G Letter," was attached to the email. Surveyor reviewed the attached letter, "1/15/26 @ 1:37 am ...I [Family Member G] received morphine for [Resident 1] and will administer until [Name Of Facility] receives orders to do so ... [Signature Of Family Member G] ..." 2.) A file titled, "Pharmacy Packing Slips," was reviewed the first delivery of Morphine Sul Soln for Resident 1 was signed by Facility Nurse M on 01/16/2026. On 01/30/2026, Surveyor reviewed Resident 1's hospice record. The following entries were reviewed: 1.) On 01/14/2026 at 4:27 PM, Hospice Nurse F arrived at facility to visit Resident 1. Hospice Nurse F documented the following, "Narrative ...UPON ARRIVAL PATIENT IN RECLINER, [S/HE] WAS SHAKING WITH LABORED BREATHING. WRITER OBTAINED O2 SAT - 96% ON RA (ROOM AIR). WRITER DID APPLY OXYGEN FOR COMFORT ATLEAST 2 LITERS. PATIENT WAS ABLE TO ANSWER SIMPLE QUESTIONS BUT VERY SLOW TO RESPOND. PATIENT [FAMILY MEMBER G] PRESENT AND REPORTED THAT PATIENT WAS	N 432		

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N 432	Continued From page 12 STRUGGLING EARLIER TODAY AND STAFF HAD A HARD TIME TRANSFERRING PATIENT FROM WHEELCHAIR TO RECLINER. PATIENT DECLINED PAIN AND ALSO DECLINED SHORT OF BREATH. LORAZEPAM WAS GIVEN PRIOR TO ARRIVAL. WRITER DISCUSSED MORPHINE AND TO INCREASE LORAZEPAM TO EVERY 2 HOURS AS NEEDED FACILITY LPN REPORTED FOR WRITER TO SEND TO (SIC.) SCRIPTS TO WALGREENS AND FAMILY COULD PICK UP. [FAMILY MEMBER G] IS IN AGREEANCE AND WILL PICK UP AT WALGREENS ...WRITER UPDATED MED TECH TO CALL [NAME OF HOSPICE PROVIDER] WITH ANY FURTHER CHANGES OR CONCERNS. WRITER DID REPORT THAT IT IS OK TO LEAVE PATIENT IN BED. AS THIS IS ALSO REQUESTED BY [FAMILY MEMBER G] IF THAT IS WHAT PATIENT WOULD LIKE ..." 2.) On 01/14/2026 AT 11:40 PM, Hospice Nurse K arrived for a PRN hospice visit. Hospice Nurse K documented the following, " ...Vital Signs ...Pulse 96 ...Respirations 24 ...Respiration Characteristics: SHALLOW ...VISIT DETAILS ...REASON FOR PRN VISIT: POA AND DEATH DOULA REQUESTING VISIT, PT BREATHING SHALLOW AND WOULD LIKE [HIM/HER] TO HAVE MORPHINE BUT FACILITY DOES NOT HAVE ORDER YET ...Narrative ...WRITER WAS PAGED TO COME OUT TO FACILITY AS PATIENT HAD JUST RECEIVED NEW ORDERS FOR MORPHINE, AND FACILITY DID NOT HAVE ORDERS. THEREFORE, THEY WERE REQUESTING A VISIT BY A NURSE TO DRAW UP THE MORPHINE. AS THEY HAD TOLD TRIAGE THEY WERE UNABLE TO DO THIS ... WRITER CALLED AND SPOKE WITH [FACILITY NURSE L], WHO IDENTIFIED [HIMSELF/HERSELF] AS A NURSE. [S/HE]	N 432		

