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	0018316	A. BUILDING: _____ B. WING _____	C 05/19/2026

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SILVERSTONE MEMORY CARE INC	5100 SCHMIDT LANE GRAND CHUTE, WI 54913

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N 000	Initial Comments On 05/12/2026 with additional information gathered through 05/19/2026, Surveyor conducted a complaint investigation at Silverstone Memory Care Inc. As a result three deficiencies were identified. The complaint was substantiated. Census: 43	N 000		
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 ensure Resident 2's individual service plan (ISP) was updated to identify needs and interventions for fall prevention. Resident 2 had risk factors for falls and experienced a fall on 12/02/2023 and 08/18/2025. Resident 2's most recent ISP dated 10/02/2025 did not identify the resident's history of falls, risks	N 389		

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

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factors for falls or contain specific individualized interventions for fall prevention. On 12/05/2025, Resident 2 experienced another fall and was subsequently hospitalized for evaluation and treatment of his/her injuries.

Findings include:

On 05/14/2026, Surveyor reviewed the facility's undated fall policy which indicated, "It is the policy of this facility to conduct initial and routine evaluations to create and maintain an awareness of the potential of residents for fall, assess the need for additional coordination of care and identify possible interventions designed to minimize any recurrence...Once the evaluation is completed, update the service plan as indicated with information obtained...Risk Factors Include: Previous Falls, dementia diagnoses, multiple medical diagnoses, more than four prescribed medications, use of psychotropics or hypnotics, arthritis, vitamin B12 deficiency, depression, equipment-canes, walkers, wheelchairs...Identify risk factors on the service plan and include interventions..."

DHS (Department of Health Services) DQA (Division of Quality Assurance) Bureau of Assisted Living publication-00994 titled "Falls in Assisted Living Facilities" revised on 02/2022 indicated, "Falls resulting in serious injuries or death continue to occur in assisted living settings. For this reason, the DQA is reminding assisted living providers of the need to identify residents at risk for falls and to implement strategies for fall prevention...The following factors may predict an individual's likelihood of falling: Diminished level of consciousness or impaired mental status, incontinence or need for toileting assistance, impaired gait or balance, including the use of

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assistive devices, history of falls, medications, including psychotropics, sedatives, narcotics, other medical conditions, including but not limited to arthritis...Once risks are identified, the resident's ISP should contain approaches to prevent falls from occurring."

On 05/12/2026, Surveyor reviewed Resident 2's closed record. The record indicated Resident 2 was admitted to the facility on 08/02/2022 with a diagnosis to include cognitive impairment, insomnia, anxiety, delusions, osteoarthritis and dyslipidemia. Resident 2 was discharged from the facility on 12/11/2025 and did not return. Resident 2's medication regimen included a psychotropic and two antidepressant medications. According to the record, Resident 2 experienced an unwitnessed fall on 12/02/2023, resulting in a left hip fracture and another unwitnessed fall on 08/18/2025 resulting in scrapes to his/her upper back and a swollen left foot.

Resident 2's most recent ISP dated 10/02/2025 was reviewed. The ISP indicated Resident 2 ambulated with a two wheeled walker, was incontinent of both bowel and bladder, and required staff assistance for bathing, dressing and grooming. Additionally, the ISP indicated Resident 2 had dementia, was alert and oriented times one to familiar faces and required staff monitoring (cues/reminders) to complete toilieing task every hour. The ISP did not address the resident's history of falls, risk factors for falls, nor did it specify any individualized fall prevention interventions.

