STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019545	A. BUILDING: _____ B. WING _____	C 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER ROAD ESTATES	1848 RIVER ROAD SPARTA, WI 54656

(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 05/07/2026, Surveyor conducted a licensure survey and 3-complaint investigations at River Road Estates. Data collection continued through 05/19/2026. One of the 3 complaints were substantiated. Twelve deficiencies were identified. Four of the 12 were repeat violations. See Statement of Deficiency (SOD) CQOM11, dated 01/24/2024. Census: 17	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 employees reviewed were screened for communicable disease including tuberculosis (TB) using	N 220		

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

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N 220	Continued From page 1 standards set by the Centers for Disease Control and Prevention (CDC) within 90 days before the start of their employment. This is a repeat deficiency. See Statement of Deficiency (SOD) CQOM11, dated 01/24/2024. Findings include: On 05/07/2026, Surveyor reviewed the employee files for Resident Care Manager (RCM) B, Caregiver D, Caregiver E, and Caregiver F. RCM B's date of hire was 02/17/2024. Surveyor did not find evidence in RCM B's file that a communicable disease screening was completed. Caregiver D's date of hire was 10/06/2025. Surveyor did not find evidence in Caregiver D's file that a communicable disease screening was completed. Caregiver E's date of hire was 03/06/2025. Surveyor did not find evidence in Caregiver E's file that a communicable disease screening was completed. Caregiver F's date of hire was 08/08/2024. Surveyor did not find evidence in Caregiver F's file that a communicable disease screening was completed. On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and RCM B. AA A confirmed they had only been completing a TB test on staff and were not doing a communicable disease screening upon hire.	N 220		

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N 302	Continued From page 2	N 302		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents admitted were screened for clinically apparent communicable disease, including tuberculosis (TB) within 90 days before or 7 days after admission. This is a repeat deficiency. See Statement of Deficiency (SOD) CQOM11, dated 01/24/2024. Findings include: The facility is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill.	N 302		

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N 302	Continued From page 3 On 05/07/2026, Surveyor reviewed Resident 2's and Resident 3's records. Resident 2 was admitted on 05/08/2025. The record did not have evidence Resident 2 was screened for clinically apparent communicable disease upon admission. Resident 3 was admitted on 05/02/2025. The record did not have evidence Resident 3 was screened for clinically apparent communicable disease upon admission. Resident 3 had a form in his/her admission paperwork titled "Communicable Disease Screening", but it was not signed or dated. On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A stated they had residents go to a primary care appointment prior to admission and had the physicians sign paperwork indicating the residents were free from communicable disease. AA A confirmed Resident 3's communicable disease screening form was not signed or dated.	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the	N 352		

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N 352	Continued From page 4	N 352		

provider did not ensure residents received all medications in the dosages and at intervals prescribed by a practitioner.

Resident 3 did not receive his/her scheduled bumetanide medication for multiple days in October and November 2025.

Findings include:

On 03/03/2026, the department received a complaint allegation related to medication management.

On 05/07/2026 at 12:49 PM, Surveyor interviewed Resident 3 in his/her room. Resident 3 stated around Halloween s/he had been out of his/her "water pills" for a few days. Resident 3 stated s/he had been worried about not receiving the medication as s/he had recently been hospitalized for pneumonia and edema.

On 05/07/2026, Surveyor reviewed Resident 3's record.

Resident 3 was admitted to the facility on 05/02/2026 with diagnoses that included cirrhosis, nonalcoholic steatohepatitis, portal hypertension, and ascites. Resident 3 was his/her own decision maker.

An incident report dated 10/31/2025, indicated Resident 3 had approached staff on 10/31/2026 upset about not getting his/her medication for fluid buildup scheduled at 4:00 PM. The report indicated the medication had not come in yet due to the medication order not being renewed by Resident 3's physician.

