STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

(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 08/10/2023, with information collected through 09/12/2023, Surveyor conducted 2 complaint investigation at Sunset Ridge Assisted Living. Four deficiencies were identified. Both complaints were substantiated. Census: 20	N 000		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats.	N 328		

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
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

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N 328	Continued From page 1	N 328		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that a 30 day involuntary discharge notice was provided to Resident 1's legal representative when the provider issued one on 06/26/2023.

Findings include:

On 08/03/2023, the Department received a complaint alleging that the facility is discharging residents improperly.

On 08/10/2023, Surveyor conducted 2 complaint investigations. At 10:36 a.m., Surveyor asked Caregiver C if s/he is aware of any residents who have been involuntarily discharged. Caregiver C stated yes, that Licensee A had issued a 30 day discharge notice to Resident 1 and his/her care team and s/he left a few weeks ago.

Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the provider on 07/12/2021 with diagnoses including anxiety disorder, cauda equina syndrome and pressure ulcers. Surveyor reviewed an involuntary discharge summary dated 06/26/2023 stating that Resident 1 will need to find new placement by 07/26/2023. Surveyor reviewed a legal document stating that Power of Attorney F is Resident 1's activated power of attorney.

On 08/11/2023, at 10:00 a.m., Surveyor interviewed Licensee A. Surveyor asked Licensee A when s/he issued Resident 1's involuntary discharge notice. Licensee A stated that on 06/26/2023, Licensee A issued the involuntary discharge notice to Resident 1 and his/her care team. Surveyor asked if Licensee A was aware that Resident 1 has an activated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

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N 328	Continued From page 2 power of attorney. Licensee A stated yes, but s/he was not aware s/he was required to issue the involuntary discharge notice to him/her rather than Resident 1.	N 328		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update Resident 1's individualized service plan (ISP) to include wounds. Findings include: On 07/28/2023 and 08/03/2023, the Department received a complaint alleging that the facility is not providing personal cares and proper wound care. The provider is licensed as a class CNA (nonambulatory) community based residential facility (CBRF) able to serve up to 24 residents within the client groups of irreversible	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

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N 389	Continued From page 3	N 389		

dementia/Alzheimer's, advanced age, and terminally ill.

On 08/10/2023, Surveyor conducted 2 complaint investigations.

At 10:36 a.m., Surveyor asked Caregiver C if s/he is aware of any residents who have been discharged. Caregiver C stated yes, that Resident 1 was recently discharged to another facility. Surveyor asked if Resident 1 had any wounds when s/he discharged. Caregiver C stated no, not when s/he left but s/he did have known issues with skin break down on his/her heels and bottom previously that were ongoing due to his/her immobility.

Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the provider on 07/12/2021 with diagnoses including anxiety disorder, cauda equina syndrome and pressure ulcers. Surveyor reviewed a home health assessment dated 05/09/2023 with a Braden scale (pressure ulcer risk) assessment. The assessment documented the following:
Moisture - Degree to which skin is exposed to moisture
-Rarely Moist
Activity - Degree of physical activity
-Chairfast
Mobility - Ability to change and control body position
-Very Limited
Nutrition - Usual food intake pattern
-Adequate
Friction and Sheer
-Potential problem

A home health note, dated 06/27/2023, stated that Resident 1 was at high risk for skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

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N 389	Continued From page 4 breakdown. Surveyor reviewed a hospital discharge summary dated 07/25/2023, which documents, "[Resident 1] has been in assisted living facility and the staff at Sunset Ridge informed patient that [s/he] had pressure ulcers on [his/her] buttocks and this was about 12 months ago. Facility nurses dressed ulcers with bordered foam dressing daily." Surveyor reviewed Resident 1's ISP, dated 07/12/2022, which did not include wounds. The ISP was not updated to include the history of skin breakdown or the presence of a wound (current or healed), treatment and preventative measures. On 08/11/2023, at 10:00 a.m., Surveyor interviewed Licensee A. Licensee A stated s/he was not aware of Resident 1 having a wound upon discharge and s/he understands the concern for not addressing the history of a wound or preventative measures in the ISP.	N 389		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

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N 431	Continued From page 5 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor the health of Resident 1's in regards to skin break down and wounds. Findings include: On 07/28/2023 and 08/03/2023, the Department received a complaint alleging that the facility is not providing personal cares and proper wound care. The provider is licensed as a class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 24 residents within the client groups of irreversible dementia/Alzheimer's, advanced age, and terminally ill. On 07/28/2023, the Department received a complaint alleging personal cares were not being	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

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N 431	Continued From page 6	N 431		

provided and residents have pressure wounds that the facility is unaware of.

On 08/02/2023, Surveyor contacted Case Manager G to request documentation of any wounds Resident 1's may have and when they were discovered.

