STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012715	A. BUILDING: _____ B. WING _____	R-C 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINCH HOUSE	5762 FINCH LN GREENDALE, WI 53129

(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 04/29/2026, Surveyors completed a verification visit, one complaint investigation, and a standard survey at Finch House. As a result, all previous deficiencies were corrected. Sixteen new deficiencies were identified. One complaint was substantiated. Two of the 16 deficiencies are repeat deficiencies. (See Statement of Deficiency (SOD) 44E011, dated 04/25/2022, and SOD 44E014, dated 12/08/2023) Three of the 16 deficiencies are being cited a third time. (See SOD 44E011, dated 04/25/2022, SOD 44E012, dated 09/14/2022, SOD 44EO13, dated 03/01/2023, and SOD 44E014, dated 12/08/2023). One of the 16 deficiencies is being for the fifth time. (See SOD 44E011, dated 04/25/2022, SOD 44E012, dated 09/14/2022, SOD 44EO13, dated 03/01/2023, and SOD 44E014, dated 12/08/2023). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and	N 158		

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

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N 158	Continued From page 1 document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not contact the licensing agency within 7 days when they had reasonable cause to suspect caregiver misconduct in 2 of 2 incidents. In December 2025, Ex-House Manager UU allegedly stole and used Resident 13's debit card. On 04/19/2026, Caregiver QQ allegedly committed an act of neglect, affecting 7 of 7 residents. Findings include: On 04/28/2026 at approximately 7:00 AM, Surveyor reviewed the department's facility folder and identified no self-reports were submitted in 2025 and 2026. Example 1: On 03/20/2026, the department received a complaint alleging misappropriation.	N 158		

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N 158	Continued From page 2 On 04/28/2026 at approximately 10:45 AM, Surveyor interviewed House Manager OO. House Manager OO disclosed being informed by a caregiver that Ex-House Manager UU stole Resident 13's debit card and used Resident 13's debit card for personal use. House Manager OO informed Legal Guardian SS and Licensee E right away on 12/09/2026. House Manager OO reported an investigation into the allegation was conducted and completed by Director of Operations C. On 04/29/2026 at approximately 1:37 PM, Surveyor interviewed Legal Guardian SS. Legal Guardian SS reported House Manager OO informed him/her of Resident 13's debit card being stolen by Ex-House Manager UU on 12/09/2025. Legal Guardian SS reported reviewing Resident 13's transaction history, and questioned two transactions, as he/she does not believe Resident 13 would have used their debit card at the reported locations at the reported times. The two transactions in question took place on October 21, 2025. The first transaction occurred at 6:23 PM at SQ *Savoys Bars & Liquor Stores. The second transaction occurred at 10:14 PM at Brothers Petrol INC Gas Stations - Inside. Legal Guardian SS reported Resident 13 does not consume alcohol and would not go to the gas station at 10:14 PM. On 04/29/2026 at approximately 4:00 PM, Surveyor reviewed Resident 13's debit card transactions and confirmed the above transactions took place. On 04/29/2026 at approximately 3:00 PM, Surveyor reviewed a "Facility Investigation Report," dated on 12/30/2025. The report stated the following:	N 158		

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N 158	Continued From page 3 "On 12/18/2025, [Licensee E] became aware of a concern involving missing resident case second hand through [House Manager OO] first then later [Licensee E] was made aware of a debit card belonging to a resident was missing. It was later reported that the card may have been used without authorization. At the time the concern was brought to my attention, [Ex-House Manager UU] was not long employed ...Investigation Findings -The resident's debit card was reported missing and potentially used; however, no direct evidence was provided to the facility confirming who used the card -The facility did not receive supporting documentation (e.g. transaction records, police reports, or bank statements) from the guardian or case manager to substantiate the allegation -No staff members reported witnessing or having knowledge of misuse of the resident's debit card - the allegation surfaced after the [Ex-House Manager UU] employment had ended, limiting the ability to interview [him/her] as part of the investigation ...Conclusion At this time, the investigation is inconclusive due to insufficient evidence to substantiate that any caregiver misappropriated resident funds. Therefore, [Licensee E] did not report the incident to the OCQ (Office of Caregiver Quality) nor to the regional office ..." On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E denied reporting the allegations of misappropriation to the department as he/she believed only substantiated allegations were to be reported to the department. Licensee E failed to report allegations of misappropriation by Ex-House Manager UU to the department.	N 158		

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N 158	Continued From page 4 Example 2: On 04/28/2026 at approximately 10:45 AM, Surveyor interviewed House Manager OO. House Manager OO reported on 04/19/2026, upon his/her arrival at 2:00 PM, a resident informed him/her that he/she was hungry and wondered when lunch was being served. House Manager OO asked other residents within the home if they had been served lunch, and all residents denied. House Manager OO contacted Caregiver QQ via telephone and inquired why residents were not served lunch. Caregiver QQ reported all residents refused lunch. On 04/28/2026 at approximately 11:00 AM, Surveyor reviewed a "Disciplinary Action Report," dated on 04/19/2026 and completed by House Manager OO. The report stated, "On April 19th [House Manager OO] staff came in to work at 2 pm to releave [sic] [Caregiver QQ] from [his/her] shift. [He/She] left then resident stated that they didn't eat lunch. [House Manager OO] staff call [Caregiver QQ] and ask why resident didn't have lunch [he/she] stated that they all refused ..." Surveyor did not locate any investigation report related to this incident. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E denied being aware of Caregiver QQ not feeding the residents lunch. Licensee E acknowledged the incident was an act of neglect. Licensee E reported he/she was responsible for auditing staff records and reviewing all disciplinary action reports upon an employee's termination. Licensee E confirmed being aware of Caregiver QQ's termination but denied reviewing Caregiver	N 158		