An investigation for the incident that occurred with

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N 352	Continued From page 5 Resident 3 being arrested on 10/31/2025 dated 11/04/2025, indicated Resident 3 was in jail from 10/31/2025 to 11/03/2025. Resident 3's Individual Service Plan (ISP) dated 02/17/2026, indicated Resident 3 required the provider to manage his/her medications. The October 2025 Medication Administration Records (MARs) indicated Resident 3 was prescribed bumetanide 2 mg tablet to be given twice daily for accumulation of fluid caused by cirrhosis of the liver. The MAR indicated this medication had an order start date on 10/14/2025 and an end date on 11/04/2025. The medication was scheduled for 8:00 AM and 4:00 PM daily. The MAR indicated staff charted "OTH" on 10/29/2025 at 8:00 AM and on 10/30/2026 and 10/31/2025 at 8:00 AM and 4:00 PM. The MAR staff charting code indicated "OTH" meant "other". The MAR indicated through staff notations on 10/29/2025 and 10/30/2025 that the provider did not have bumetanide and/or it was not in the medication cart at the time of scheduled administration. The November 2025 MAR indicated bumetanide had a new order on 11/04/2025. The MAR indicated on 11/01/2025 through 11/03/2025 staff charted "WF". The MAR staff charting code did not have "WF" on it, but Resident 3 was in jail on those dates. The MAR indicated on 11/03/02025 at 4:00 PM through 11/04/2025 staff charted "OTH" for bumetanide administration. On 11/05/2025 and 11/06/2025 at 8:00 AM staff had charted "OTH" for bumetanide administration. The MAR indicated through staff notations on 11/04/2025 through 11/06/2025 that the provider did not have the medication available.	N 352		

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N 352	Continued From page 6 On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A confirmed that they had ongoing issues with getting medications refilled for residents and were considering switching pharmacies along with reviewing their medication refill process. AA A stated regarding Resident 3's bumetanide medication that it had been out for a few days due to waiting for the physician to refill the medication order. AA A and RCM B indicated they had made multiple attempts to call the pharmacy and physician, but these had not all been documented.	N 352		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3's right to the least restrictive environment was honored. The provider searched Resident 3's room and took items without his/her consent. Findings include: On 03/03/2026, the department received a	N 356		

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N 356	Continued From page 7 complaint allegation related to resident rights. On 05/07/2026 at 12:49 PM, Surveyor interviewed Resident 3 in his/her room. Resident 3 stated around Halloween s/he had police called on him/her and was put in jail for a few days. Resident 3 stated when s/he returned to the facility, s/he knew someone had been in his/her room. Resident 3 stated s/he found out the provider had searched his/her room. Resident 3 indicated later the provider returned his/her items, such as utensils, a hammer, a pliers, a screwdriver, multiple scissors, etc. On 05/07/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 05/02/2026 with a diagnosis of depression, anxiety disorder, and other psychoactive substance abuse with unspecified psychoactive substance-induced disorder. Resident 3 was his/her own decision maker. Resident 3's Annual Assessment dated 02/17/2026, indicated Resident 3 had episodes of depression and anxiety. The assessment indicated Resident 3 had hoarding tendencies and would become upset when staff offered to help organize his/her space. The assessment indicated Resident 3 would sometimes be verbally aggressive towards staff and/or other residents. An investigation for the incident that occurred with Resident 3 being arrested on 10/31/2025 dated 11/04/2025, indicated on 11/03/2025 staff searched Resident 3's room per the owner's request to look for potential damage to his/her room. The investigation indicated the provider	N 356		

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N 356	Continued From page 8 took a spoon that had residue on it from Resident 3's room. The investigation indicated the spoon was given to police and was tested for drugs, which came back negative. The investigation indicated on 11/05/2025, Resident 3 approached the provider about suspecting someone had gone through his/her room and s/he had some personal items missing. The investigation read in part, "Additionally, [Resident 3] mentioned that [s/he] plans to contact the police by the end of the day if [his/her] missing belongings are not returned. [His/Her] items were later returned by the owner after a long conversation. The investigation indicated on 11/07/2025, Resident 3 approached Assistant Administrator (AA) A and Resident Care Manager (RCM) B, which read in part, "[Resident 3] also shared that during [his/her] room search, a spoon was taken out and tested by police for drugs. [S/He] felt this was a violation and expressed that it was unjustified." On 05/15/2026 at 3:50 PM, Surveyor received an email from AA A. The email indicated Resident 3's room was searched by the provider on 10/31/2025 and read in part, " ...due to immediate safety concerns related to threats the resident was reportedly making before leaving the facility. During the search, staff located and removed a pocket knife, a house-owned screwdriver, a house-owned hammer, over-the-counter medications, and a spoon with questionable residue on it. Following the incident, the facility later recognized that the approach taken was not the proper procedure for handling these concerns. In response, the facility arranged Ombudsman training and reviewed appropriate resident rights, safety, and investigative procedures with management/staff to help prevent similar situations moving forward."	N 356		