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N 432	Continued From page 13 STATED THAT THEY DON'T HAVE ANY ORDERS FOR THE MORPHINE TO GIVE. SO THERE IS NOTHING [S/HE] CAN CLICK OFF IN THE COMPUTER. WRITER THEN PLACED A CALL TO SUPERVISOR, [HOSPICE NURSE E], WHO WAS ABLE TO PUSH THE ORDER THROUGH. WRITER THEN CONTACTED FACILITY AND WAS UNABLE TO GET THROUGH. ATTEMPTED 3 TIMES TO CALL [FACILITY NURSE L] BACK AS WELL AS A DIFFERENT PHONE NUMBER LISTED, AND NO ANSWER ...WRITER WENT OUT TO FACILITY, AND [FAMILY MEMBER G] WAS VERY FRUSTRATED AS [S/HE] FELT THE FACILITY WAS VERY UNORGANIZED AND WAS HAVING DIFFCULTY FINDING STAFF AS WELL. WRITER DID FIND A STAFF MEMBER WHO TEXTED THE MED PASSER. WHO SHOWED UP 30 MINUTES LATER AND CALLED [HIS/HER] SUPERVISOR, [DON B], ON SPEAKERPHONE. [DON B] AT FIRST CALM AND STATED THAT THE ONLY WAY TO ADMINISTER MORPHINE TO PATIENT WOULD BE IF WRITER DID IT. WRITER DID GIVE ONE DOSE OF MORPHINE TO PATEINT; HOWEVER, THE MORPHINE WAS UNABLE TO BE LOCATED FOR OVER AN HOUR AS NO ONE IN THE FACILITY OR OVER THE PHONE KNEW WHERE IT WAS LOCATED. MED TECH ALSO HAD LEFT FACILITY AT SOME POINT ...THE MS04 (MORPHINE SULFATE SOLUTION) EVENTUALLY WAS LOCATED IN THE DON OFFICE. WHICH [S/HE] PROVIDED A CODE TO ONE OF THE STAFF MEMBER TO OBTAIN. WRITER INSTRUCTED MED TECH TO GIVE P.R.N. LORAZEPAM EVERY 2 HOURS AS PATIENT HAD A SIGNIFICANT DECLINE AND ANXIETY IN THE PAST 24 HOURS ...WHILE THIS WAS ALL TAKING PLACE, WRITER WAS WITH PATIENT AND [FAMILY	N 432		

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N 432	Continued From page 14 MEMBER G]. PATIENT HAS NOT BEEN ABLE TO GET OUT OF BED AS [S/HE] IS TOO WEAK. [S/HE] IS IN A SEMI-COMATOSE STATE. BREATHING WITH [HIS/HER] MOUTH OPEN AND SHALLOW BREATHS. [HIS/HER] HEART RATE WAS 95 ...THERE IS NO MOTTLING; HOWEVER, PATIENT IS PALE, WARM, AND DIAPHORETIC ...WRITER SPENT ROUGHLY 3 HOURS AT THE FACILITY BETWEEN ALL OF THE ABOVE EVENTS TAKING PLACE AND SEVERAL PHONE CALLS MADE BACK AND FORTH BETWEEN DON AND MED TECHS WRITER OBSERVED ONE OF THE CAREGIVERS WALKING INTO THE PATIENT'S ROOM AND YELLING AT [FAMILY MEMBER G] ... NONE OF THE STAFF MEMBERS HAD NAME TAGS ON. STAFF MEMBER WAS OBSERVED EATING A SANDWICH IN MEDS ROOM BEHIND THE MED TECH WHO WAS ARGUING WITH WRITER AND [FAMILY MEMBER G] THAT [S/HE] WORKS THERE AND NOTHING [S/HE] CAN DO ... WHILE WRITER WAS THERE MED PASSER HAD WALKED INTO A ROOM WITH [DON B] ON SPEAKER PHONE AND AT THAT TIME WRITER HAPPENED TO HAVE CASE MANAGER ALSO ON WORK PHONE, AND [S/HE] HAD STATED [S/HE] WAS EXTREMELY UNHAPPY WITH US FOR VARIOUS REASONS. WRITER INFORMED [HIM/HER] THAT THE ORDERS HAD BEEN PUSHED THROUGH AND THERE WAS NOTHING MORE TO DO UNTIL THEIR PHARMACY WOULD BE ABLE TO PROCESS THE ORDERS IN THEIR SYSTEM FOR STAFF TO ADMINISTER. HOWEVER, [DON B] WAS EXTREMELY LOUD AND AGGRESSIVE IN [HIS/HER] SPEECH AS FAR AS SAYING [S/HE] DOESN'T WANT THE MORPHINE AT THE FACILITY ..."	N 432		