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N 158	Continued From page 5 QQ's disciplinary action report. Licensee E did not report Caregiver QQ's act of neglect to the department.	N 158		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the provider and its operation did not comply with all laws governing the Community Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. As a result of this verification visit, complaint investigation and standard survey, a total of 16 violations were issued. Six of the 16 violations were repeat deficiencies related to physical environment, licensee ensuring facility complies with laws, administrator supervising daily operations, and conducting evacuation drills. This requirement is being cited for the third time. See Statements of Deficiency (SOD) 44E013, dated 03/01/2023 and SOD 44E014, dated 12/08/2023. Findings include: The provider is licensed as a Class CNA (non-ambulatory) facility to care for 8 residents in the client groups of irreversible	N 196		

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N 196	Continued From page 6	N 196		

dementia/Alzheimer's disease, advanced aged, intellectually disabled and emotionally disturbed/mental illness. On 04/28/2026, the facility census was 7.

On 04/28/2025 at approximately 7:00 AM, Surveyor reviewed the facility's compliance history within the past 6 years. Since 02/02/2022 to date, the department has conducted a total of 7 regulatory visits consisting of 5 complaint investigations, 3 licensing surveys, and 5 verification visits. Six of the 7 visits resulted in deficiencies, substantiated complaints, and/or enforcement actions. The facility's compliance history identified the following:

SOD ZWY411, dated 02/02/2022, consisted of one complaint investigation with no identified deficiencies.

SOD 44E011, dated 04/25/2022, consisted of a licensing survey and one complaint investigation. The complaint was unsubstantiated. Twenty deficiencies were identified. The deficiencies included:

N0214 - DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation.
N0404 - DHS 83.37(1)(e) Medication Regimen, Administration Review.
N0406 - DHS 83.37(1)(g) Disposition Of Medications
N0446 - DHS 83.41(1)(b) Equipment.
N0447 - DHS 83.41(1)(c) Dishwashing.
N0452 - DHS 83.41(3)(b) Food Safety.
N0479 - DHS 83.42(2) Resident Records Safeguarded
N0481 - DHS 83.43(1) Environment Safe, Clean, And Comfortable
N0499 - DHS 83.45(3) Toxic Substances

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N 196	Continued From page 7 N0502 - DHS 83.46(1)(a) Comfortable And Safe Temperatures N0504 - DHS 83.46(1)(c) Heating System Maintenance N0525 - DHS 83.47(2)(d) Fire Drills. N0526 - DHS 83.47(2)(e) Other Evacuation Drills N0530 - DHS 83.47(3) Fire Inspection N0531 - DHS 83.47(4)(a) Fire Extinguishers Type and Inspection. N0535 - DHS 83.48(1)(b) Smoke And Heat Detectors Per Nfpa 72 N0538 - DHS 83.48(3)(a) Fire Detection Systems Inspected Annually N0554 - DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room. N0558 - DHS 83.48(8)(b) Sprinkler System Installation And Maintenance N0612 - DHS 83.55(3) Bath and Toilet Areas: Hand Drying SOD 44E012, dated 09/14/2022, consisted of a verification visit. Nine deficiencies were identified. Eight of the 9 deficiencies were repeat deficiencies. The deficiencies consisted of: N0214 - DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation. This requirement was a repeat deficiency. N0404 - DHS 83.37(1)(e) Medication Regimen, Administration Review. This requirement was a repeat deficiency. N0446 - DHS 83.41(1)(b) Equipment. This requirement was a repeat deficiency. N0447 - DHS 83.41(1)(c) Dishwashing. This requirement was a repeat deficiency. N0452 - DHS 83.41(3)(b) Food Safety. This requirement was cited for a third time. N0503 - DHS 83.46(1)(b) Portable Space Heaters Prohibited N0525 - DHS 83.47(2)(d) Fire Drills This	N 196		

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N 196	Continued From page 8	N 196		

requirement was a repeat deficiency.
N0531 - DHS 83.47(4)(a) Fire Extinguishers Type and Inspection. This requirement was a repeat deficiency.
N0554 - DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room. This requirement was a repeat deficiency.

SOD 44E013, dated 03/01/2023, consisted of a verification visit and 2 complaint investigations. Two of 2 complaints were substantiated. The department issued a no new admission order to the provider. Nine deficiencies were identified. Four of the 9 deficiencies were repeat deficiencies. The deficiencies consisted of:

N0165 - DHS 83.12(4)(c) Reporting Incidents With Serious Injury
N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0214 - DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation. This requirement was cited for the third time.
N0352 - DHS 83.32(3)(h) Rights Of Residents: Receive Medication
N0370 - DHS 83.34(3) More Than $200 Personal Funds From Resident
N0431 - DHS 83.38(1)(g) Health Monitoring
N0447 - DHS 83.41(1)(c) Dishwashing. This requirement was cited for the third time.
N0531 - DHS 83.47(4)(a) Fire Extinguishers Type and Inspection. This requirement was cited for the third time.
N0554 - DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room. This requirement was cited for the third time.