On 05/12/2026, Surveyor reviewed Resident 2's observation notes and the following was noted:

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N 389	Continued From page 3 *On 08/18/2025 at 2:30 PM- "Staff heard a loud bang when beginning walk through this morning, staff went into residents' room and found resident on [his/her] bathroom floor in between [his/her] shower and toilet...Resident has 2 scrapes on upper back as well as left foot being swollen and red...Left ankle is slightly swollen, denies pain, no warmth, staff states [s/he's] walking with a slight limp...[Resident 2] also states last night [s/he] fell twice in [his/her] room and got [him/herself] up." *On 08/18/2025 at 2:45 PM- "Left foot is red and swollen from fall this morning. Resident doesn't put much pressure on left leg...Resident told family [s/he] was pacing all night, fell multiple times and got up..." *On 11/23/2025 at 11:45 AM- "While washing [Resident 2] up for the day, [Resident 2] was pretty unsteady, lost his balance in the bathroom. Staff had to hold [him/her] up and walk [him/her] to the toilet." *On 12/05/2025 at 5:45 AM- "Staff called legal representative about an unwitnessed fall. Night shift was doing rounds and found resident in [his/her] recliner with bruising on [his/her] face and two black eyes...Told Staff to send resident to St. Elizabeth's hospital..." *On 12/05/2025 at 12:30 PM- "[Resident 2] was transferred from St. Elizabeth's to ThedaClark Neenah with diagnoses of subdural hematoma, subarachnoid hematoma, multiple skull fractures (displaced temporal bone, nondisplaced odontoid), T1 fracture, and fracture of multiple ribs..." Following the 08/18/2025 fall, the facility completed a "Fall Potential Assessment and Evaluation" for Resident 2 dated 08/19/2025 which indicated, "1. Past History or pattern of falls- 1. No falls since admission in 2023 2. Current pattern of falls-None. 3. Condition of the	N 389		

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resident: Alert and Orientated x 1-2. Dx: cognitive impairment, delusions, dyslipidemia, insomnia, osteoarthritis, depression, and anxiety. Meds: Aripiprazole 10 mg daily, Fluoxetine 40 mg daily, Mirtazapine 30 mg daily 4. Interventions and Alternatives considered and/or attempted: 1-hour checks. 5. Potential Risks Reviewed (discussed with resident and Responsible party) None 6. Resident's Ability to Understand and accept risk: NA 7. Determination: Low risk, first fall since admission. No potential risks noted." The evaluation failed to identify Resident 2's risk factors for falls including, cognitive impairment (dementia), incontinence, osteoarthritis, use of an assistive device, history of a past fall with significant injury and the administration of a daily psychotropic medication and two antidepressant medications.

Resident 2's ISP dated 10/02/2025 was silent to the resident's history of falls, risk factors for falls and individualized interventions for falls prevention. On 12/05/2025, Resident 2 had another unwitnessed fall and was subsequently hospitalized for evaluation and treatment of his/her injuries and did not return to the facility.

On 05/14/2026 at 1:51 PM, Director A verified the ISP dated 10/02/2025 was the most current ISP for Resident 2. On 05/19/2026 at 10 AM, Surveyor discussed Resident 2's fall risk factors and ISP with Director A and Administrator B. Director A and Administrator B acknowledged Resident 2's most recent ISP dated 10/02/2025 did not identify the resident's history of falls, risk factors for falls or specific individualized intervention(s) for fall prevention. No additional information was provided.

In conclusion, the facility did not update the ISP to

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N 389	Continued From page 5 identify Resident 2's history of falls, risks factors for falls or specific individualized intervention(s) to prevent falls from occurring.	N 389		
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 interview and record review, the provider did not provide or arrange services adequate to meet the medication needs of residents. Resident 2 had a physician's order for latanoprost eye drops nightly at bedtime for glaucoma. Resident 2 did not receive the latanoprost as ordered on 09/18/2025, 10/18/2025 and 10/19/2025 because the eye drops were either empty or on order. Findings Include: On 05/12/2026, Surveyor reviewed Resident 2's closed record which indicated, the resident was admitted to the facility on 08/02/2022 with diagnosis to include cognitive impairment, anxiety	N 432		

