STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012989	A. BUILDING: _____ B. WING _____	R-C 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GYPSY HILL COUNTRY HOME AFH	E2602 - 470TH AVE MENOMONIE, WI 54751

(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 10/14/2025, Surveyor conducted a verification visit and standard licensing survey at Gypsy Hill Country Home. Seven violations were identified. Three of 7 violations were repeat deficiencies. See Statement of Deficiencies (SOD) 621O11, dated 01/11/2022; 122E11, dated 03/06/2023; and 122E12, dated 03/29/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 2	{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 observation, record review, and interview, the licensee did not comply with laws governing the home and operation. Licensee A did not follow Department orders that were issued on 04/09/2024 with Statement of Deficiencies (SOD) 122E12, which resulted in one repeat deficiency. This is a repeat violation. See SOD 621O11, dated 01/11/2022. Findings include: On 04/09/2024, the Department issued the following enforcement orders with SOD 122E12,	M 216		

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

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M 216	Continued From page 1 dated 03/06/2024: "Based on the results of the Department's investigation, and pursuant to Wis. Stat.§ 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Gypsy Hill Country Home AFH: 1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., 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. WITHIN 45 DAYS of receipt of this notice, the licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) 122E12. The licensee's corrective measures shall address: MEDICATION ADMINISTRATION AND MANAGEMENT, to include the development of a procedure to address how the licensee will: - document medication orders, medication administration, and missed/refused doses; - administer medications to ensure residents receive medications at the intervals and dosages prescribed. - prevent medication errors and respond to medication errors if they occur; - obtain prescription medications and refills in a timely manner; - securely store and manage medications; and - dispose of discontinued and outdated medications. Resources are available at: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm ADDITIONALLY, WITHIN 45 DAYS of receipt of this notice, the	M 216		

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M 216	Continued From page 2	M 216		

licensee shall provide training to all service providers on the corrective actions taken to resolve each deficiency identified in SOD 122E12. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training."

On 10/14/2025, Surveyor conducted a verification visit and standard licensing survey. The provider did not correct 1 violation identified in SOD 122E12 and 6 additional violations were identified related to new employee health screening, training, and fire safety.

On 10/14/2025 at 12:25 PM, Surveyor interviewed Licensee A. Licensee A stated s/he was not great with paperwork. Licensee A stated Nurse Manager (NM) B was overseeing the records and compliance at the facility, but NM B stopped doing this in the fall of 2023.

At 12:43 PM, Surveyor asked Licensee A for evidence that s/he completed his/her enforcement orders. Licensee A indicated s/he was not aware of any enforcement orders. Surveyor reviewed the Notice and Order letter that accompanied SOD 122E12 with Licensee A. Licensee A stated s/he never saw the Notice and Order letter. Licensee A stated, "I did not do special orders... I've never come across this [Notice and Order letter]." Licensee A stated s/he recalled getting the SOD, and s/he told NM B to take care of everything. Surveyor clarified Licensee A's previous statement that NM B left his/her position in the fall of 2023; Licensee A stated that was true. NM B was no longer working at the facility when SOD 122E12 was issued.

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M 216	Continued From page 3 Licensee A stated s/he should have read the SOD and Notice and Order letter. Licensee A stated was going to work on being more organized. Cross references: M0232 DHS 88.04(2)(g)1 Health Screening For Staff M0246 DHS 88.04(5)(b) Training-8 Hours Annually M0334 DHS 88.05(4)(b)1 Fire Safety-Smoke Detectors M0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation M0348 DHS 88.05(4)(d)2.c Semi-Annual Fire Drills M0464 DHS 88.07(3)(d) Medication- Written Order	M 216		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 staff employed at	M 232		

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M 232	Continued From page 4	M 232		

the facility (Caregiver C and Caregiver D) were screened for communicable disease, including tuberculosis, within 90 days before the start of employment.

This is a repeat violation. See Statement of Deficiencies (SOD) 122E11, dated 03/29/2023.

Findings include:

The Department of Health Services publication Tuberculosis Screening and Testing: Health Care Personnel (HCP) and Caregivers (including assisted living staff) states:
"Perform baseline testing for all HCP and caregivers without documented evidence of prior LTBI [latent tuberculosis] or TB disease... IGRA [blood test] or TST may be performed; IGRA is preferred... If TST is used as the baseline testing, 2-step testing is recommended for HCP and caregivers who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative, and documentation of results is available, a one-step TST may be performed before hire." (Retrieved 10/14/2025 from https://dhs.wisconsin.gov/publications/p02382.pdf)

The provider is licensed to care for 4 residents in the client groups physically disabled, developmentally disabled, traumatic brain injury, and emotionally disturbed/mental illness.

On 10/14/2025, Surveyor reviewed employee records.

