Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510123	A. BUILDING: _____ B. WING _____	R-C 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CIRCLE	211 6TH AVE N PO BOX 187 STRUM, WI 54770

(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 01/09/2026, Surveyor conducted a verification visit at Family Circle. One deficiency was identified. One of 1 deficiency was a repeat violation (see SOD 37KF11, dated 01/30/2025). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
{N 328}	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy	{N 328}		

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
	510123	A. BUILDING: _____ B. WING _____	R-C 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CIRCLE	211 6TH AVE N PO BOX 187 STRUM, WI 54770

(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 328}	Continued From page 1 agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide an involuntary discharge notice to Resident 1 that included the following requirements: the reason and justification for discharge, a statement indicating the resident may ask for Department review, the contact information for the regional office's director, or the contact information for the regional office ombudsman program. This is a repeat deficiency. See Statement of Deficiency (SOD) 37KF11, dated 01/30/2025. Findings include: The provider is licensed to care for 16 residents in the client groups of advanced age, alcohol/drug dependent and emotionally disturbed/mental illness. On 04/01/2025, the provider received a Notice and Order letter with the Statement of Deficiency (SOD) 37KF11. The letter contained Special Orders, which indicated the provider was to develop and implement corrective measures to protect and promote each resident's right to receive a 30 day written advance notice of discharge with all required information. On 01/09/2026 Surveyor conducted a verification visit for SOD 37KF11. On 01/09/2025 at 9:50 AM, Surveyor interviewed Administrator A and asked if there had been any involuntary discharges since May 2025.	{N 328}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510123	A. BUILDING: _____ B. WING _____	R-C 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CIRCLE	211 6TH AVE N PO BOX 187 STRUM, WI 54770

(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 328}	Continued From page 2 Administrator A stated there had been an involuntary resident discharge and Surveyor requested the resident's record. On 01/09/2026 at 10:07 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/22/2025 and was his/her own decision maker. A 30-day discharge notice dated 08/15/2025, was sent to the managed care organization (MCO) via email. The email read, "[Provider] at this time is issuing a 30-day notice to request change of placement for [Resident 1]." The email did not include the reason and justification for discharge, a statement indicating the resident may ask for Department review, the contact information for the regional office's director, or the contact information for the regional office ombudsman program. Surveyor asked Administrator A if Resident 1 had received a written 30-day notice of discharge and Administrator A stated s/he had not. Administrator A stated Resident 1 was discharged on 09/11/2025 to a facility with an alcohol treatment program as s/he had been actively drinking. On 01/09/2026 at 11:35 AM, Surveyor interviewed Administrator A during the exit conference. Administrator A stated Resident 1 had an extensive discharge with multiple care team members involved for his/her specific treatment program placement. Surveyor reviewed with Administrator A the DHS 83 code for involuntary discharge notice requirements.	{N 328}		