SOD 44E014, dated 12/08/2023, consisted of a verification visit and licensing survey. The department issued a no new admission order

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extension to the provider. Fourteen deficiencies were identified. Seven of the 14 deficiencies were repeat deficiencies. The deficiencies consisted of:

N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws. This requirement was a repeat deficiency.
N0214 - DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation. This requirement was cited for the fourth time.
N0219 - DHS 83.17(1) Licensee Conduct Caregiver Background Check
N0220 - DHS 83.17(2)(a) Employees Screened For Communicable Diseases
N0352 - DHS 83.32(3)(h) Rights Of Residents: Receive Medication. This requirement was a repeat deficiency.
N0366 - DHS 83.34(1) Limitations On Control Of Resident Funds
N0407 - DHS 83.37(1)(h) Scheduled Psychotropic Medications
N0416 - DHS 83.37(2)(e) Other Administration Given Or Delegated by Rn
N0427 - DHS 83.38(1)(c) Leisure Time Activities
N0480 - DHS 83.42(3) Access To Resident Records
N0481 - DHS 83.43(1) Environment Safe, Clean, And Comfortable. This requirement was a repeat deficiency.
N0499 - DHS 83.45(3) Toxic Substances. This requirement was a repeat deficiency.
N0554 - DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room. This requirement was cited for the fourth time.
N0612 - DHS 83.55(3) Bath and Toilet Areas: Hand Drying. This requirement was a repeat deficiency.

SOD 44E015, dated 10/23/2024, consisted of a

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N 196	Continued From page 10 verification visit. The facility census at the time of the survey was 0. One deficiency was identified. One of 1 deficiency was a repeat deficiency. The deficiency identified was: N0554 - DHS 83.48(6)(e) Integrated Heat Detector in Laundry Room. This requirement was cited for the fifth time. On 04/29/2026, Surveyors conducted a verification visit, complaint survey, and licensing survey. As a result, 16 deficiencies were identified. Six of the 16 deficiencies were repeat deficiencies. The deficiencies identified were: N0158 - DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws. This requirement was cited for the third time. N0214 - DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation. This requirement was cited for the fifth time. N0219 - DHS 83.17(1) Licensee Conduct Caregiver Background Check N0230 - DHS 83.19 Orientation N0247 - DHS 83.22 (1)-(4) Task Specific Training N0305 - DHS 83.28(6) Resident Rights, Grievance Procedures, Rules N0310 - DHS 83.29 Admission Agreement Include Services, Charges N0386 - DHS 83.35 (3)(a) Comprehensive Individualized Service Plan N0387 - DHS 83.35(3)(b) Service Plan Development, Parties Involved N0393 - DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0416 - DHS 83.37(2)(e) Other Administration Given Or Delegated by Rn. This requirement was a repeat deficiency.	N 196		

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N0450 - DHS 83.41(2)(c) Nutrition: Meals
N0481 - DHS 83.43(1) Environment Safe, Clean, And Comfortable. This requirement was cited for a third time.
N0525 - DHS 83.47(2)(d) Fire Drills This requirement was cited for a third time.
N0526 - DHS 83.47(2)(e) Other Evacuation Drills. The requirement was a repeat deficiency.

On 04/28/2026 at approximately 4:00 PM, Surveyor reviewed the department's facility folder. Surveyor identified a letter sent from Attorney MM. The letter was dated and sent to the department on 02/10/2023. The letter stated the following:

" ...As you may be aware, my clients previously entered a transaction whereby [Buyer NN] ...would purchase the following facilities: ...Finch House, 5762 Finch Ln, Greendale, WI ... On January 6, 2023, [Owner NN] was provided a notice of default regarding its obligations under the transaction contracts and was provided an opportunity to cure said defaults. As of today's date, [Owner NN] has failed to cure is defaults, and my clients [Licensee E] have elected to retake possession of the facilities ...As such, it is hereby noticed to DHS that all pending CHOW (Change of Ownership) applications for ...Finch House ... must be denied and closed ..."

On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E acknowledged the facility's compliance history. Licensee E reported filing for a change of ownership in 2022 and allowed Owner NN to continue operating the facility under Licensee E's license. Licensee E reported discharging all residents in 2024 to work on coming back into compliance with DHS 83. Licensee E began

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N 196	Continued From page 12 admitting residents in April 2025. Licensee E acknowledged the deficiencies that were identified on 04/28/2026 while Surveyors were onsite. Licensee E reported he/she would need to work with the new house manager and nurse on the identified deficiencies.	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on interview, record review, and observation, the administrator did not supervise the daily operation of the Community-Based Residential Facility (CBRF) including resident care, finances and physical environment. Licensee E, who served in the administrator role for the facility, did not provide the necessary supervision to ensure the physical environment was maintained, residents received proper care, and their rights were respected. This requirement is being cited for the fifth time. See Statements of Deficiency (SOD) 44E011	N 214		

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(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 214	Continued From page 13 dated 04/25/2022, SOD 44E012, dated 09/14/2022, SOD 44E013, dated 03/01/2023, and SOD 44E014, dated 12/18/2023. Findings include: On 04/28/2026 at approximately 9:35 AM, Surveyor conducted an onsite verification visit and standard survey. During the survey, Surveyors conducted interviews with residents, legal guardians, staff, and administration. Surveyors made observations of the facility's physical environment. Surveyors reviewed investigation documents related to resident rights and resident care (allegations of misappropriation of Resident 13's funds and allegations of neglect by a caregiver). As a result of the survey, 16 deficiencies were identified. Six of the 16 deficiencies were repeat deficiencies. The deficiencies identified were: N0158 - DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws. This requirement was cited for the third time. N0214 - DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation. This requirement was cited for the fifth time. N0219 - DHS 83.17(1) Licensee Conduct Caregiver Background Check N0230 - DHS 83.19 Orientation N0247 - DHS 83.22 (1)-(4) Task Specific Training N0305 - DHS 83.28(6) Resident Rights, Grievance Procedures, Rules N0310 - DHS 83.29 Admission Agreement Include Services, Charges N0386 - DHS 83.35 (3)(a) Comprehensive Individualized Service Plan	N 214		