Caregiver C was originally employed at the facility from 06/24/2019 to 2022. Caregiver C was

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M 232	Continued From page 5 rehired on 08/23/2023. Caregiver C's record included evidence of a 1-step TST completed on 09/23/2019. Caregiver C's record did not include evidence s/he was screened for other communicable illnesses when s/he was hired in 2019 or 2023. Caregiver D was hired on 09/02/2025. Caregiver D's record included a TB baseline test (IGRA) completed on 05/10/2025. Caregiver D's record did not include evidence s/he was screened for other communicable illnesses. On 10/14/2025 at approximately 11:30 AM, Surveyor interviewed Licensee A. Surveyor asked if Licensee A had additional employee health screening documentation. Licensee A stated s/he did not.	M 232		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee eligible for continuing education (Licensee A) completed training requirements in 2023 or 2024.	M 246		

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M 246	Continued From page 6 Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled, developmentally disabled, traumatic brain injury, and emotionally disturbed/mental illness. On 10/14/2025 at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A explained that s/he had been the main caregiver at the facility since licensure (2009). Surveyor reviewed Licensee A's 2023 and 2024 continuing education. Licensee A completed 4 hours of continuing education in 2023. This training, completed on 04/07/2023, included the following topics: pressure injuries, abuse and neglect, body mechanics, and infection control. In 2024, Licensee A completed 9 hours of training on resident rights, human immunodeficiency virus (HIV), and safe patient handling. At 12:24 PM, Surveyor interviewed Licensee A. Licensee A stated s/he tried to complete 8 hours of training annually. Licensee A stated s/he did not complete resident rights training in 2024, but s/he did in 2023. Licensee A stated the topics changed every year. Licensee A stated s/he sought out trainings from various sources every year. Licensee A confirmed Surveyor reviewed all of the training Licensee A did in 2023 and 2024.	M 246		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically	M 334		

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M 334	Continued From page 7 interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure smoke detectors were located on the ceiling of each habitable room in the facility. Findings include: During a survey on 03/28/2023, Surveyor provided technical assistance to Licensee A regarding smoke detectors. On 10/14/2025, Surveyor toured the facility. The each of the 4 bedrooms and the living room had a smoke detector located on the wall, not on the ceiling. At 1:38 PM, Surveyor interviewed Licensee A. Licensee A stated the smoke detectors were installed on the walls prior to licensure. Licensee A stated s/he would contact his/her electrician to get the smoke detectors placed on the ceilings.	M 334		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION	M 346		

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M 346	Continued From page 8 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 record review and interview, the provider did not assess evacuation capabilities annually for 1 of 2 residents (Resident 1). Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled, developmentally disabled, traumatic brain injury, and emotionally disturbed/mental illness. On 10/14/2025, Surveyor reviewed resident records. Resident 1 was admitted to the facility on 03/25/2024. Resident 1's record included an evacuation assessment dated 12/02/2022. At 12:52 PM, Surveyor interviewed Licensee A. Licensee A stated Resident 1's last documented evacuation assessment was completed on 12/02/2022.	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	M 348		

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M 348	Continued From page 9 maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct semi-annual fire drills with all household members in between 2022 and 2025. Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled, developmentally disabled, traumatic brain injury, and emotionally disturbed/mental illness. On 10/14/2025, Surveyor requested the provider's emergency drill documentation from Licensee A. At approximately 12:30 PM, Licensee A stated s/he documented evacuation drills on each resident's evacuation assessment. Licensee A reviewed Resident 2's evacuation assessment and stated the last documented emergency drill was conducted on 09/12/2024 (over 1 year ago). Surveyor reviewed Resident 1's evacuation assessment which indicated the last drill Resident 1 participated in occurred on 12/02/2022. At 12:52 PM, Surveyor interviewed Licensee A. Licensee A stated s/he did not have record of Resident 1 participating in evacuation drills in 2023 or 2024.	M 348		
{M 464}	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a	{M 464}		

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{M 464}	Continued From page 10 prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure written orders were on file for all prescription medications administered to 2 of 2 residents at the facility. The provider did not obtain written orders specifying who by name or position was permitted to administer medication to 1 of 2 residents at the facility. This is a repeat deficiency. See Statement of Deficiencies (SOD) 122E11, dated 03/29/2023 and 122E12, dated 03/06/2024. Findings include: On 10/14/2025, Surveyor reviewed resident records. Resident 1 was admitted to the facility on 09/09/2022. According to Resident 1's October medication administration record (MAR), the provider administered the following medication to Resident 1: - Benztropine 0.5 mg BID (twice a day) - Divalproex Sodium Dr 500 mg at 8:00 AM and 1000 mg at 8:00 PM	{M 464}		

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{M 464}	Continued From page 11 - Haloperidol 5 mg daily - Hydroxychloroquine 400 mg daily - Hydroxyzine HC 25 mg BID - Omeprazole Dr 20 mg daily - Paliperidone ER 12 mg daily - Quetiapine Fumarate 300 mg daily and up to 2 times a day as needed (PRN) Resident 1's record did not include written orders for these medications. Resident 1's record did not include a written order from Resident 1's prescribing physician(s) giving the provider authority to administer Resident 1's medication. Resident 2 was admitted to the facility on 03/25/2014. According to Resident 2's October medication administration record (MAR), the provider administered the following medication to Resident 2: - Combivent inhaler 4 times per day - Escitalopram 10 mg - Hydroxyzine HCL 20 mg BID - Omeprazole DR 40 mg - Oxybutynin CL ER 10 mg Resident 2's record did not include written orders for these medications. On 10/14/2025 at approximately 12:30 PM, Surveyor asked Licensee A if s/he had written orders for Resident 1's and Resident 2's medications. Licensee A reviewed each record and could not find written orders referenced above.	{M 464}		