STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 06/25/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey of Serenity Gardens at S65 W13866 Sherwood Circle in Muskego, WI. Five citations of noncompliance were issued, including 4 repeat citations of noncompliance previously issued with statement of deficiency (SOD) QBGJ11 issued on 07/21/2022. Census: 4	M 000		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure 1 sample caregiver completed 15 hours of training to include resident rights training prior to or within 6 months after starting to provide care in 2022. Caregiver C did not receive initial training on resident rights. This requirement is being cited for the second	M 244		

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
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 244	Continued From page 1 time. See Statement of Deficiency (SOD) QBGJ11, issued 07/21/2022. The findings include: On 06/25/2024 at 9:15 A.M., Surveyor observed Caregiver C in the kitchen of the home. Caregiver C told Surveyor s/he had been employed as a caregiver at this home for approximately 2 to 3 years. On 06/25/2024 at 1:22 P.M., Licensee A and Surveyor reviewed Caregiver C's employee file, including Caregiver C's initial training. Caregiver C's hire date was 08/22/2022. Licensee A told Surveyor Caregiver C's employee file did not contain any evidence Caregiver C had completed initial training on resident rights prior to nor following Caregiver C's start of employment on 08/22/2022. Licensee A told Surveyor s/he was not aware of this requirement. Cross Reference: M0246 DHS 88.04(5)(b) Training - 8 Hours Annually	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received.	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 246	Continued From page 2	M 246		

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure 3 of 3 sample caregivers completed 8 hours of training related to the health, safety, welfare, rights and treatment of residents annually, as required.

Licensee A, Caregiver B, and Caregiver C did not receive 8 hours of annual training in 2023, as required.

The findings include:

On 06/25/2024 at 9:15 A.M., Surveyor observed Caregiver C in the kitchen of the home.
Caregiver C told Surveyor s/he had been employed as a caregiver at this home for approximately 2 to 3 years.

On 06/25/2024 at approximately 10:00 A.M., Licensee A and Caregiver B told Surveyor both were at the facility almost daily to provide care and supervision for all 4 residents, including Resident 1, Resident 2, Resident 3, and Resident 4.

On 06/25/2024 at 1:22 P.M., Licensee A and Surveyor reviewed Licensee A's, Caregiver B's, and Caregiver C's employee file, including review of annual training for 2023.
Licensee A's and Caregiver B's hire date was 03/01/2021, following Resident 1's admission to the facility.
Caregiver C's hire date was 08/22/2022.
Surveyor asked Licensee A to provide Surveyor with evidence of Licensee A's, Caregiver B's, and Caregiver C's annual training completed for 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 246	Continued From page 3 Licensee A provided Surveyor with certificates related to topics including restrictive measures, harm reduction, incident reporting, and mental illness included within Licensee A's, Caregiver B's, and Caregiver C's employee files. These certificates did not include the recipient's name of each training, the date of completion for each training, nor the length of time for each training. Licensee A told Surveyor s/he did not have evidence Licensee A, Caregiver B, nor Caregiver C had completed 8 hours of training related to the health, safety, welfare, rights and treatment of residents annually, as required, in 2023. Cross Reference: M0244 DHS 88.04(5)(a) Training - 15 Hours Within 6 Months	M 246		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not evaluate 2 of 2 sample residents annually for evacuation time, using the departments form. Resident 2 and Resident 4 were not evaluated annually for evacuation time in 2023 nor thus far in 2024.	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 346	Continued From page 4 This requirement is being cited for the second time. See Statement of Deficiency (SOD) QBGJ11, issued 07/21/2022. The findings include: This non-ambulatory AFH is licensed to serve up to 4 residents of advanced age, physical disability, have diagnoses including developmental disability, dementia, terminal illness and, or receive public funding. On 06/25/2024, Surveyor observed Resident 2 and Resident 4 ambulating throughout the home during this onsite survey. At 10:00 A.M., Caregiver B told Surveyor Resident 2 and Resident 4 required verbal cues with activities of daily living and safety needs related to diagnoses including developmental disabilities. On 06/25/2024 at 12:19 P.M., Licensee A and Surveyor reviewed Resident 2's record, including evidence of Resident 2's most recent annual evacuation evaluation. Resident 2's date of admission was 07/14/2021 with diagnoses including developmental disability. Licensee A provided Surveyor with documentation of Resident 2's annual evacuation evaluation dated 07/28/2022. Licensee A told Surveyor s/he was unable to locate any evidence Resident 2's evacuation evaluation was completed in 2023 or anytime after 07/28/2022. On 06/25/2024 at 12:38 P.M., Licensee A and Surveyor reviewed Resident 4's record, including evidence of Resident 4's annual evacuation evaluation. Resident 4's date of admission was 03/06/2023	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 346	Continued From page 5 with diagnoses including developmental disability. Licensee A provided Surveyor with documentation of Resident 4's evacuation evaluation dated 03/06/2023. Licensee A told Surveyor this was the only evacuation evaluation completed since Resident 4's admission to the facility. Cross Reference: M0348 DHS 88.05(4)(d)2.c. Semi-Annual Fire Drills	M 346		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on observation, interview, and record review, the licensee did not conduct semi-annual fire drills with all household members in 2023 and thus far in 2024, including documentation of the drill with the date and evacuation time for each drill. This requirement is being cited for the second time. See Statement of Deficiency (SOD) QBGJ11, issued 07/21/2022. The findings include: This non-ambulatory AFH is licensed to serve up to 4 residents of advanced age, physical disability, have diagnoses including developmental disability, dementia, terminal illness and, or receive public funding.	M 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 348	Continued From page 6 On 06/25/2024, Surveyor observed Resident 2 and Resident 4 ambulating throughout the home during this onsite survey. At 10:00 A.M., Caregiver B told Surveyor Resident 2 and Resident 4 required verbal cues with activities of daily living and safety needs related to diagnoses including developmental disabilities. Caregiver B told Surveyor Resident 1 required the use of a walker for stability to change clothes and required the use of and assistance with a wheelchair throughout the home and to exit the home. Caregiver B told Surveyor Resident 3 was able to ambulate throughout and out of the home with a walker related to an amputated foot. At approximately 12:30 P.M., Surveyor observed Caregiver B assist Resident 1 out the home in a wheelchair to the back yard for lunch. On 06/25/2024 at approximately 1:30 P.M., Surveyor asked Licensee A to provide fire drill documentation for 2023 and thus far in 2024. Licensee A told Surveyor s/he did not have documentation of any fire drills conducted in 2023 and thus far in 2024. Licensee A told Surveyor s/he was confused between resident evacuation evaluations and semi-annual fire drills. Licensee A told Surveyor s/he would ensure documentation of semi-annual fire drills would be completed in the future. Cross Reference: M0346 DHS 88.05(4)(d)2.b. Fire Evacuation Annual Evaluation	M 348		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 466	Continued From page 7 by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on interview and record review, the provider did not keep a record of all prescription medications controlled, dispensed, or administered by the licensee or caregivers including the name of the resident, the name of the particular medication, the date and time the resident took the medication, and errors and omissions for Resident 2 and Resident 4. This requirement is being cited for the second time. See Statement of Deficiency (SOD) QBGJ11, issued 07/21/2022. The findings include: Example 1: Resident 2 On 06/25/2024 at approximately 12:05 P.M., Licensee A, Caregiver B, and Surveyor reviewed Resident 2's prescription medications, including documentation of administration for June 2024. Surveyor observed Resident 2's medications stored in a kitchen cabinet containing a lock. Caregiver B told Surveyor all of Resident 2's prescribed medications were controlled, dispensed, and administered by caregivers. Caregiver B told Surveyor a pre-printed medication administration record (MAR) received from the pharmacy was utilized to document	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 466	Continued From page 8	M 466		