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N 214	Continued From page 14 N0387 - DHS 83.35(3)(b) Service Plan Development, Parties Involved N0393 - DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0416 - DHS 83.37(2)(e) Other Administration Given Or Delegated by Rn. This requirement was a repeat deficiency. N0450 - DHS 83.41(2)(c) Nutrition: Meals N0481 - DHS 83.43(1) Environment Safe, Clean, And Comfortable. This requirement was cited for a third time. N0525 - DHS 83.47(2)(d) Fire Drills This requirement was cited for a third time. N0526 - DHS 83.47(2)(e) Other Evacuation Drills. The requirement was a repeat deficiency. On 04/28/2026, Surveyor reviewed the facility's electronic record with the department. Director of Operations C was identified as serving in the administrator role. On 04/28/2026 at approximately 1:39 PM, Surveyors interviewed House Manager OO. House Manager OO reported Director of Operations C was still the administrator, however, Licensee E was the individual he/she reported to with concerns about the facility. House Manager OO reported when allegations of abuse and neglect are identified, he/she informs Licensee E right away. House Manager OO reported Licensee E is responsible for conducting investigations and reporting the allegations/findings to the department. House Manager OO stated he/she has informed Licensee E of the conditions of the physical environment since he/she was hired, which was in December 2025. House Manager OO reported communicating via telephone with Licensee E on a weekly basis but denied Licensee E came to facility daily.	N 214		

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N 214	Continued From page 15 On 04/29/2026 at approximately 10:00 AM, Surveyors interviewed Licensee E. Licensee E confirmed being the individual who oversees the day-to-day operations of the facility. Licensee E disclosed Director of Operations is available if he/she needs assistance. Licensee E stated he/she visits the facility about "once a week or once every other week." Licensee E reported talking with House Manager OO on a weekly basis about any concerns that may have come up. Licensee E reported having designees who completed certain portions of the admission process and onboarding for staff. Licensee E stated he/she has developed checklists for each designee to complete audits and ensure all documents are completed and received prior to admission and onboarding of staff. Licensee E stated the same designees are then responsible for auditing resident and staff records. For example, Nurse PP is responsible for ensuring staff trainings are up to date and residents' care plans and medications are reviewed and up to date. Licensee E reported he/she is responsible for reviewing any staff disciplinary write-ups and/or terminations.	N 214		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of	N 219		

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N 219	Continued From page 16 misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider permitted Caregiver RR to work in the facility alone and have direct contact with the residents even though Caregiver RR was convicted on 06/21/2007 for 940.01(1)(A) - 1st Degree Intentional Homicide. This conviction prohibited Caregiver RR from working as a caregiver in the home until rehabilitation approval was received. The Governmental Findings Report from the Department of Safety and Professional Services did not indicate any rehabilitation review and approval was obtained. Findings include: On 04/28/2026 at approximately 11:00 AM, Surveyor reviewed Caregiver RR's record. Caregiver RR was hired on 02/05/2025. Caregiver RR's Background Information Disclosure (BID) form was signed and completed on 02/05/2025. Caregiver RR checked the "Yes" box on the form in response to question 1 under "Section A - Acts, Crimes, And Offenses That May Act As A Bar Or Restriction. 1. Do you have any criminal charted pending against you or were you ever convicted of any crimes anywhere, including in federal, state, local, military, and tribal courts? If Yes, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified	N 219		

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N 219	Continued From page 17 copy of the judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents." Caregiver RR wrote "2006-Miwaukee, WI-Attempted Homicide." The governmental findings from the Department of Justice (DOJ), dated 02/03/2026, indicated Caregiver RR was convicted on 06/21/2007 for 940.01(1)(A) - 1st Degree Intentional Homicide. The Governmental Findings Report, dated 02/03/2026, did not indicate any rehabilitation review and approval was obtained. On 04/28/2026 at approximately 1:39 PM, Surveyor interviewed House Manager OO. House Manager OO acknowledged Caregiver RR's criminal background history. House Manager OO has known Caregiver RR since he/she was a child and tried to assist Caregiver RR "on getting back on [his/her] feet." House Manager OO was not aware Caregiver RR's conviction barred from Caregiver RR from working within the home until Caregiver RR completed rehabilitation review. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E acknowledged Caregiver RR's criminal background history. Licensee E reported "questioning" Caregiver RR's conviction, but talked with House Manager OO, who "vouched" for Caregiver RR. Licensee E denied comparing Caregiver RR's conviction to Chapter 12 to see if Caregiver RR was eligible to work within the home.	N 219		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with	N 230		

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N 230	Continued From page 18 orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 (Caregiver QQ and Caregiver RR) of 3 staff reviewed received orientation in the required topics: (2) Prevention and reporting of resident abuse, neglect, and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible, (4) Emergency and disaster plan and evacuation procedures, (5) Community Based Residential Facility (CBRF) policies and procedures, (6) Recognizing and responding to resident changes of condition. Findings include: The provider is licensed as a Class CNA (non-ambulatory) facility to care for 8 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, intellectually disabled and emotionally disturbed/mental illness. On 04/28/2026, the facility census was 7.	N 230		