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N 432	Continued From page 6 and delusions. Resident 2 was discharged from the facility on 12/11/2025 and did not return. Additionally, the facility managed and administered all of Resident 2's medication. Resident 2 had a physician's order for, "Latanoprost 0.005% eye drops, instill one drop into both eyes nightly at bedtime for glaucoma (7 PM)." On 05/12/2026, Surveyor reviewed Resident 2's September 2025 eMAR (electronic Medication Administration Record) which revealed Resident 2 did not receive her/his latanoprost eye drops at 7 PM on 09/18/2025 because the eye drops were "On order. None left in the bottle." Resident 2's October 2025 eMAR revealed Resident 2 did not receive his/her latanoprost eye drops at 7 PM on 10/18/2025 and 10/19/2026 because "the eye drops were empty and on order." On 05/12/2026 at approximately 1:45 PM, Surveyor shared Resident 2's eye drop medication was not administered on the above dates due to the above documented reason(s) with Director A and Administrator B. Director A and Administrator B acknowledged Resident 2's September 2025 and October 2025 eMAR documentation. Director A indicated, "Staff should be checking the medication refrigerator for replacement eye drops and re-ordering eye drops timely when they're running low by clicking the re-order button in the resident's eMAR."	N 432		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right	Y3244		

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Y3244	Continued From page 7 to (I) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, staff interviews and record review, the provider did not ensure Residents received proper care and treatment within the capacity of the facility. Resident 1 utilized the facility's call light system to request assistance with personal care needs. Staff failed to respond to Resident 1's call light in a timely manner, resulting in the resident waiting more than 25 minutes for assistance. In addition, Resident 1's bedside call button was determined to be malfunctioning. Although staff replaced the bed wall unit batteries and adjusted the faceplate, the resident continued to experience delayed response times. The facility did not implement a system to ensure call light equipment was routinely inspected, tested, and maintained to ensure proper functionality and timely resident assistance. Findings include:	Y3244		

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Y3244	Continued From page 8 On 05/12/2026 at approximately 9 AM, Surveyor toured the facility with Administrator B. Administrator B confirmed every resident room was equipped with an accessible bed station call button and bathroom pull cord. Additionally, Surveyor observed several residents actively wearing or carrying a personal pendent call button. On 05/12/2026 at 3 PM, Surveyor observed Resident 1 in her/his recliner, with a bed station call button mounted to the wall near the head of the resident's bed. Surveyor interviewed Resident 1. Resident 1 indicated s/he has resided in the facility for over two weeks and utilizes her/his call button for assistance with personal services. Resident 1 reported using the call light for assistance with changing soiled linens, transferring in and out of the bed/chair, and receiving PRN (as needed) medication. Resident 1 stated, "I've soiled my bed and had to wait hours for someone to come in and help me clean it up...It was uncomfortable...There's been many times, I've waited a long time for staff to answer my call...Either my call light is not working, or staff are ignoring my call." On 05/13/2026, Surveyor reviewed Resident 1 medical record. The resident was admitted to the facility on 04/28/206 with diagnosis to include diabetes. Review of Resident 1's ISP (Individual Service Plan) dated 05/12/2026 indicated, the resident required monitoring for toileting tasks and assistance with bathing, grooming and dressing. Review of the facility's "Past Calls" from 04/28/2026 through 05/12/2026 verified Resident 1's concerns of waiting a long time for assistance. The call alarm history for Resident 1 showed the	Y3244		

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Y3244	Continued From page 9 following wait times for assistance: *04/28/2026 at 5:35 PM response time 5 hours *04/29/2026 at 8:40 AM response time 30 minutes *04/30/2026 at 3:38 PM response time 35 minutes *05/01/2026 at 3:07 PM response time 4 hours 58 minutes *05/02/2026 at 8:09 PM response time 31 minutes *05/03/2026 at 6:56 PM response time 31 minutes *05/03/2026 at 7:28 PM response time 1 hour 9 minutes *05/04/2026 at 4:59 AM response time 2 hours 42 minutes *05/04/2026 at 5:48 PM response time 1 hour 5 minutes *05/08/2026 at 2:54 AM response time 46 minutes *05/12/2026 at 6:10 AM response time 30 minutes On 05/12/2026 at 5:15 PM, Surveyor interviewed Director A regarding the above call history report for Resident 1. Director A acknowledged the "Past Call" report documented multiple occurrences Resident 1 waited over 25 minutes and stated, "I think anything over fifteen minutes is unacceptable." On 05/12/2026 at 3:15 PM, Surveyor interviewed Caregiver D about the facility's call light system. Caregiver D explained when a resident uses their personal pendant or call light located in their bedroom or bathroom area, the notification goes to a pager carried by staff and a beeping sound is heard. The pager will display the room number and location of the call. Surveyor then	Y3244		