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N 432	Continued From page 15 3.) On 01/15/2026 at 7:37 PM, Hospice Nurse F documented the following, "Narrative... UPON ARRIVAL PATIENT IN BED, MOUTH OPEN AND SLEEPING. WHEN WRITER DID SAY [HIS/HER] NAME AND ASK (SIC.) SIMPLE QUESTIONS [S/HE] DID RESPOND APPROPRIATELY ... [FAMILY MEMBER G] PRESENT FOR VISIT AND REPORTS THAT [S/HE] HAS BEEN COMFORTABLE. [S/HE] REPORTED THAT PRIOR TO WRITERS ARRIVAL [DON B] HAD COME IN AND WAS NOT VERY PLEASANT TO [HIM/HER] AND NOT ONCE LOOKED AT THE PATIENT. [S/HE] CALMLY ASKED [HIM/HER] TO GIVE PATIENT LORAZEPAM EVERY TWO HOURS FOR [HIS/HER] COMFORT. WRITER WAS REPORTED TO BY MED TECH THAT THEY STILL DO NOT HAVE ORDERS FOR THE MORPHINE OR THE LORAZEPAM ... [FAMILY MEMBER G] REPORTED THAT LAST NIGHT [S/HE] SIGNED A DOCUMENT FOR THE FACILITY SO THAT [S/HE] COULD ADMINISTER MORPHINE TO PATIENT. [S/HE] HAS BEEN GIVING PATIENT MORPHINE EVERY TWO HOURS. WRITER DISCUSSED WITH [FAMILY MEMBER G] AND [S/HE] IS GOING TO TRIAL GIVING MORPHINE EVERY FOUR HOURS AS NEEDED AND WE'LL ADJUST IF NEEDED... WRITER MADE TWO VISITS TO FACILITY TODAY AND TRIED TO CONTACT [DON B] BY PHONE TO COORDINATE WITH [HIM/HER] A PLAN OF CARE FOR PATIENT. [DON B] HAS NOT RETURNED WRITERS MESSAGE AND WRITER UNABLE TO LOCATE [HIM/HER] IN FACILITY... PATIENT DOES APPEAR TO BE TRANSITIONING AND IS BEING PLACED ON DAILY VISITS ...NOTE ...WRITER WAS UPDATED THAT [DON B] AT THE [NAME OF FACILITY] IS OK WITH RN TO COMING OUT TO PREFILL MORPHINE SYRINGES FOR	N 432		

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N 432	Continued From page 16 PATIENT TO GET THROUGH THE NIGHT ...WRITER ARRIVED AT FACILITY AND WAS DIRECTED INTO A CONFERENCE ROOM WHERE [DON B] AND LPN AND ADMINISTRATOR ...WERE PRESENT. WRITER WAS DIRECTED TO ONLY FILL 10 SYRINGES AND TO ENSURE THAT THE SYRINGES WERE CAPPED AND LABELED. WRITER SAT IN ROOM WITH 3 OF THEM AND PREFILLED 10 SYRINGES OF 0.5 ML. THE SYRINGES WERE LABELED WITH PATIENT NAME, DOB, MEDICATION NAME AND THE DIRECTIONS TO GIVE 0.5ML EVERY 2 HOURS AS NEEDED. WRITER ALSO INITIATLED EACH LABEL. [DON B] WITNESSED THAT THERE WAS 24 ML REMAINING IN THE MORPHINE BOTTLE AND IT WAS PUT BACK IN PATIENT ROOM FOR [FAMILY MEMBER G]." 4.) On 01/16/2026 at 6:24 PM, Hospice Nurse F documented the following, "DAILY RN VISIT ...UPON ARRIVAL PATIENT IN BED APPEARING UNCONFORTABLE. LABORED BREATHING, FACIAL GRIMACING. WRITER SPOKE TO A MED TECH AND ASKED IF MORPHINE WAS GIVEN. [S/HE] REPORTED THAT [S/HE] HAD NOT GIVEN ANY. WRITER ASKED WHEN THE LAST TIME PATIENT HAD MORPHINE AND [S/HE] OPENED THE CART AND 10 SYRINGES REMAINED THAT WAS FILLED FOR PATIENT LAST NIGHT. NO MORPHINE GIVEN THROUGH THE NIGHT. WRITER ASKED THAT PATIENT GET MORPHINE AND LORAZEPAM NOW AS [S/HE] IS UNCOMFORTABLE. [FACILITY NURSE M] AT FACILITY REPORTED THAT MORPHINE FROM MEDICATION MANAGEMENT HAD NOT BEEN ENTERED YET FOR SCHEDULED EVERY 4 HOURS AND DOES NOT BELIEVE THE MORPHINE HAS BEEN DELIVERED ...[FAMILY	N 432		