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N 356	Continued From page 9 On 05/19/2026 at 1:00 PM, Surveyor interviewed AA A and RCM B. AA A stated staff did not initially know Resident 3's room search was against his/her rights when the owner asked them to do it due to safety concerns with Resident 3's verbal aggression. AA A indicated all of Resident 3's personal items were returned and staff were educated after the incident regarding resident rights. Resident 3's right to the least restrictive environment was not honored when the provider searched his/her room and took items belonging to him/her without his/her consent.	N 356		
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 review and revise Resident 3's individual service plan (ISP), when there was a change in Resident 3's behavior.	N 389		

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N 389	Continued From page 10 This is a repeat deficiency. See Statement of Deficiency CQOM11, dated 01/24/2024. Findings include: On 05/07/2026 at 9:45 AM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A indicated they had been struggling to manage Resident 3's behaviors. AA A indicated Resident 3 was easily triggered and would feel attacked by staff and other residents. On 05/07/2026 at approximately 11:15 AM, Surveyor interviewed Caregiver E. Caregiver E stated Resident 3 was "mean" and "bullied" staff and other residents. Caregiver E indicated on Halloween, Resident 3 became upset and threw a bowl of candy with kids present causing staff to contact law enforcement. On 05/07/2026 at 12:23 PM, Surveyor interviewed Resident 2. Resident 2 indicated s/he did not participate in activities as frequently and did not leave his/her room as often due to Resident 3's volatile and disruptive behavior. On 05/07/2026 at 12:49 PM, Surveyor interviewed Resident 3 in his/her room. Resident 3 confirmed on Halloween s/he had police called on him/her and was put in jail for a few days due to disorderly conduct. On 05/07/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 05/02/2026 with a diagnosis of depression, anxiety disorder, and other psychoactive substance abuse with unspecified psychoactive	N 389		

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substance-induced disorder. Resident 3 was his/her own decision maker.

An incident report dated 10/31/2025, indicated Resident 3 was verbally aggressive and threw a Halloween candy bowl after being told s/he could not have leftovers heated up later by staff. The incident report indicated Resident 3's verbal aggression increased due to him/her being upset about not having medication available in the facility and staff later again approaching him/her offering his/her evening medications. Eventually, law enforcement was called and arrested Resident 3 for disorderly conduct and s/he spent 4 days in jail.

An investigation report related to the incident that occurred with Resident 3 being arrested on 10/31/2025 dated 11/04/2025, indicated in the plan of correction the provider would create a behavior plan for Resident 3.

Behavior tracking sheets dated from 11/25/2025 through 12/17/2025, indicated Resident 3's behavior was being tracked by the provider. The tracking sheets indicated Resident 3 had multiple behaviors that included physical aggression, verbal aggression, and micro-managing staff.

Resident 3's Individual Service Plan (ISP) dated 02/17/2026, indicated Resident 3 had episodes of depression and anxiety. The ISP indicated Resident 3 would experience episodes of crying, social withdrawal, lack of motivation, and increased sleep. The ISP indicated Resident 3 had hoarding tendencies and would become upset when staff were willing to help organize his/her space. The ISP indicated Resident 3 would sometimes be verbally aggressive towards staff and/or other residents using curse words,

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N 389	Continued From page 12 threatening language/mannerisms, name calling, or demeaning language. The ISP did not indicate how behaviors would be monitored or managed by staff. On 05/19/2026 at 1:00 PM, Surveyor interviewed AA A and RCM B. AA A indicated Resident 3's behaviors had started 2 weeks after his/her admission. AA A indicated it was difficult to figure out and manage Resident 3's needs and behaviors. AA A confirmed they did not have a behavior support plan for Resident 3. AA A indicated they had been trying to work with Resident 3's care team to create a behavior plan, but felt they were not receiving enough support.	N 389		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure scheduled psychotropic medications were reviewed at least quarterly for 4 of 4 residents reviewed (Resident 2, Resident 3, Resident 4, and Resident 5).	N 407		