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questioned Caregiver D about Resident 1's long wait times. Caregiver D confirmed Resident 1 was having problems with his/his call light not working and stated, "I think it's been fixed." Surveyor then asked Caregiver D to test Resident 1's call light near the resident's bed and within the resident's bathroom. Surveyor noted both call lights were working properly.

On 05/12/2026 at 3:30 PM, Surveyor interviewed Caregiver C about the call light system and Resident 1. Caregiver C indicated Resident 1 has reported s/he pressed his/her call light for assistance, but no one came to his/her room. Caregiver C then stated, "I know [Resident 1] has been having issues with [his/her] call button. When [Resident 1] pressed [his/her] button, the signal would not go through to the pager." Caregiver C went on to say, "When residents activate their call light it should route to the pager, if the call doesn't show up on the pager staff have no way of knowing if a resident needs assistance."

On 05/12/2026 at 3:45 PM, Surveyor interviewed Caregiver E regarding Resident 1. Caregiver E confirmed Resident 1 uses his/her call light appropriately, specifically for requesting PRN medication and assistance with transfers. Caregiver E reported Resident 1's bed station call light worked inconsistently when s/he first moved in and stated, "When [Resident 1's] call light was not working staff did thirty-minute checks on [him/her] until it was fixed." Surveyor then asked how the facility checks the call lights to make sure they're working. Caregiver E stated, "There's no way of knowing if a device isn't working or if a battery is low, unless a resident tells us."

On 05/12/2026 at 3:20 PM, Surveyor interviewed

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Director A regarding Resident 1's call light. Director A indicated s/he became aware "about a week ago" Resident 1's bed station call light was not functioning properly and maintenance replaced the batteries. Following the battery replacement, Resident 1 reportedly came to Director A's office and stated the call light continued to malfunction and was only working intermittently. Director A stated, "Knowing the batteries had just been replaced, I adjusted the faceplate slightly and [Resident 1's] call light began functioning again." Director A indicated, staff were instructed to conduct frequent checks on Resident 1 when his/her call light was not functioning properly.

On 05/12/2026 at 10:50 AM, Surveyor interviewed Family Member F. Family Member F stated, "[Resident 2] had a personal pendant call button that didn't work for months because the batteries weren't working...When we talked to staff about it they told us they didn't have any batteries to replace the old ones."

On 05/12/2026 at approximately 1:30 PM, Surveyor asked Administrator B and Director A about the facility's call light system. Administrator B and Director A indicated the facility utilizes a wireless call light system, which includes a bedroom wall station, a bathroom pull cord station and a wearable pendant, all which are battery operated. Surveyor questioned how often the batteries are checked and replaced. Director A and Administrator B both confirmed the facility did not have a current system in place to check the batteries in the devices. Surveyor then asked about the facility's protocol for monitoring and auditing the call light system to ensure proper functionality. Director A and Administrator B confirmed the facility's call light system was not

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Y3244	Continued From page 12 being routinely checked, tested or maintained. On 05/12/2026 at 5:15 PM, Director A told Surveyor s/he spoke with the call light vendor and gained valuable insight into how the facility's wireless call light system functions. Director A stated, "The vendor will be emailing me weekly reports for all devices (pendants, bed and bath stations) to identify low batteries and system faults." Director A indicated s/he plans to schedule vendor training for him/herself and the management team, who will then train the remaining staff on the operations of the call light system. In conclusion, Staff did not respond to Resident 1's call light in a timely manner. Addtionally, the facility identified faults with Resident 1's bedside call button and did not implement a system to ensure call light devices were routinely inspected, tested and maintained to ensure proper functionality and timely resident assistance.	Y3244		