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N 432	Continued From page 17 MEMBER G] REPORTS THAT [S/HE] IS GOING TO BE HAVE (SIC.) [NAME OF HOME HEALTH AGENCY] STARTING TONIGHT TO SIT WITH [RESIDENT 1] ..." INTERVIEWS: On 01/27/2026 at 9:51 AM, Surveyor interviewed Caregiver J. Caregiver J stated Resident 1 was his/her "buddy" and s/he had visited him/her while s/he was dying. Caregiver J reported staff had discussed that there were issues between hospice and facility when managing Resident 1's pain. On 01/27/2026 at 12:00 PM, Surveyor interviewed Administrator A about his/her investigation into Family Member G's grievance. Administrator A reported that Family Member G approached him/her after Resident 1's passing to report Resident 1 didn't receive pain medication as ordered at end of life. Administrator A stated for their investigation s/he interviewed Facility Nurse M and Facility Nurse M reported that hospice had provided a medication order which was different from the medication facility had in the cart. Administrator A stated after interviews with other clinical staff members s/he had concluded that the issues with medications had been on the fault of the hospice. Administrator A stated [Name Of Facility Pharmacy] will transcribe medication order to the facility EMAR and facility nurses approve the orders. Writer asked Administrator A why Family Member G had hired a home health agency to stay with Resident 1. Administrator A stated Family Member G had told him/her, "I want more people involved. I don't trust you guys to care for him/her." On 01/27/2026 at 12:20 PM, Surveyor	N 432		

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N 432	Continued From page 18 interviewed Med Passer I. Med Passer I stated that s/he remembered at the beginning of his/her shift a hospice nurse approached him/her to ask for pain medication for Resident 1. Med Passer, I reported s/he administered the morphine upon request. Med Passer, I stated before s/he administered Resident 1's Morphine s/he was struggling to breathe but when s/he assessed Resident 1 afterwards his/her breathing had slowed, and s/he looked more comfortable. On 01/27/2026 at 1:00 PM, Surveyor interviewed DON B. Surveyor asked DON B to review the 01/14/2026 faxed T.O. from Resident 1's hospice provider. DON B acknowledged Doctor N's order for an increase in lorazepam and start of Morphine concentrate was faxed to facility on the afternoon of 01/14/2026. Surveyor then showed DON B Resident 1's observations notes labeling the T.O. as invalid. DON B acknowledged his/her notations on 01/15/2026 at 12:50 AM and 7:50 AM that facility didn't have valid orders for Morphine. DON B identified the 01/14/2026 faxed T.O. from Resident 1's hospice to be the order s/he had noted as invalid in the observation notes. Surveyor asked DON B what specifically made the 01/14/2026 telephone order invalid. DON B took a few minutes to review his/her documentation and said, "I don't know exactly. It is my understanding that narcotics are not to be ordered by telephone." DON B acknowledged the afternoon of 01/14/2026 s/he was made aware Resident 1 started the active dying process and would require Morphine for pain management. DON B stated on 01/14/2026 s/he had notified hospice that facility wouldn't be able to get Morphine from their usual pharmacy until the next day, and hospice had been okay with that plan. DON B explained in the middle of the night Family Member G decided Resident 1 needed	N 432		

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Morphine right away and got a script filled at Walgreen's then brought it back to the facility. DON B stated when staff called him/her in the middle of the night s/he didn't feel comfortable taking a bottle of Morphine concentrate that had been in Family Member G's personal possession. Surveyor asked DON B when s/he was called that night if s/he came into the facility. DON B stated s/he was on-call overnight and it wasn't expected of him/her to come into the facility, just pick up the phone. Surveyor asked DON B what the 24/7 RN coverage advertised in facilities admission agreement meant to him/her, and DON B stated s/he would pick up the phone during their on-call hours. Surveyor asked DON B how they thought Family Member G got Walgreens to dispense a bottle of Morphine Sul Soln if the T.O. wasn't valid. DON B stated s/he didn't know but Walgreens likely received a different electronic order to dispense the Morphine Sul Soln. DON B acknowledged Walgreen's would have required a valid physician's order to dispense a bottle of Morphine Sul Soln to Family Member G. Surveyor asked why DON B refused to have the hospice nurse draw up syringes of Morphine Sul Soln for facility staff, and DON B stated it was against facility policy. DON B stated that was why it was decided Family Member G would administer Resident 1's Morphine overnight. Surveyor asked DON B why s/he didn't transcribe Doctor N's order for Morphine to Resident 1's MAR when they received the original 01/14/2026 order. DON B stated that only pharmacy could transcribe medication orders to resident EMARS. Surveyor asked DON B why s/he didn't re-package the Morphine Sul Soln when they returned to the facility the next morning. DON B stated s/he was told during training that facility staff are not allowed to re-pack resident medications. Surveyor indicated that per DHS Chapter 83 an