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N 407	Continued From page 13 Findings include: The provider is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. On 05/19/2026 at, Surveyor reviewed Resident 2's, Resident 3's, Resident 4's, and Resident 5's records. Resident 2 was admitted to the facility on 05/08/2025. Resident 2's record contained one scheduled psychotropic review completed on 12/15/2025. Resident 2's Medication Administration Record (MAR) indicated s/he was prescribed the following scheduled psychotropic medications and their start dates: -citalopram 09/19/2025 -gabapentin 02/25/2026 -aripiprazole 09/19/2025 -buspirone 09/19/2025 -trazadone 02/25/2026 Resident 3 was admitted to the facility on 05/02/2025. Resident 3's record contained one scheduled psychotropic review completed on 12/15/2025. Resident 3's MAR indicated s/he was prescribed the following scheduled psychotropic medications and their start dates: -duloxetine 10/20/2025 -trazadone 02/16/2026 Resident 4 was admitted to the facility on 01/19/2018. Resident 4's record contained scheduled psychotropic reviews completed on 12/11/2025, 11/21/2024, 07/11/2024, and 01/30/2024. Resident 4's MAR indicated s/he was	N 407		

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N 407	Continued From page 14 prescribed the following scheduled psychotropic medications and their start dates: -duloxetine 08/13/2025 -buspirone 08/13/2025 -gabapentin 08/13/2025 Resident 5 was admitted to the facility on 10/19/2022. Resident 5's record contained scheduled psychotropic reviews completed on 12/15/2025 and 07/11/2024. Resident 5's MAR indicated s/he was prescribed the following scheduled psychotropic medication and its start date: -bupropion 01/26/2026 On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A stated Registered Nurse (RN) C was responsible for completing psychotropic medication reviews and they were not documented anywhere else. On 05/19/2026 at 3:16 PM, Surveyor interviewed RN C. RN C confirmed psychotropic medication reviews were his/her responsibility. RN C indicated s/he was typically at the facility monthly but due to other obligations s/he had not been on top of getting the psychotropic medication reviews done as required. Resident 2's, Resident 3's, Resident 4's, and Resident 5's scheduled psychotropic medication was not reviewed by a registered nurse, pharmacist, or practitioner at least quarterly.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on	N 408		

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N 408	Continued From page 15	N 408		

an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on interview and record review, for as needed (PRN) psychotropic medications, the provider did not conduct monthly reviews, for 3 of 3 residents reviewed that were prescribed a PRN psychotropic medication.

Findings include:

The facility is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill.

On 05/19/2026 at, Surveyor reviewed Resident 2's, Resident 4's, and Resident 5's records.

Resident 2 was admitted to the facility on

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N 408	Continued From page 16	N 408		

05/08/2025. Resident 2's record contained PRN psychotropic reviews completed on 01/06/2026, 12/15/2025, 09/26/2025, and 08/06/2025. Resident 2's PRN psychotropic review indicated Resident 2 was taking trazadone PRN since at least August 2025. The MARs indicated Resident 2 was administered this medication 2 times in March 2026 before it was discontinued on 03/07/2026.

Resident 4 was admitted to the facility on 01/19/2018. Resident 4's record contained PRN psychotropic reviews completed on 04/14/2026, 01/06/2026, 12/11/2025, 09/26/2025, 08/06/2025, 07/09/2025, and 05/05/2025. Resident 4's MAR indicated s/he was prescribed melatonin PRN since 08/13/2025. The MARs indicated Resident 4 was not administered this medication 03/01/2026 through 05/12/2026.

Resident 5 was admitted to the facility on 10/19/2022. Resident 5's record contained PRN psychotropic reviews completed on 04/14/2026, 01/06/2026, 12/15/2025, 08/06/2025, 07/09/2025, 05/05/2025, and 03/22/2025. Resident 5's MAR indicated s/he was prescribed melatonin PRN 06/23/2023. The MARs indicated Resident 5 was not administered this medication 03/01/2026 through 04/23/2026, when it was put on hold.

On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A stated Registered Nurse (RN) C was responsible for completing psychotropic medication reviews and they were not documented anywhere else.

On 05/19/2026 at 3:16 PM, Surveyor interviewed Registered Nurse (/RN) C. RN C confirmed psychotropic medication reviews were his/her

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N 408	Continued From page 17 responsibility. RN C indicated s/he was typically at the facility monthly but due to other obligations s/he had not been on top of getting the psychotropic medication reviews done as required. The provider did not monitor at least monthly for the inappropriate use of PRN psychotropic medication.	N 408		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure resident prescription medications were securely stored in 1 of 1 area. Resident 1 had a prescribed oral solution sitting on the sink in an unsecured community bathroom. Findings include: The facility is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. On 05/07/2026 at approximately 10:30 AM, Surveyor observed on the unsecured community bathroom two bottles of prescription mouthwash sitting on the sink counter unsecured. The labels on both bottles indicated they were Resident 1's	N 419		