Resident 2's medication administration.
Licensee A provided Surveyor with Resident 2's June 2024 medication administration record (MAR). Resident 2's June 2024 MAR included the following prescribed medications; Buspar 10 mg [milligrams] to be administered 3 times per day, Zyrtec 10 mg to be administered every morning, clonazepam 0.5 mg to be administered 2 times per day, Depakote 500 mg to be administered every morning, guanfacine 2 mg to be administered every morning, hydroxyzine pamoate 50 mg to be administered 3 times per day, lisdexamfetamine dimesylate 50 mg to be administered every morning, Trileptal 600 mg to be administered 2 times per day, Risperdal 1.5 mg to be administered 2 times per day, and Zoloft 200 mg to be administered every morning, Ritalin 20 mg to be administered every afternoon at 2:00 P.M., Depakote 750 mg to be administered every evening, guanfacine 3 mg to be administered every evening, and Trazadone 100 mg to be administered every evening. Between 06/17/2024 and 06/25/2024, none of Resident 2's medications included documentation of administration.
Caregiver B told Surveyor s/he was sure all of Resident 2's prescribed medications were administered between 06/17/2024 and 06/25/2024. Caregiver B said s/he had not received a pre-printed MAR for Resident 2's prescribed medications for this time-frame so none of the medications administered to Resident 1 were documented by caregivers.

Example 2: Resident 4

On 06/25/2024 at approximately 12:30 P.M., Licensee A, Caregiver B, and Surveyor reviewed Resident 4's prescription medications, including documentation of administration for June 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017907	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY GARDENS	S65 W13866 SHERWOOD CIRCLE MUSKEGO, WI 53150

(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 466	Continued From page 9 Surveyor observed Resident 4's medications stored in a kitchen cabinet containing a lock. Caregiver B told Surveyor all of Resident 4's prescribed medications were controlled, dispensed, and administered by caregivers. Caregiver B told Surveyor a pre-printed medication administration record (MAR) received from the pharmacy was utilized to document Resident 4's medication administration. Licensee A provided Surveyor with Resident 4's June 2024 medication administration record (MAR). Resident 4's June 2024 MAR included the following prescription medications; Abilify 5 mg to be administered every morning, calcium carbonate 600 mg to be administered every morning, Concerta 72 mg to be administered every morning, Prozac 50 mg to be administered every morning, guanfacine 2 mg to be administered 2 times per day, Ritalin 10 mg to be administered every morning, 1 multivitamin tablet every morning, Prilosec 20 mg to be administered every morning, and vitamin D 2,000 units to be administered every morning, and ciclopironox 8 % solution to be applied to Resident 4's "nail" daily. None of Resident 4's medications included documentation of administration on 06/15/2024, 06/16/2024, 06/18/2024, and 06/23/2024. Resident 4's second daily dose of guanfacine 2 mg was not documented as administered between 06/17/2024 and 06/24/2024. Caregiver B told Surveyor s/he was sure all of Resident 4's medications were administered by caregivers between 06/17/2024 and 06/24/2024, as prescribed, but the caregivers did not document all of the administration. Caregiver B told Surveyor s/he tried to keep up with caregivers and ask them document medication administration, but had not done so for this time frame.	M 466		