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N 432	Continued From page 20 RN is capable of re-packaging medication for caregivers to administer, and DON B stated s/he was not aware of that. DON B stated the plan to have Family Member G administer Resident 1's Morphine was to be sure s/he received their pain medication until facility could receive the Morphine from their usual pharmacy. DON B acknowledged facility had Family Member G administer Resident 1's Morphine per the physician order for an unknown period of time, Family Member G wasn't a trained medication technician, Family Member G hadn't documented any administrations of Morphine in Resident 1's record, and Family Member G had an unsecured scheduled II narcotic on their person within facility. Surveyor showed DON B Resident 1's MAR and asked why from 01/15/2026 until the morning of 01/16/2026 Resident 1 didn't have any documented administrations of Morphine. DON B stated Family Member G had administered Resident 1's Morphine into 01/15/2026 but could not specify an end time. DON B stated s/he believed facilities usual pharmacy didn't deliver the Morphine until the morning of 01/16/2025. DON B maintained hospice was at fault for not following facilities procedures. DON B acknowledged facility was Resident 1's primary care provider and had made an agreement to administer Resident 1's medications per their physician's order. On 01/28/2026 at 1:40 PM, Surveyor interviewed Hospice Nurse F. Hospice Nurse F stated s/he saw Resident 1 on 01/14/2026 and had assessed s/he was uncomfortable, likely beginning of dying process. Hospice Nurse F stated s/he told DON B that Resident 1 would need an increase in Lorazepam and to start Morphine. DON B stated facility didn't have those medications readily available. Hospice Nurse F reported DON B, and	N 432		

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a second facility nurse instructed them to have the scripts for Lorazepam and Morphine sent to Walgreens and to have Family Member G pick it up. Hospice Nurse F stated s/he did as s/he was instructed. Hospice Nurse F stated s/he got a phone call that night from another hospice nurse who was at the facility and was notified facility couldn't administer the Morphine because they didn't have a valid order. Hospice Nurse F stated s/he had sent the order for Morphine to facility, Walgreens and facilities usual pharmacy on 01/14/2026. Hospice Nurse F stated the hospice nurse present at the facility had offered to draw up pre-filled doses of Morphine for facility caregivers to administer. However, DON B refused to trouble shoot how to get Resident 1's Morphine administered with hospice and seemed more focused on arguing about the semantics of the situation than figuring out a safe way to manage Resident 1's pain. Hospice Nurse F reported while conversing with the hospice nurse at the facility there was a time, s/he overheard DON B raising his/her voice at Family Member G through a speakerphone about the Morphine. Hospice Nurse F reported following this argument it was decided Family Member G would be given the bottle of Morphine Concentrate to administer doses to Resident 1. Hospice Nurse F stated on 01/15/2026 from approximately midnight until approximately 5:00 PM, Family Member G had been left in charge of administering Resident 1's Morphine. Hospice Nurse F stated Family Member G had been administering Morphine approximately every 2-4 hours during that time frame. Hospice Nurse F reported on 01/15/2025 at approximately 5:00 PM, facility agreed to allow him/her to draw-up and cap 10 syringes of Morphine concentrate for facility staff to begin administrations of Morphine. Hospice Nurse F stated DON B and DON C observed him/her

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draw-up/cap the 10 syringes of Morphine before transporting them to the facility medication cart. Hospice Nurse F stated Family Member G had been awake all night administering Resident 1's Morphine and so Family Member G went home to get some sleep. Hospice Nurse F stated s/he had verified before leaving facility late on 01/15/2026 that Resident 1 was comfortable. Hospice Nurse F reported s/he next saw Resident 1 at approximately 9:30 AM the next morning (01/16/2026) with Family Member G. Hospice Nurse F stated when s/he entered Resident 1's room s/he was very uncomfortable, Resident 1 was breathing loudly and shallow while sweating and grimacing. Hospice Nurse F stated Family Member G started crying when s/he witnessed Resident 1's discomfort. Hospice Nurse F stated s/he immediately hunted down the current med passer and discovered Resident 1 hadn't received any of the 10 pre-filled morphine syringes s/he had supplied to the facility the previous day.

On 01/28/2026 at 2:15 PM, Surveyor interviewed Death Doula O. Death Doula O stated s/he visited Resident 1 daily from 01/14/2026 until his/her passing on 01/18/2026. Death Doula O reported s/he had a professional history as a hospice nurse. Death Doula O reported that the pharmacy contracted by facility hadn't brought the Morphine needed for over a day. Death Doula O stated for the first 24-36 hours of Resident 1's dying process s/he witnessed him/her grimacing, tight throat muscles, and guarded. Death Doula O stated the facility nurse appeared upset with Family Member G and not appropriately focused on managing Resident 1's pain.