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N 230	Continued From page 19 The following definition of Wis. Admin. Code § DHS 83.02 is as follows: Wis. Admin. Code § DHS 83.02(22) "Employee" means any person who works for a CBRF or for an entity that is affiliated with the CBRF or that is under contract to the CBRF, who is under direct control of the CBRF or corporation affiliated with the CBRF and who receives compensation subject to state and federal employee withholding taxes. On 04/28/2026 at approximately 11:00 AM, Surveyors reviewed staff files and identified the following: Caregiver QQ was hired on 04/04/2026. Caregiver OO's record contained an undated, unsigned, and incomplete "Orientation Checklist". Caregiver OO's record did not contain evidence of having completed orientation training in prevention and reporting resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; CBRF policies and procedures; recognizing and responding to resident changes of condition. Caregiver RR was hired on 02/05/2026. Caregiver RR's record contained an undated, unsigned and incomplete "Orientation Checklist." Caregiver RR's record did not contain evidence of having completed orientation training in prevention and reporting resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster	N 230		

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N 230	Continued From page 20 plan and evacuation procedures; CBRF policies and procedures; recognizing and responding to resident changes of condition. On 04/28/2026 at approximately 1:39 PM, Surveyor interviewed House Manager OO. House Manager OO reported he/she provided onsite training but was not a part of Human Resource and refused to sign the "Orientation Checklist" as the signature line stated, "Director of Human Resources Signature." House Manager OO could not confirm if Caregiver OO and Caregiver RR completed all the orientation requirements. House Manager OO confirmed Caregiver OO and Caregiver RR worked alone with the residents. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E was aware each "Orientation Checklist" did not contain a signature and date of completion. Licensee E reported leaving the signature line blank for the trainer to sign. Licensee E reported the staff who trained the caregiver should have signed the "Orientation Checklist." Licensee E denied an individual from human resources provided the training. Licensee E stated House Manager OO provides training "for a couple days." Licensee E reported he/she would modify the current "Orientation Checklist" to reflect the current orientation process.	N 230		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall	N 247		

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N 247	Continued From page 21 successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 (Caregiver QQ and Caregiver RR) of 3 employees reviewed obtained training related to personal cares.	N 247		

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N 247	Continued From page 22 Caregiver QQ and Caregiver RR were responsible for providing daily cares to the residents, however, Caregiver QQ and Caregiver RR did not have training related to personal cares prior to or within 90 days after assuming personal cares duty. Findings include: On 04/28/2026 at approximately 11:30 AM, Surveyor reviewed employee files. The following was identified: Caregiver QQ was hired on 04/04/2026. Caregiver QQ's file did not contain evidence of training related to personal cares or evidence of meeting an exemption for training related to personal cares. Caregiver RR was hired on 02/05/2026. Caregiver RR's file did not contain evidence of training related to personal care or evidence of meeting an exemption for training related to personal cares. Caregiver RR's employment application dated 01/03/2026 did not indicate Caregiver RR had prior experience as a caregiver. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E disclosed the nurse is responsible for providing training to the caregivers. Licensee E reported not having a nurse "for a couple months." Licensee E denied alternate ways of trainings were provided or offered to the caregivers prior to them completing a specific task.	N 247		

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N 305	Continued From page 23	N 305		
N 305	83.28(6) Resident rights, grievance procedure, rules Resident rights, grievance procedure, and house rules. Before or at the time of admission, the CBRF shall provide and explain resident rights, the house rules of the CBRF as required under s. DHS 83.32 (2), and the grievance procedure, including written information regarding the names, addresses and telephone numbers of all resident advocacy groups serving the client groups in the facility, including the long term care ombudsman program and the protection and advocacy services of Disability Rights Wisconsin, Inc. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a signed statement acknowledging the provider explained resident rights and the grievance procedure to 4 (Resident 13, Resident 14, Resident 15, and Resident 16) of 5 residents reviewed. Findings include: On 04/28/2026 at approximately 12:00 PM, Surveyor reviewed resident's files. The following was identified: Resident 13 was admitted to the home on 04/17/2025. Resident 13's record indicated Resident 13 was assigned a legal guardian on 06/05/2025. Surveyor did not locate a signed statement acknowledging the provider explained resident rights and the grievance procedure. Resident 14 was admitted to the home on 11/18/2025. Resident 14's record indicated	N 305		

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N 305	Continued From page 24	N 305		

Resident 14 had a legal guardian. Resident 14's record contained a signed statement, dated 11/18/2025 acknowledging the provider explained resident rights and the grievance procedure, however, the signed statement was signed by Resident 14 and not Resident 14's legal guardian.

Resident 15 was admitted to the home on 05/01/2025. Resident 15's record indicated Resident 15 had an activated Power of Attorney for Healthcare (POAHC) document. Resident 15's record contained a signed statement, dated 06/15/2025, acknowledging the provider explained resident rights and the grievance procedure, however, the document was signed by Resident 15 and not Resident 15's activated POAHC agent.

Resident 16 was admitted to the home on 03/27/2026. Resident 16's record indicated Resident 16 was their own decision maker. Resident 16's record did not contain evidence of a signed statement acknowledging the provider explained resident rights and the grievance procedure.

On 04/29/2026 at approximately 1:37 PM, Surveyor interviewed Legal Guardian SS, Resident 13's legal guardian. Legal Guardian SS denied signing a statement acknowledging the provider explained resident rights and the grievance procedure as the provider did not explain resident rights and/or the grievance procedure to Legal Guardian SS.

