STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	C 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

(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 06/10/2026, Surveyor conducted a complaint investigation at Lilac Springs Assisted Living LLC. Two (2) deficiencies were identified. The complaint was substantiated. Census: 13	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after law enforcement personnel were called the facility on 04/21/2026 due to Resident 1's aggressive behaviors. Findings include: On 06/10/2026, Surveyor conducted a complaint investigation. Surveyor reviewed Resident 1's closed record, that was provided by Administrator B. Resident 1 was admitted to the facility on 04/20/2026 with diagnoses including ischemic stroke and acute	N 164		

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

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N 164	Continued From page 1 encephalopathy/confusion/agitation. On 06/10/2026 at 8:13 a.m., Administrator B stated that Resident 1 was verbally and physically aggressive and was at the facility for less than 24 hours. Surveyor reviewed the facility's progress notes for Resident 1 which documented: -04/21/2026, "...Writer tried to redirect multiple times with resident refusing and getting verbally aggressive with signs of physical aggression starting. Writer called police for assistance to try to help redirect along with calling [Licensee A] and having [him/her] on speaking so [s/he] could listen. Writer and officer spent a minimum of an hour in the room trying to redirect resident to [his/her] own room resident refused and got verbally aggressive and also hit tv tray table with [his/her] fist for the second time. Was also refusing [his/her] morning medications. Writer had also called resident's [power of attorney (POA)] for redirection which did not help. Decision was made for resident to be sent back out to hospital for medication management for behaviors..." On 06/10/2026 at 8:39 a.m., Administrator B stated that s/he called the police on 04/21/2026 with concerns about Resident 1. S/he stated that Resident 1 almost hit a staff member and was slamming his/her fists on a tv tray and was not redirectable. Administrator B stated that s/he did not fill out an incident report or send a written report to the department within 3 working days after law enforcement was called to assist with Resident 1's safety and welfare. On 06/10/2026 at 9:30 a.m., Licensee A stated that s/he is aware that a self-report should have	N 164		

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N 164	Continued From page 2 been submitted to the department after local law enforcement was called on 04/21/2026 but s/he was unaware that Administrator B did not submit the report.	N 164		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide Resident 1's legal guardian a 30-day written advance notice of the involuntary discharge. Resident 1 was admitted to the provider on 04/20/2026 and was sent to the hospital and involuntarily discharged from the facility on 04/21/2026. Findings include: On 05/18/2026, the department received a complaint alleging the provider did not involuntarily discharge a residents in accordance with chapter 83.	N 326		

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N 326	Continued From page 3 On 06/10/2026, Surveyor conducted a complaint investigation. Surveyor reviewed Resident 1's closed record, that was provided by Administrator B. Resident 1 was admitted to the facility on 04/20/2026 with diagnoses including ischemic stroke and acute encephalopathy/confusion/agitation. On 06/10/2026 at 8:13 a.m., Administrator B stated that Resident 1 was verbally and physically aggressive and was at the facility for less than 24 hours. Administrator B stated that s/he went to assess Resident 1 at the hospital where s/he had been recovering from a stroke. Surveyor reviewed Resident 1's hospital record from 03/21/2026 to 04/20/2026. The hospital record documented: -Resident exhibited persistent and fluctuating encephalopathy with agitation, confusion, and poor short-term memory, attributed to advanced dementia with vascular component. -Throughout the admission, resident demonstrated significant cognitive-communication impairment and required 24/7 supervision. -Seroquel was used as needed for agitation, and olanzapine was scheduled nightly; lorazepam was discontinued due to excessive sedation and paradoxical agitation. -Placement efforts were complicated by behavioral issues, agitation, and lack of safe home support; multiple assisted living and skilled nursing facilities declined placement due to his/her care needs and financial constraints. -Resident remained medically stable for discharge, with ongoing management of agitation and confusion, and continued to require supervision and support for activities of daily	N 326		

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N 326	Continued From page 4 living due to advanced dementia and persistent cognitive and behavioral symptoms. Surveyor reviewed the facility's progress notes for Resident 1 which documented: -04/21/2026, "Resident slept well until 3:00 a.m. when [s/he] started to stir. Next time staff checked on [him/her s/he] had left [his/her] room and moved to the main guest bathroom. Staff tried to redirect resident back to [his/her] room as [s/he] was falling asleep fully clothed while still sitting on the toilet. Resident did not want to leave the bathroom and refused all offers that staff gave [him/her]." -04/21/2026, "Writer was informed at 530am that resident started wondering at about 3am locked [him/herself] in the public restroom and ended up going into another residents room and refused to leave. Both staff members tried to redirect [him/her] and nothing worked. At 6am another staff member went in to redirect [him/her] to get [him/her] to go to [his/her] room staff tried to hold [his/her] hand to redirect [him/her] and resident got aggressive and tried to hit staff member. Writer tried to redirect multiple times with resident refusing and getting verbally aggressive with signs of physical aggression starting. Writer called police for assistance to try to help redirect along with calling [Licensee A] and having [him/her] on speaking so [s/he] could listen. Writer and officer spent a minimum of an hour in the room trying to redirect resident to [his/her] own room resident refused and got verbally aggressive and also hit tv tray table with [his/her] fist for the second time. Was also refusing [his/her] morning medications. Writer had also called resident's [power of attorney (POA)] for redirection which did not help. Decision was made for resident to be sent back out to hospital for medication management for behaviors..."	N 326		

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N 326	Continued From page 5 On 06/10/2026 at 9:15 a.m., Administrator B state that the hospital called the facility the next day to discharge Resident 1 back to the facility. Administrator B stated that s/he talked with Resident 1's POA stating s/he would help him/her find another facility for Resident 1. Administrator B state that s/he informed the hospital that Resident 1 could not return to the facility and that s/he talked to Resident 1's POA stating they could not accept Resident 1 back to the facility due to his/her level of care. Administrator B stated that s/he did not go to the hospital to assess Resident 1 to see if s/he would be appropriate to return. S/he stated that s/he did not know a 30 day written discharge notice was needed since Resident 1 was at the facility for less than 24 hours. On 06/10/2026 at 9:30 a.m., Licensee A stated that s/he was aware of Resident 1's basic information; that s/he was violent and hit care staff. Licensee A stated s/he was admitted to a local hospital and was aware that the facility did not accept Resident 1 back. Licensee A stated that s/he was unaware that the licensee was to give Resident 1's legal representative a 30 written advanced notice of the involuntary discharge and asked, "How much is this going to cost me."	N 326		