On 01/29/2026 at 2:00 PM, Surveyor interviewed Family Member G. Family Member G reported

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s/he was very unhappy with how much pain Resident 1 was in at the end of his/her life. Family Member G stated that s/he had picked-up Morphine for Resident 1 from Walgreens. Family Member G stated when s/he returned to facility s/he gave the bottle of Morphine Concentrate to a staff member but didn't know their name. Family Member G stated s/he knew Resident 1 was in pain because s/he was struggling to breathe, moaning and grimacing. Family Member G stated when hospice arrived it was discovered facility couldn't administer the Morphine. Family Member G described being distressed Resident 1 would remain in pain. Family Member G stated DON B was loudly telling them over speakerphone that "It was illegal for the Morphine to be there." Family Member G stated it was decided that night s/he would sign a release to oversee Resident 1's Morphine. Family Member G reported s/he signed the release and administered the morphine per the pharmacy label, which s/he administered every 2 hours until the following afternoon. Family Member G stated later that afternoon hospice nurse filled 10 syringes of morphine for facility to administer to Resident 1. Family Member G stated s/he then went home to rest, and trusted facility would manage Resident 1's pain. However, when s/he returned to the facility with the hospice nurse the next morning, they found Resident 1 to be in pain and struggling to breath. Family Member G reported the hospice nurse discovered all 10 pre-filled syringes remained in the facility medication cart and Resident 1 hadn't received any Morphine overnight. Family Member G stated Resident 1 had gone from being administered PRN Morphine approximately every 2 hours to having nothing for approximately 15 hours. Family Member G reported s/he was fearful staff wouldn't administer Morphine when s/he wasn't present and so s/he decided to hire a

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 01/27/2026

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

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N 432	Continued From page 24	N 432		

home health agency to have a caregiver to sit with Resident 1 overnight.

On 01/30/2026 at 12:00 PM, Surveyor had an exit interview with Administrator A, DON C, Regional Nurse E and Regional Director D. Surveyor explained that during his/her record review of facility records. It was discovered the pharmacy had documented receiving the order for Resident 1's Morphine Sulfate 100/5ml 0.5ml as needed Q2HR on 01/14/2026 and activated the order on 01/15/2026, the January MAR showed the Morphine Sulfate order start date was 01/15/2026 0000 (midnight), and DON B documented not having an order for Morphine on the MAR at 12:50 AM on 01/15/2026. Regional Nurse E discussed facility staff not being accustomed to the elements of a telephone order, and hospice not following facility procedure related to urgent medications. Surveyor explained hospice reported being instructed to have a family member pick up the Morphine from Walgreens by DON B. Regional Nurse E reported s/he had not been made aware of that. Administrator A, DON C, Regional Nurse E and Regional Director D acknowledged the responsibility of administering Resident 1's Morphine was placed on Family Member G at 1:37 AM, while there was an active order for the 0.5 ml/10mg of Morphine to be administered Q2HR on the facility EMAR. Administrator A, DON C, Regional Nurse E and Regional Director D acknowledged hospice had provided a valid order for morphine and offered to draw up/cap pre-filled syringes the night of 01/15/2026. Surveyor explained a concern of Resident 1 not receiving any doses of PRN Morphine for approximately 15 hours from the afternoon of 01/15/2026 until the morning 01/16/2026 at 10:07 AM. Surveyor explained Hospice Nurse F and Family Member G

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N 432	Continued From page 25 described Resident 1 as displaying non-verbal signs of pain, like grimacing, rapid breathing, tight throat muscles, and sweating the morning of 01/16/2026. Surveyor described how Hospice Nurse F discovered facility staff hadn't administered any of the 10 Morphine syringes pre-filled by Hospice Nurse F. Administrator A, DON C, Regional Nurse E and Regional Director D acknowledged Family Member G reported consistent administration of Morphine to Resident 1 every 2 hours while it was in their possession. Administrator A, DON C, Regional Nurse E and Regional Director D acknowledged Resident 1 on 01/16/2026 was documented as non-verbal and requiring Morphine for pain management. Administrator A, DON C, Regional Nurse E and Regional Director D acknowledged from approximately 12:00 PM on 01/16/2026 until his/her passing facility med passers administered PRN Morphine consistently until Resident 1's passing on 01/18/2026.	N 432		