On 08/03/2023, at 10:25 a.m., Case Manager G confirmed that Resident 1 currently has 2 wounds. S/he stated that Resident 1 had recently moved to another community based residential facility (CBRF) and shortly after admission 2 wounds were discovered by his/her home health nurse and a caregiver. Case Manager G provided Surveyor with Wound Doctor D's wound clinic notes for Resident 1 dated 07/25/2023 and 08/01/2023. Case Manager G stated, "At the 8/1 appointment, it was determined that the wounds have not improved, they have gotten worse. The MD ordered 5x week wound care which [Resident 1's] home health agency is not able to accommodate. I have called to determine if there is any way around that, if not we may have to get [Resident 1] to a Nursing home where [s/he] can get the wound treatment more often then what can be provided at [new provider]."

The hospital wound clinic notes document: 07/25/2023, "[Resident 1] has been in assisted living facility and the staff at Sunset Ridge informed patient that [s/he] had pressure ulcers on [his/her] buttocks and this was about 12 months ago. Facility nurses dressed ulcers with bordered foam dressing daily." Wound clinic notes document Resident 1's wounds as, "Lower back: left buttock at ischial area with pressure ulcer, full thickness that has necrotic skin, necrotic subcutaneous fat and slough. There is no periwound redness to suggest infection. Right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 431	Continued From page 7	N 431		

buttock at ischial area with pressure ulcer that is full thickness involving the subcutaneous fat. No periwound redness." Both areas received debridement. The pressure of the left buttock was documented as stage 3 as well as the pressure ulcer of the right buttock. The wound clinic notes documented pictures of both wounds. 08/01/2023, "Resident 1] is here for follow up of left and right buttock pressure ulcers. [S/he] has been treated with Aquacel Ag packing and bordered foam 2 times a week." Wound clinic notes document Resident 1's wounds as, "Lower back: left buttock with necrotic skin, subcutaneous fat and muscle. Foul smelling, periwound skin is indurate and with compression 3-5 cc's of tan purulent material expressed from the wound." Both areas received debridement. The pressure of the left buttock was documented as stage 3 and the pressure ulcer of the right buttock was documented as stage 4. The wound clinic notes documented pictures of both wounds.

On 08/10/2023, Surveyor conducted 2 complaint investigations at Sunset Ridge Assisted Living.

At 10:36 a.m., Surveyor asked Caregiver C and asked if Resident 1 had any wounds when s/he discharged. Caregiver C stated no, not when s/he left but s/he did have known issues with skin break down on his/her heels and bottom previously that were ongoing due to his/her immobility. Caregiver C was on the phone with Manager B and Surveyor asked if Manager B was aware of Resident 1 having any wounds or open areas upon discharge. Caregiver C relayed that Manager B stated no s/he was not aware of any wounds.

Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the provider on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

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N 431	Continued From page 8	N 431		

07/12/2021 with diagnoses including anxiety disorder, cauda equina syndrome and pressure ulcers. Surveyor reviewed a home health assessment dated 05/09/2023 with a Braden scale (pressure ulcer risk) assessment. The assessment documented the following:
Moisture - Degree to which skin is exposed to moisture
-Rarely Moist
Activity - Degree of physical activity
-Chairfast
Mobility - Ability to change and control body position
-Very Limited
Nutrition - Usual food intake pattern
-Adequate
Friction and Sheer
-Potential problem

A home health note, dated 06/27/2023, stated that Resident 1 was at high risk for skin breakdown.

Surveyor reviewed Resident 1's ISP, dated 07/12/2022, which did not include the history of skin breakdown or the presence of a wound (current or healed), treatment and preventative measures. The ISP states:
-Toileting: Resident is on a bowel schedule. One assist with toileting uses sliding board. Resident to maintain normal bowel/bladder habits. To remain clean, free of odor and any signs of skin breakdown for one ISP year.
-Bathing: Resident transfers from his/her wheelchair with stand by assist with slide board. Resident to maintain overall good body hygiene and no signs of infection for the next ISP year. Frequency once weekly, daily.
-Grooming: Staff to monitor the cleanliness of fingernails, cares and showers. Staff to clean

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

(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 431	Continued From page 9	N 431		

when needed. Staff will communicate any concerns to the facility RN. Staff to monitor and report any changes. Resident to maintain a neat/clean appearance. To have no evidence of body odor or any signs of infection for one ISP year. Staff to assist maintain good hygiene.

Surveyor reviewed the provider's daily log notes for July 2023. The daily log notes document that on 07/16/2023, Resident 1 had "bleeding from butt". On 07/19/2023, documentation states that Resident 1 had a BM accident and had a shower. Daily documentation for Resident 1 ended on 07/20/2023; there was no documentation of skin concerns or wounds.

At 11:23 a.m., Surveyor asked Caregiver C about the documentation on 07/16/2023 stating that Resident 1 was bleeding from his/her butt. Caregiver C stated Resident 1's buttock was bleeding but it wasn't from a wound, s/he believes it was from a hemorrhoid. Surveyor asked who had determined that. Caregiver C stated s/he was unsure. Surveyor asked Caregiver C if Resident 1 needed assistance with toileting and pericare. Caregiver C stated yes, that Resident 1 was not mobile so staff assisted with toileting, pericare and showers. Surveyor reviewed the wound clinic notes with Caregiver C and asked why there was no documentation of either wound if caregivers were toileting, bathing and providing pericare for Resident 1, including a documented shower on 07/19/2023. Caregiver C observed the wound clinic documentation, including pictures of the wounds, and stated s/he does not know how they could have been missed.

