STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020919	A. BUILDING: _____ B. WING _____	C 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELENS HOUSE LOURDES	3100 E LOURDES DR APPLETON, WI 54915

(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
M 000	INITIAL COMMENTS On 10/15/2025, Surveyors conducted 2 complaint investigations at Helen's House Lourdes. Additional information was gathered through 10/21/2025. As a result of the investigation, the complaints were substantiated, and 1 deficient practice was identified. Census: 4	M 000		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, the Licensee did not ensure compliance with all laws governing the AFH. The provider did not ensure investigations into allegations of caregiver misconduct were documented, reported, or identified as a grievance. Resident 1's medical records were not kept secured, as the provider was unable to account for 4 months of missing records that contained resident private health information and resulted in 25 doses of prescription medication that was unable to be accounted for. Findings include: On 09/16/2025 and 09/17/2025, the Department received complaints alleging the provider was not in compliance with state regulations. Medication, Documentation, and Confidentiality/ Security of Records and Information: On 10/15/2025, Surveyors reviewed Resident 1's	M 216		

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

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M 216	Continued From page 1 record and noted Resident 1 was admitted on 05/07/2019 with diagnoses including agitation and anxiety. Resident 1 had an activated Power of Attorney for Healthcare (POA D.) Resident 1 was prescribed Trazadone 12.5 mg up to 3 times daily PRN (as needed) for anxiety or agitation with an indication of "Trouble sleeping." On 10/20/2025 at 9:00 AM, Surveyor interviewed POA D. POA D was unclear about dates, but stated in July of 2025 s/he brought concerns regarding Caregiver C's demeanor towards Resident 1 to Licensee A's attention. POA D believed Caregiver C's interactions with Resident 1 escalated the resident's anxiety which led to Caregiver C Frequently calling POA D to request trazadone be administered. POA D felt the medication was being relied upon to sedate the resident instead of Caregiver C utilizing other interventions with the resident. The pharmacy order tracking sheet noted 30 tablets of Trazadone were ordered on 12/31/2024, then not again until approximately 6 months later on 06/12/2025. The medication was then reordered on 08/20/2025, less than 2 months from the last time it was received from the pharmacy. Surveyor reviewed Resident 1's Individual Service Plan and daily charting observation notes from June and July in 2025 and noted no indication of a change in the resident's condition that would indicate an increased need for the trazadone was documented. The observation notes included 5 entries from Caregiver C that noted increased anxiety and/or agitation was noted for Resident 1, with Caregiver D's notations indicating s/he called POA D for permission prior to administering PRN Trazodone.	M 216		

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M 216	Continued From page 2 On 10/15/2025 at 10:30 AM, Surveyor interviewed Licensee A with Manager E present at times. Licensee A stated the provider documented all medications given on a paper hardcopy Medication Administration Record (MAR) for each resident and kept it in a file cabinet in the basement where his/her office is located. Licensee A stated him/herself, Manager E and Administrator B were in charge of reviewing the resident records, including the MARs, to ensure accuracy since Former RN F left employment in mid-September 2025. Surveyor requested to review Resident 1's MAR from May 2025 through October 2025. Neither Licensee A or Manager E were able to located the MAR for Resident 1 for May 2025 through August 2025. Licensee A stated RN F recently left employment and s/he believed RN F may have the records on his/her person as Licensee A stated Former RN F was still in possession of a company computer which contained private resident information and a cellular work phone. As of 10/21/2025, Licensee A stated s/he was unable to get in contact with Former RN F and was still unable to locate Resident 1's may-August 2025 MARs. Surveyor reviewed per the observation notes, 5 tablets of Trazodone were noted as given between June 2025-July 2025 which left 25 tablets unaccounted for between the medication being delivered on 06/12/2025 and reordered on 08/20/2025 without the MAR. Prior to the process of the state survey investigation revealing the discrepancy, the provider had not been aware there was a discrepancy of 25 doses of Trazadone. Licensee A was unable to account for the 25 tablets of Trazadone and could not state if the medication was given to the resident or potentially diverted. On 10/15/2025 At 10:00 AM, Surveyor	M 216		

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M 216	Continued From page 3	M 216		

interviewed Caregiver G. Caregiver G indicated Resident 1 had a tendency to become anxious and discussed multiple interventions that were used to soothe him/her. Caregiver G stated Resident 1 had PRN Trazadone ordered and stated the medication was given occasionally by caregivers but only with prior permission from POA D and when other methods of intervention did not work. Caregiver G did not have knowledge about the missing MAR's or unaccounted for tablets of Trazadone.

On 10/21/2025 at 1:14 PM Surveyor received an e-mail from Licensee A:
" ... I couldn't come up with the MAR. The only explanation is that someone stole them. Those are the only MARS that we are missing from any resident since 2018. We never had this happen before. We will be switching to EMAR early next month which would eliminate this missing information.
I'm going to keep an investigation open looking for the MAR ..."

Investigation, Grievance, and Reporting:
During the interview 10/20/2025 at 9:00 AM with POA D, POA D stated after bring his/her concerns regarding Caregiver C's demeanor and use of PRN medication to Licensee A's attention in July 2025, s/he never received a written response to his/her grievance but was told Caregiver C was relocated to one of the provider's other licensed facilities as of 08/01/2025. POA D stated s/he heard Caregiver C was returning to work at the facility and on 09/16/2025 s/he brought his/her concerns to License A's attention again as s/he had not received a response to his/her grievance reported in July 2025.

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M 216	Continued From page 4 On 10/15/2025 at 10:30 AM Surveyor interviewed Licensee A. Licensee A confirmed in July 2025 POA D brought forth concerns related to Caregiver C's interactions and demeanor with Resident 1 and concerns the PRN Trazadone medication was being overly used by Caregiver C and possibly administered without his/her permission. Licensee A stated s/he "looked into it" in July but did not have documentation. Licensee A stated s/he reviewed the medication by discussing it with Former RN F and believed the Trazadone had been given a total of 3 times by Caregiver C from June to July 2025. License A stated s/he did not review the MAR, but relied on Former RN F's account when asked. Licensee A stated s/he had no reason to believe Caregiver C had verbal/ mental/ emotional misconduct as s/he believed the caregiver was just "louder" than other caregivers and that it was an issue of personal preference rather than potential abuse. Licensee A did not recognize the report as a grievance or allegation of caregiver misconduct that required a documented investigation and reporting. After the allegations were reported in July 2025, an investigation was not documented, the allegations of caregiver misconduct were not reported to the Office of Caregiver Quality (OCQ,) and no grievance summary was sent to POA D. Licensee A stated on 09/16/2025 s/he was confronted by POA D who raised the same issues reported to him/her in July. Licensee A stated at this time s/he took a few notes and believed that Former RN F was going to complete an investigation. Surveyor requested to review the investigation. Licensee A stated Former RN F left employment mid-September 2025 and s/he was unable to locate any documentation to indicate an investigation was conducted or reported to OCQ. Licensee A stated to his/her knowledge no	M 216		

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M 216	Continued From page 5 grievance summary was sent to POA D. Licensee A stated s/he would update his/her notes to include any aspects of investigation that were completed, report the allegation to OCQ as was required, and provide POA D with the required written summary conclusion of his/her grievance.	M 216		