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	0018754	A. BUILDING: _____ B. WING _____	R-C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 11/12/2025, Surveyors conducted 2 verification visits and 4 complaint investigations for Statement of Deficiencies (SODs) S3HD11 and 4TLG11. Data collected through 11/18/2025. Three of 4 complaints were substantiated. Ten deficiencies were identified. Six of the 10 deficiences were repeat deficiences. See Statements of Deficiency (SOD) 8R5711, dated 06/27/2022, SOD 8R5712, dated 11/10/2022, and SOD 4TLG11, dated 12/10/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 16	{N 000}		
{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 interview, 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. The licensee did not ensure all deficiencies in Statement of Deficiency (SOD) J5JP12 were corrected. This is a repeat deficiency. See Statement of Deficiency (SOD) 4TLG11, dated 12/10/2024.	{N 196}		

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

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{N 196}	Continued From page 1 Findings include: The provider is licensed to care for up to 18 residents in the client groups of: irreversible dementia/Alzheimer's disease, advanced age, and terminally ill. At the time of the survey the census was 16. Surveyor conducted 2 verification visits and 4 complaint investigations from 11/12-11/18. A total of 10 violations were identified and 3 of 4 complaints were substantiated. Six of the 10 violations were repeat deficiencies. On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Administrator A stated they have recently had a lot of staff turnover. Administrator A stated s/he cannot speak to what happened in the past regarding multiple different concerns within the facility, however, s/he apologized and promised they will do better moving forward. Administrator A acknowledged a disconnect within some of their processes that need to be corrected. S/he stated they will be working hard to ensure compliance moving forward. The licensee did not ensure the CBRF and its operations complied with all laws governing the CBRF. Cross References: N0218 DHS 83.16(2) Resident Care Staff At Least 18 Years Old N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0427 DHS 83.38(1)(c) Leisure Time Activities. N0431 DHS 83.38(1)(g) Health Monitoring	{N 196}		

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{N 196}	Continued From page 2 N0432 DHS 83.38(1)(h) Medication Administration. N0490 DHS 83.44(2)(b) Toilet And Bathing Area. N0503 DHS 83.46(1)(b) Portable Space Heaters Prohibited. N0504 DHS 83.46(1)(c) Heating System Maintenance	{N 196}		
N 218	83.16(2) Resident care staff at least 18 years old Resident care staff shall be at least 18 years old. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident care staff was at least 18 years old. Findings include: On 8/12/2025, the Department received a complaint regarding staff working under the age of 18. On 11/12/2025, Surveyor reviewed employee files. Caregiver G was hired 08/04/2025. Caregiver G's date of birth was 11/15/2008. Caregiver G was not 18 years old. On 11/12/2025 at approximately 1:30 PM, Surveyor interviewed Director B. Surveyor asked if they received a waiver for Caregiver G to work under 18 years of age. Director B showed surveyor a waiver request that was filled out for Caregiver G. The waiver did not indicate whether the waiver was approved or denied. Surveyor asked if there was confirmation that the waiver was approved. Director B stated that would have been done by the previous director and s/he	N 218		

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N 218	Continued From page 3 would have to look. On 11/13/2025, Surveyor checked department records. The records did not indicate an approved waiver for Caregiver G. On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Administrator A stated it was the director's responsibility to fill out and submit the waiver to the department. S/he stated that they cannot fix what happened in the past but will ensure that future waivers will be filled out and sent to the department right away.	N 218		
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 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 did not conduct a criminal background check (CBC) for 3 of 4 caregivers reviewed.	N 219		

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N 219	Continued From page 4 This is a repeat deficiency. See Statement of Deficiency (SOD) 8R5712, dated 11/10/2022. Findings include: On 11/07/2025, the Department received a complaint regarding the provider not completing background checks on their employees. On 11/12/2025, at approximately 10:10 AM, Surveyor requested background checks on Director B, Caregiver G, Caregiver H, and Caregiver I. At approximately 1 PM, Surveyor received the requested information from Director B. Director B's date of hire was 04/16/2024. Director B's background check was completed 11/12/2025, the day of survey. Caregiver G's date of hire was 08/04/2025. Caregiver G's background check was completed 11/12/2025, the day of survey. Caregiver I's date of hire was 09/15/2025. Director I's background check was completed 11/12/2025, the day of survey. On 11/12/2025, Director B stated that they could not find the background information for 3 of the 4 employees, so they had Administrator A run new background checks. Director B stated they were still looking and would let surveyor know if they found them. On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Administrator A stated background checks were supposed to be done when they offer employment to the caregiver.	N 219		