On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E reported Resident 13 was an emergent placement by Milwaukee County. Licensee E stated Milwaukee County was in the process of

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N 305	Continued From page 25 obtaining a legal guardian for Resident 13. Licensee E stated he/she "totally missed sending the admission agreement to the legal guardian." Licensee E reported the admission agreement contained the statement acknowledging the provider explained resident rights and the grievance procedure. Licensee E reported Resident 14's legal guardian refused to sign the admission agreement until his/her concerns about the admission agreement were addressed. Licensee E reported he/she tried to have Resident 14's legal guardian sign admission paperwork prior to admission, however, "it was difficult." Licensee E reported leaving the admission agreement in Resident 15's bedroom for Resident 15's POAHC agent to sign but believes Resident 15 signed the documents instead. Licensee E acknowledged Resident 16 is their own person but could not state why he/she did not have a signed statement acknowledging the provider explained resident rights and the grievance procedure. Licensee E reported he/she is responsible for ensuring admission paperwork is signed prior to admission.	N 305		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all	N 310		

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N 310	Continued From page 26 additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident signed an admission agreement prior to or at the time of admission for 5 (Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17) of 5 residents reviewed. Findings include: On 04/28/2026 at approximately 12:00 PM, Surveyor reviewed resident's files. The following was identified:	N 310		

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(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 310	Continued From page 27	N 310		

Resident 13 was admitted to the home on 04/17/2025. Resident 13's record indicated Resident 13 was assigned a legal guardian on 06/05/2025. Surveyor did not locate an admission agreement prior to or at the time of admission for Resident 13.

Resident 14 was admitted to the home on 11/18/2025. Resident 14's record indicated Resident 14 had a legal guardian. Resident 14's record contained a signed admission agreement, dated 11/18/2025 however, the admission agreement was signed by Resident 14 and not Resident 14's legal guardian.

Resident 15 was admitted to the home on 05/01/2025. Resident 15's record indicated Resident 15 had an activated Power of Attorney for Healthcare (POAHC) document. Resident 15's record contained a signed admission agreement, dated 06/15/2025, however, the document was signed by Resident 15 and not Resident 15's activated POAHC agent.

Resident 16 was admitted to the home on 03/27/2026. Resident 16's record indicated Resident 16 was their own decision maker. Resident 16's record did not contain a signed admission agreement.

Resident 17 was admitted to the facility on 05/02/2025. Resident 17's record indicated Resident 17 was their own decision maker. Resident 17's admission agreement was signed on 06/24/2025. Resident 17's admission agreement was not signed prior to or upon admission.

On 04/29/2026 at approximately 1:37 PM, Surveyor interviewed Legal Guardian SS. Legal

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N 310	Continued From page 28 Guardian SS denied signing an admission agreement once he/she was assigned to be Resident 13's legal guardian. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E reported Resident 13 was an emergent placement by Milwaukee County. Licensee E stated Milwaukee County was in the process of obtaining a legal guardian for Resident 13. Licensee E stated he/she "totally missed sending the admission agreement to the legal guardian." Licensee E reported Resident 14's legal guardian refused to sign the admission agreement until his/her concerns about the admission agreement were addressed. Licensee E reported he/she tried to have Resident 14's legal guardian sign admission paperwork prior to admission, however, it was difficult. Licensee E reported leaving the admission agreement in Resident 15's bedroom for Resident 15's POAHC agent to sign but believes Resident 15 signed the documents instead. Licensee E acknowledged Resident 16 is their own person but could not state why he/she did not have a signed admission agreement. Licensee E reported he/she is responsible for ensuring admission agreements are signed prior to or upon admission.	N 310		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2.	N 386		

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N 386	Continued From page 29 Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the individualized service plan (ISP) for 3 (Resident 14, Resident 16, and Resident 17) of 5 resident's reviewed did not identify the resident's specific activities of daily living (ADL) needs, specified methods for delivering needed care, and approaches related to their ADL self-care performance deficit. Findings include: On 04/28/2026 at approximately 9:35 AM, Surveyors completed an onsite tour with House Manager OO. Surveyor observed Resident 14's room to have a strong unspecific odor. As Surveyors were touring the home, Surveyors interviewed House Manager OO. House Manager OO reported Resident 14 does not like to shower and continued to refuse to take a shower. On 04/28/2026 at approximately 12:00 PM, Surveyor reviewed residents' files. The following was identified: Resident 14 was admitted to the facility on 11/18/2025. Resident 14's ISP with a start date of 11/18/2025 did not address any ADL self-care	N 386		

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N 386	Continued From page 30 performance deficits and/or behaviors related to Resident 14's refusal to take showers. Resident 16 was admitted to the facility on 03/27/2026. Resident 16's ISP with a start date of 03/27/2026 stated, "total assist with cares ...unable to self-direct with ADL ..." Resident 16's ISP did not identify specific program services and/or approaches. In addition, Resident 16's ISP did not specify any methods for delivering any needed care. Resident 17 was admitted to the facility on 05/02/2025. Resident 17's ISP with a start date of 06/24/2025 stated, "Staff to provide and offer all ADL's." Resident 17's ISP did not identify specific program services and/or approaches. In addition, Resident 17's ISP did not specify any methods for delivering any needed care. On 04/29/2026 at approximately 10:00 AM, Surveyors interviewed Licensee E. Licensee E reported he/she has recently hired a new nurse. Licensee E stated the nurse was hired on 04/12/2026 on a part time basis. Licensee E reported he/she would have a conversation with the nurse regarding the ISP as Licensee E expects the nurse to complete all ISPs.	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If	N 387		