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N 419	Continued From page 18 chlorhexidine 0.12% oral solution. On 05/07/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/06/2025 and was his/her own decision maker. Resident 1's most current individual service plan (ISP), indicated Resident 1 was independent with oral care and staff were to manage and administer Resident 1's medications. Resident 1's April and May 2026 medication administration records (MARs) indicated Resident 1 was prescribed chlorhexidine 0.12 % oral solution to be used twice per after brushing teeth. The MAR indicated Resident 1 was to rinse with 15 ml or one capful and spit out. The MAR indicated staff were documenting administration of the chlorhexidine oral solution to Resident 1. On 05/07/2026 from 9:34 AM to 3:15 PM, Surveyor observed residents moving freely throughout the facility. On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A stated they initially kept Resident 1's prescribed oral solution in the medication cart but had moved it to the community bathroom per Resident 1's request. AA A indicated they would secure the prescribed oral solution immediately.	N 419		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the	N 488		

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N 488	Continued From page 19 temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the clothes dryer at the facility had tubing of a rigid material. Findings include: The facility is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. On 05/07/2026 at approximately 10:30 AM, Surveyor observed the laundry room in the facility had two clothes dryers. Surveyor observed both clothes dryers had a vent that consisted partially of a non-rigid, flexible tubing. The portion of tubing that was non-rigid was approximately 2 feet long and led from the back of the dryer to the back wall. On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A stated the laundry room was in the newer part of the building, which was completed about 1 year ago. AA A indicated s/he understood the concern and would get the dryer vent changed to a rigid material. The provider did not ensure clothes dryer vent tubing was of a rigid material.	N 488		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating	N 504		

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N 504	Continued From page 20 system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a heating contractor or local utility company completed maintenance service on the furnaces as required. Findings include: The facility is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. On 05/07/2026 at 12:46 PM, Surveyor requested the provider's last furnace inspection from Assistant Administrator (AA) A. On 05/07/2026 at 2:55 PM, Surveyor asked AA A about the last furnace inspection after not receiving one upon initial request. AA A stated s/he had not had one done. Surveyor gave AA A a deadline to receive the last furnace inspection for 05/11/2026 at 3:00 PM.	N 504		

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N 504	Continued From page 21 As of 05/11/2026 at 5:00 PM, Surveyor had not received the provider's last furnace inspection. On 05/12/2026 at 2:10 PM, Surveyor again requested the provider's last furnace inspection. On 05/14/2026 at 2:08 PM, Surveyor received a furnace inspection via email from the provider. The furnace inspection for the gas furnace was dated 05/08/2026. On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A stated there were two furnaces within the building. AA A stated one furnace was gas and another was a boiler. AA A confirmed there were no documented furnace inspections prior to the furnace inspection done on 05/08/2026 for the gas furnace.	N 504		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible material was stored at least 3 feet away from the furnace. This is a repeat deficiency. See SOD CQOM11, dated 01/24/2024. Findings include: The facility is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged,	N 507		

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N 507	Continued From page 22 physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. On 05/07/2026 at approximately 10:30 AM, Surveyor observed the facility's furnace and water heater utility room. The room contained a walker, multiple pails of paint, ladder, and tarps within 3 feet of the two water heaters. The room contained a tool cart, shop vac, multiple leaf blowers, wooden wheeled cart, wood, plastic, and several cardboard boxes within 3 feet of the furnace. On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A confirmed the gas furnace was in the utility room. AA A indicated s/he understood the concern and would get the items removed immediately.	N 507		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other evacuation drills were conducted at least semi-annually in 2024 and 2025. Findings include: The facility is licensed to provide services for up to 22 residents within the following client groups: developmentally disabled, advanced aged, physically disabled, irreversible	N 526		

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N 526	Continued From page 23 dementia/Alzheimer's disease, and terminally ill. On 05/07/2026 at 12:46 PM, Surveyor requested to review other evacuation drill documentation for 2024 and 2025. Surveyor was provided a binder that included fire drills but Surveyor did not find any evacuation drills for 2024 or 2025. On 05/12/2026 at 2:10 PM, Surveyor again requested evacuation drills for 2024 and 2025. On 05/14/2026 at 2:08 PM, Surveyor received further documentation requested from the provider but did not find any evacuation drills. On 05/19/2026 at 1:00 PM, Surveyor interviewed Assistant Administrator (AA) A and Resident Care Manager (RCM) B. AA A confirmed evacuation drills had not been done in 2024 and 2025 but would start doing them moving forward.	N 526		