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N 219	Continued From page 5 Administrator A stated the directors pass along the information of the new hire to him/her and s/he runs the background checks. S/he stated s/he cannot speak to what happened in the past. Administrator A stated s/he realized they missed quite a few of them, and all s/he can do was apologize and promise they will do better in the future.	N 219		
{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 1's or Resident 2's individual service plan (ISP) when they had a change in physical condition. This is a repeat deficiency. See Statements of Deficiency (SOD) 8R5711, dated 06/27/2022; SOD 8R5712, dated 11/10/2022; and SOD 4TLG11, dated 12/10/2024.	{N 389}		

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{N 389}	Continued From page 6	{N 389}		

Resident 1
On 11/12/2025 at 10:55 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he recently developed a sore on his/her bottom. S/he stated that the wound had been there once before but had healed. Resident 1 told Surveyor that s/he had just been to the clinic to have it evaluated. S/he stated they prescribed some salve to put on it.

On 11/12/2025, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 05/06/2024 and had diagnoses that included: chronic anticoagulation, hypertension, and lymphedema of both lower extremities.

Surveyor reviewed Resident 1's ISP, dated 09/24/2025. In the skin section of Resident 1's ISP it read: "Skin- Wound Assessment 1. Wound location: abdominal folds. Managing Wound - Resident self applies powder and cream as needed for redness to abdominal folds. Per resident has not needed to us any powder or creams in weeks."

Surveyor requested all wound assessment charting on Resident 1. Surveyor received a wound assessment completed by Registered Nurse (RN) D dated 11/05/2025. The wound assessment indicated Resident 1 had a pressure injury on his/her right buttock. The assessment indicated this was a stage 2 pressure injury. Under the treatment plan portion of the wound assessment, it indicated "to apply barrier cream PRN (as needed) daily until evaluation is completed via wound clinic for further instruction."

Resident 1's pressure injury on the right buttock

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{N 389}	Continued From page 7	{N 389}		

was not added to his/her ISP when the change in condition occurred.

Resident 2
On 11/13/2025, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on 10/20/2025 with diagnoses including: spastic quadriplegic cerebral palsy, osteoporosis, general weakness, obstructive and reflux uropathy, urinary retention, and catheter dependent.

Resident 2's ISP, dated 10/29/2025, read, "Toileting needs - toileting pattern: Uses call pendant to alert staff of the need for assistance with toileting for bowel movements. Staff to assist on and off of toilet and perform peri care. Resident has suprapubic cath (catheter)."

Resident 2's ISP did not include the updated intervention on 11/07/2025 which included flushing his/her catheter with 60ml (milliliters) of normal saline once a day. The previous order was to flush catheter with 30ml of normal saline TID (three times a day). The ISP also did not include any information regarding catheter care for resident, frequency of emptying the catheter, or information regarding catheter changes.

On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A about reviewing and updating ISP's. Administrator A stated that it was a collaborative effort between the caregivers, team leads, and the nurse. The expectation was that the team lead would update the nurse, and the nurse would follow up and review/revise the ISP. Administrator A acknowledged the importance of keeping the ISP updated upon change in condition. S/he stated they were working diligently

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{N 389}	Continued From page 8 to fix their processes to ensure ISPs were updated moving forward.	{N 389}		
{N 427}	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. This is a repeat deficiency. See Statement of Deficiency (SOD) 4TLG11, dated 12/10/2024. Findings include: On 10/09/2025, the Department received a complaint regarding activities not being completed. On 11/12/2025 at approximately 9 AM, Surveyor toured the facility with Caregiver F. Surveyor noticed an activity calendar posted in the dinning	{N 427}		

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{N 427}	Continued From page 9	{N 427}		

room on a white board. It listed that the activities for that day were: 10 AM snacks, 11:30 AM daily chronicles, 2 PM manicures. Surveyor interviewed Caregiver F about activities. S/he stated they do not have an activity director, and that staff are responsible for doing them.

At 9:15 AM, Surveyor interviewed Resident 6 about activities. Resident 6 stated s/he did not get involved in activities, but s/he did not see them take place.

At 10:15 AM, Surveyor interviewed Resident 7 about activities. Resident 7 stated a lady comes in to do bingo once a week. Surveyor asked if there were any other activities that took place besides bingo. Resident 7 stated not that s/he knew of.

At 10:55 AM, Surveyor interviewed Resident 1 about activities. Resident 1 stated bingo was the only one they did. S/he stated someone comes in and they would give them fruit for prizes. Resident 1 stated there was no other activities that s/he was aware of.

At approximately 2 PM, Surveyor interviewed Caregiver E about activities. Caregiver E stated they happen occasionally. S/he stated on day shift there was not time to complete them, but sometimes on the afternoon shift they might have time.

Surveyor did not observe the posted activities performed while on site. Surveyor did observe bingo taking place after lunch. Surveyor spoke with the person facilitating bingo. S/he explained that s/he was a volunteer who came in every Wednesday to lead bingo for the residents.