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N 387	Continued From page 31 a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident or the resident's legal representative (if applicable), or Managed Care Organization (MCO) care management team signed the individual service plan (ISP), acknowledging their involvement in, understanding of, and agreement with the ISP for 3 (Resident 14, Resident 15, and Resident 17) of 5 residents reviewed. Findings include: On 04/28/2026 at approximately 12:00 PM, Surveyor reviewed resident's files. The following was identified: Resident 14 was admitted to the home on 11/18/2025. Resident 14's record indicated Resident 14 had a legal guardian and was enrolled in an MCO care management program. Resident 14's ISP, dated 11/18/2025, was not signed by Resident 14's legal guardian or Resident 14's MCO care management team acknowledging their involvement in, understanding of, and agreement with the Resident 14's ISP.	N 387		

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N 387	Continued From page 32 Resident 15 was admitted to the home on 05/01/2025. Resident 15's record indicated Resident 15 had an activated Power of Attorney for Healthcare (POAHC) document and was enrolled in a MCO care management program. Resident 15's ISP, dated 07/22/2025, was not signed by Resident 15's activated POAHC agent or Resident 15's MCO care management team acknowledging their involvement in, understanding of, and agreement with the Resident 15's ISP. Resident 17 was admitted to the facility on 05/02/2025. Resident 17's record indicated Resident 17 was their own decision maker and was enrolled in a MCO care management program. Resident 17's ISP, dated 06/24/2025, was not signed by Resident 17 or Resident 17's MCO care management team acknowledging their involvement in, understanding of, and agreement with the Resident 17's ISP. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E reported ISPs should be completed with the resident, resident's legal representative and if enrolled in a care management program, their assigned MCO care management team. Licensee E could not state why the above residents' ISPs were not signed by the required individuals as the nurse was responsible for ensuring ISPs were signed by the required individuals. Licensee E reported he/she would work with Nurse PP about ensuring ISPs are signed by the required individuals.	N 387		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations.	N 393		

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N 393	Continued From page 33 Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 5 (Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17) of 5 residents were evaluated, using the form provided by the department, within 3 days of the resident's admission to determine whether the resident was able to evacuate the community based residential facility (CBRF) within 2 minutes. Findings include: On 04/28/2026 at approximately 12:00 PM, Surveyor reviewed resident's files. The following was identified: Resident 13 was admitted to the home on 04/17/2025. Resident 13's record did not contain evidence of a completed resident evacuation assessment. Resident 14 was admitted to the home on 11/18/2025. Resident 14's record did not contain	N 393		

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N 393	Continued From page 34 evidence of a completed resident evacuation assessment. Resident 15 was admitted to the home on 05/01/2025. Resident 15's record did not contain evidence of a completed resident evacuation assessment. Resident 16 was admitted to the home on 03/27/2026. Resident 16's record did not contain evidence of a completed resident evacuation assessment. Resident 17 was admitted to the facility on 05/02/2025. Resident 17's record did not contain evidence of a completed resident evacuation assessment. On 04/28/2026 at approximately 1:39 PM, Surveyor interviewed House Manager OO. House Manager OO could not state why residents were not evaluated, using the form provided by the department, within 3 days of the resident's admission to determine whether the resident was able to evacuate the CBRF within 2 minutes. House Manager OO believes it was the responsibility of Intake TT to complete the evacuation evaluation as he/she completed all intake documents. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E reported it was House Manager OO's responsibility to complete each resident's evacuation evaluation within 3 days of admission. Licensee E stated he/she would have a conversation with House Manager OO about the need to complete a resident's evacuation evaluation within 3 days of admission.	N 393		

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N 416	Continued From page 35	N 416		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure injectables medications were delegated by a Registered Nurse (RN) pursuant to the Nurse Practice Act [s. N 6.03(3)] and in accordance with accepted standards of practice for 2 (House Manager OO and Caregiver RR) of 2 unlicensed caregivers reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) 44E014, dated 12/08/2023. Findings include: Chapter N6.03(3) is the Standard of Practice for RN's and addresses the supervision and direction of delegated tasks. The RN may delegate a task based on the educational preparation and demonstrated abilities of the person supervised but must provide direction and assistance, and observe, monitor, and evaluate the effectiveness of the delegated tasks. On 04/28/2026 at approximately 9:35 AM, Surveyor completed a tour of the facility kitchen. Surveyor observed Resident 3's in-use insulin	N 416		

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N 416	Continued From page 36	N 416		

stored in the kitchen refrigerator.

On 04/28/2026 at approximately 11:30 AM, Surveyor reviewed employee records and identified the following:
House Manager OO was hired on 12/08/2025. House Manager OO's file did not contain evidence of receiving RN delegation for administering injectable medications.

Caregiver RR was hired on 02/05/2026. Caregiver GG's file did not contain evidence of receiving RN delegation for administering injectable medications.

On 04/28/2026 at approximately 12:00 PM, Surveyor reviewed Resident 15's record. Resident 15 was admitted to the home on 05/01/2025 with diagnoses including diabetes. Resident 15's medication administration record (MAR) with a "Print Date Range" of 01/27/2026-02/26/2026 indicated Resident 15 received Lantus Solostar 100unit/milliliters (ML), inject 22 units under the skin every night at bedtime for diabetes. Resident 15's MAR indicated House Manager OO administered Resident 15's insulin 1 time between 01/27/2026-02/26/2026 and Caregiver GG administered Resident 15's insulin 4 times between 01/27/2026-02/26/2026.

On 04/28/2026 at approximately 1:39 PM, Surveyor interviewed House Manager OO. House Manager OO denied receiving insulin training prior to administering Resident 15's insulin. House Manager OO denied being observed by Nurse PP prior to administering Resident 15's insulin.