On 08/11/2023, at 4:50 p.m., Surveyor interviewed Power of Attorney F and asked if s/he was aware of Resident 1's wounds. Power of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

(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 431	Continued From page 10	N 431		

Attorney F stated that s/he was not made aware of Resident 1's wounds until s/he moved out of Sunset Ridge and into the new provider. Power of Attorney F stated that with the size of the wounds there is no way that they happened over night, and caregivers should have seen and smelled the wounds if they were providing proper cares, toileting and showers for Resident 1.

On 08/11/2023, at 10:00 a.m., Surveyor interviewed Licensee A. Licensee A stated s/he was not aware of Resident 1 having any wounds upon discharge and s/he understands the concern.

On 08/25/2023 at 10:56 a.m., Surveyor interviewed Wound Nurse E from the wound clinic Resident 1 had been treated at. Surveyor asked Wound Nurse E if Resident 1 could have developed the documented wounds over night. Wound Nurse E stated, "No, not overnight. This is bad, that's for sure." Wound Nurse E took Resident 1's weight, immobility and suprapubic catheter into account and stated that if the provider was repositioning Resident 1 every 2 hours that these wounds would have taken a long time to develop, they would not have appeared quickly. Wound Nurse E added that there was a lot of slough and dark colored slough, that there was a lot to get down to pink (healthy) tissue. That the wounds weren't just a stage 2 and superficial, "it's deep" and staff should have seen something before this.

On 09/12/2023, Surveyor reviewed documentation from the CBRF Resident 1 transferred to directly from Sunset Ridge Johnson Creek on 07/20/2023. The documentation includes:
-An incident report dated 07/21/2023 at 10:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 431	Continued From page 11 a.m. that states, "Resident ' s [home health] nurse was checking [his/her] skin and the nurse noticed 2 open bed sores on both buttocks. The nurse brought it up to staff and staff and nurse cleaned up the areas and put clean pads on the wounds." -A verbal order from Resident 1's medical doctor, dated 07/21/2023 at 11:32 a.m. that states, "Pressure sores noted at new assisted living. Patient to see wound md next week...stage 4 right buttock / stage 3 left buttock...husband aware and saw wounds. Foam dressing bll buttock pressure sores change prn til sees wound md. Skin Assessment: History/Diagnosis stage 4 wound concern right. Stage 3 wound concern left. Pointer finger to mid finger knuckle deep." -A progress note on 08/04/2023, Resident 1 was taken to hospital for treatment of wounds. -A progress note on 08/07/2023, [Resident 1] was discharged from the system. Discharge Reason: Moved to Skilled Nursing Facility. Notes: Moved to Skilled Nursing Facility -- Notes: Resident was taken to the hospital by [spouse], due to the bed sores that resident had from previous facility. Our facility was unable to accommodate to the needs that resident is in need of for [his/her] to wounds. On 09/12/2023, at 12:51 p.m., Power of Attorney F confirmed that Resident 1 had been moved to a skilled nursing facility and the doctors estimate that s/he will require 12 months of treatment to try to resolve the wounds. Power of Attorney F stated that this should have never happened to Resident 1 while in an assisted living facility.	N 431		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

(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 454	Continued From page 12	N 454		

resident at the CBRF. Each record shall include all of the following:
(a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014539	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET RIDGE ASSISTED LIVING	1275 REMMEL DRIVE JOHNSON CREEK, WI 53038

(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 454	Continued From page 13 PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update Resident 1's record to include a summary of his/her discharge information. Findings include: On 08/03/2023, the Department received a complaint alleging that the facility is discharging residents improperly. On 08/10/2023, Surveyor conducted 2 complaint investigations. At 11:23 a.m., Surveyor asked Caregiver C if s/he	N 454		

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N 454	Continued From page 14 is aware of any residents who have been discharged. Caregiver C stated yes, that Resident 1 was recently discharged to another facility. Surveyor asked if Caregiver C recalls the exact date. Caregiver C stated no. Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the provider on 07/12/2021 with diagnoses including anxiety disorder, cauda equina syndrome and pressure ulcers. Caregiver C provided Surveyor with Resident 1's progress notes, which had no documentation of his/her discharge. At 11:25 a.m., Caregiver C stated that s/he only has Resident 1's paper record that there may be documentation of Resident 1's discharge in ECP (electronic charting). At 3:06 p.m., Surveyor emailed Manager B and asked for further documentation on Resident 1 that may be in ECP. At 5:08 p.m., Manager B stated, "Anything that we have would be on paper for [Resident 1]." Surveyor reviewed the provider's daily log notes for July 2023. The daily documentation for Resident 1 ended on 07/20/2023. The provider did not document a summary of Resident 1's discharge information.	N 454		