STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010867	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMOMILE ASSISTED LIVING LTD I I	842 JUPITER DRIVE MADISON, WI 53718

(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 03/31/2026, the bureau of assisted living southern regional office conducted 3 complaint investigations at Chamomile Assisted Living LTD II a CBRF located in Madison, WI. As a result of this survey, 1 violation of DHS Chapter 83 was issued. One of 3 complaints were substantiated. Census: 6	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individualized service plan (ISP) was implemented and followed as written. Resident 1's ISP documented his/her history of suicide attempt in 2020 with chronic passive suicidal ideation. The ISP instructed provider to keep plastic bags locked/secured out of his/her room. On 03/16/2026, Resident 1 became agitated with staff. Resident 1 went to his/her room and put a plastic bag over his/her head. Caregiver B and Caregiver C witnessed Resident 1's attempt at asphyxiation and took the plastic bag away from him/her. FINDINGS INCLUDE:	N 388		

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

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N 388	Continued From page 1 On 03/31/2026, the Department received a complaint regarding resident safety. On 04/01/2026 at 8:15 AM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 had a significant history of suicidal ideation and behavior. Administrator A stated Resident 1 was upset Caregiver C left his/her room to answer another resident's call light. Resident 1 yelled at Caregiver B about his/her anger towards Caregiver C. Caregiver B asked Resident 1 to go back to his/her room and wait for Caregiver C. Resident 1 went back to his/her room. Caregiver B and Caregiver C went to Resident 1's room to assist with evening care and found Resident 1 with a bag over his/her head. Caregiver B was yelling while s/he took the plastic bag away from Resident 1. Caregiver B and Caregiver C removed all the plastic bags in his/her room. On 04/01/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 06/04/2025. Resident 1 was diagnosed with but not limited to: major depressive disorder, mild neurocognitive disorder, and history of stroke. Resident 1 was his/her own decision maker. On 04/01/2026, Surveyor reviewed Resident 1's incident report dated 03/16/2026. Administrator A documented the following, " ...After dinner, [Caregiver C] escorted [Resident 1] and another resident in the elevator to the lower level. [S/he] then assisted [him/her] to [his/her] room and instructed [him/her] to wait until staff were available to assist [him/her] with bedtime care. [S/he] left to assist the other resident to their room. During this time, [Resident 1] returned upstairs to [Caregiver B] and began yelling about staff not caring. [Caregiver B] asked [him/her] to	N 388		

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N 388	Continued From page 2	N 388		

return to [his/her] room and wait for assistance. [Resident 1] then returned downstairs to [his/her] room. [Caregiver C] and [Caregiver B] went together to assist [him/her] using a 2-person approach and found [him/her] with a plastic bag over [his/her] head in [his/her] room. [Caregiver B] immediately removed the bag. Both caregivers assisted [Resident 1] with [his/her] bedtime routine and helped [him/her] get into bed. All plastic bags were removed from [his/her] room. [S/He] had no injuries and was checked on every hour for the remainder of the night ..."

On 04/10/2026, Surveyor reviewed Resident 1's ISP signed by Resident 1 on 06/03/2025. Attached to the ISP was a behavioral service plan (BSP) attached to it. The BSP was signed by Resident 1 on 10/20/2025. The BSP documented the following, " ...[Resident 1] has diagnosis of major depressive disorder and adjustment disorder. [S/He] experiences passive suicidal ideations and has one prior suicide attempt in 2020 ...Endorses passive suicidal ideations ...Ensure [s/he] does not have access to hazardous items (i.e. sharps, chemicals, medications, ropes, elastic bands, plastic bags) ...HOME & COMMUNITY ENVIRONMENTAL CONSIDERATIONS AND MODIFICATIONS items that should be locked/secured at all times...Plastic bags large enough to be placed over head (i.e. wastebasket liner) ..."

On 04/01/2026 at 10:56 AM, Surveyor emailed Administrator A the above findings.