On 04/29/2026 at approximately 10:00 AM,

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N 416	Continued From page 37 Surveyor interviewed Licensee E. Licensee E reported Nurse PP was hired on 04/12/2026. Licensee E acknowledged Nurse PP has not completed any caregiver delegation at this time, as Nurse PP only works part-time. Licensee E reported the prior nurse left the company "a couple months" prior to Nurse PP starting. Licensee E confirmed not having a nurse for "a couple months" while searching for a nurse to replace the previous nurse.	N 416		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make reasonable adjustments to the menu for individual resident's food likes or document any deviations from the planned menu for 7 of 7 residents. Findings include: On 04/28/2026 at approximately 9:35 AM, Surveyor toured the community based residential facility. Surveyor observed the weekly menus located on the refrigerator within the kitchen. Surveyor observed the weekly menu to state, "Winter/Spring Menu Week 2." Per "Winter/Spring Menu Week 2" menu, the	N 450		

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N 450	Continued From page 38 following was to be served for lunch: "Minestrone soup with crackers, egg salad sandwich, potato chips, strawberry Jell-O with bananas." At approximately 12:00 PM, Surveyor observed the lunch served to residents was egg noodles with pizza. On 04/28/2026 at approximately 1:39 PM, Surveyor interviewed House Manager OO. House Manager OO reported the residents do not like the food that was listed on the menu. House Manager OO deviated from the menu to serve food the residents like and would eat. House Manager OO reported having conversations with Licensee E regarding the menu and purchasing food the residents enjoy, however, Licensee E has not adjusted the menu with the residents' food likes. House Manager OO denied being aware that any deviation from the menu should be documented. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E was not aware residents did not like the meals that were on the menu. Licensee E stated he/she is responsible for developing the menus and placing online orders for groceries to be delivered to the facility. Licensee E stated he/she would work with the residents and House Manager OO to develop a menu to include residents' food likes.	N 450		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the	N 481		

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N 481	Continued From page 39 intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and homelike. The facility had fly ribbons hanging within the facility and broken windows. This had the potential to affect 7 of 7 residents. This requirement is being cited for the third time. See Statements of Deficiency (SOD) 44E011, dated 04/25/2022, and SOD 44E014, dated 12/08/2023. Findings include: On 04/28/2026 at approximately 9:35 AM, Surveyors toured the facility with House Manager OO and observed the following: Kitchen -Scented fly ribbon hanging on the ceiling near the kitchen sink. The fly ribbon contained multiple gnats. -Scented fly ribbon hanging on the ceiling near the white board. The fly ribbon contained multiple gnats. -Kitchen window located near the white board contained a crack approximately 24 inches long. Resident 15's bedroom -Scented fly ribbon hanging on the wall near Resident 15's bed. The fly ribbon contained multiple gnats.	N 481		

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N 481	Continued From page 40 Resident 18's bedroom -Resident 18's bedroom contained 1 window. The window had an approximate 16 inch crack. Resident 19's bedroom -One of 4 television legs was broken. The television was being held up by a book. On 04/28/2026 at approximately 1:39 PM, Surveyor interviewed House Manager OO. House Manager OO acknowledged the environmental concerns. House Manager OO reported the fly ribbons have been up since his/her date of hire, which was 12/05/2025. House Manager OO reported having multiple conversations with Licensee E regarding the broken windows. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee acknowledged the environmental concerns. Licensee E reported maintenance hung the fly ribbons up when no residents were within the home and should have been taken down prior to any residents admitting into the home. Licensee E stated he/she will begin looking into having the windows replaced.	N 481		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time.	N 525		

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N 525	Continued From page 41 The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted quarterly for 3 of 4 quarters in 2025. This requirement is being cited for the third time. See Statements of Deficiency (SOD) 44E011, dated 04/25/2022, and SOD 44E012, dated 09/14/2022. Findings include: On 04/28/2026 at approximately 10:45 AM, Surveyor reviewed safety records. Surveyor observed no evidence of fire drills that were conducted in 2025. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E reported the facility was vacant until 04/2025. Licensee E asked for additional time to look for the document as he/she believed fire drills were conducted. Surveyor asked that additional documents be sent to this Surveyor by end of day on 04/29/2026.	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012715	A. BUILDING: _____ B. WING _____	R-C 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINCH HOUSE	5762 FINCH LN GREENDALE, WI 53129

(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 525	Continued From page 42 On 04/30/2026 at 10:34 AM, Surveyor received an electronic mail (e-mail) from Licensee E. The e-mail stated, "At this time, I was unable to locate documentation confirming that fire drills were completed during that period. Based on available information, it appears that drills may not have been conducted or properly documented under the previous manager ..."	N 525		
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 tornado, flooding, or other emergency or disaster drills were conducted semi-annually for 1 (2025) of 1 year. This is a repeat deficiency. See Statement of Deficiency (SOD) 44E011, dated 04/25/2022. Findings include: On 04/28/2026 at approximately 10:45 AM, Surveyor reviewed safety records. Surveyor observed no evidence of other evacuation drills that were conducted in 2025. On 04/29/2026 at approximately 10:00 AM, Surveyor interviewed Licensee E. Licensee E reported the facility was vacant until 04/2025. Licensee E asked for additional time to look for the document as he/she believed other evacuation drills were conducted. Surveyor	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012715	A. BUILDING: _____ B. WING _____	R-C 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINCH HOUSE	5762 FINCH LN GREENDALE, WI 53129

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N 526	Continued From page 43 asked that additional documents be sent to this Surveyor by end of day on 04/29/2026. On 04/30/2026 at 10:34 AM, Surveyor received an electronic mail (e-mail) from Licensee E. The e-mail stated, " ... Based on available information, it appears that drills may not have been conducted or properly documented under the previous manager ..."	N 526		