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{N 427}	Continued From page 10 On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Administrator A stated they had iPads available to residents with different interactive activities for residents to utilize. Administrator A stated there had recently been a lot of staff turnover. S/he acknowledged the importance of activities for residents and stated they will provide re-education to staff regarding the importance of ensuring activities were completed.	{N 427}		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	{N 431}		

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{N 431}	Continued From page 11	{N 431}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not record changes in the resident's health status in the resident's record and did not document communication with the resident's physician and health care providers.

This is a repeat deficiency. See Statement of Deficiency (SOD) 4TLG11, dated 12/10/2024.

Findings include:

On 08/12/2025 and 10/09/2025, the Department received complaints regarding lack of nurse follow up following out of range vital signs.

On 11/13/2025, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the facility 07/18/2024 with diagnoses including: Insulin dependent type 2 diabetes mellitus, altered mental status, heart failure, chronic pain, major depressive disorder, and pyelonephritis.

Resident 5's "Planned Service" document showed the following service to be completed at 8 AM, 12 PM, and 5PM: "Record-Blood Glucose. Wearing gloves and following agency procedure, check blood glucose and record. Notify RN (Registered Nurse) if: If Blood Glucose is less than 70 or greater than 300."

Surveyor requested blood glucose documentation for September, October, and November of 2025.

In September, Residents 5's blood sugar charting showed his/her blood sugar was greater than 300 on the following dates:

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{N 431}	Continued From page 12 - 09/01/2025 at 12 PM - 301 - 09/13/2025 at 12 PM - 308 - 09/20/2025 at 5 PM - 303 There was no documentation that the nurse was notified regarding any of these blood sugar readings. In October, Residents 5's blood sugar charting showed his/her blood sugar was greater than 300 on the following dates: - 10/09/2025 at 4:36 PM - 351 - 10/10/2025 at 11:44 AM - 376 - 10/11/2025 at 4:33 PM - 329 - 10/12/2025 at 4:42 PM - 357 - 10/13/2025 at 11:49 AM - 375 - 10/22/2025 at 11:39 AM - 310 There was no documentation that the nurse was notified regarding any of these blood sugar readings. Resident 8. Resident 8 was admitted to the facility on 11/10/2021. Resident 8 had diagnoses that included: acute respiratory failure, hypertension, anemia, and peptic ulcer disease. On 11/12/2025, Surveyor requested vital sign documentation for August 2025 to present for Resident 8. Resident 8's blood pressure instructions read, "Notify RN if: Systolic (top number) B/P (blood pressure) is less than 90 or greater than 180 and the Diastolic (bottom number) is less than 50 or greater than 90." From August 2025 to October 2025, Resident 8 had 7 blood pressure readings that were out of	{N 431}		

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the normal range that required a notification to the RN. The out-of-range blood pressures were as follows:

- 8/01/2025, 185/117
- 9/05/2025, 148/100
- 9/28/2025, 139/92
- 9/30/2025, 133/96
- 10/01/2025, 141/95
- 10/03/2025, 133/109
- 10/04/2025, 155/100

The only documentation regarding notification to the RN was on 08/01/2025 that stated "will notify nurse."

On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Surveyor asked Administrator A what the process was for notifying the nurse when vital signs were out of the normal range. Administrator A stated that the expectation was that when vital signs were out of the noted range in the resident's chart that caregiving staff would notify the nurse. S/he stated that based on the reading and physician orders, the nurse would advise staff on what to do next. Surveyor asked Administrator A where the documentation regarding notification of the nurse would be. Administrator A reported that caregivers are supposed to enter a progress note when they notify the nurse, hospice, or MCO (managed care organization). Administrator A believed that staff were notifying the nurse regarding out-of-range vitals, but just not documenting it. Administrator B stated that Resident 5's notifications may have been documented in his/her hospice binder instead of the progress notes. Administrator A acknowledged the lack of documentation regarding nurse notification in resident's chart. S/he will provide education to staff on the

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{N 431}	Continued From page 14 importance of documenting notification to the nurse in the resident's chart. Surveyor requested Administrator A send documentation form the hospice binder if s/he found it. Surveyor never received any further documentation.	{N 431}		
{N 432}	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider failed to provide medication administration appropriate to meet the needs of 2 of 5 residents reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) 4TLG11, dated 12/10/2024. Findings include: On 03/04/2025, the facility was issued special orders. The special orders read: "Based on the results of the Department's	{N 432}		

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{N 432}	Continued From page 15 investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Vitacare Living - Medford II: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. WITHIN 45 DAYS of receipt of this notice, the licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency 4TLG11. The licensee shall develop (or review/revise) a written procedure and conduct staff training to address: Medication Management and Administration -Including how the facility will: (a) document medication orders, medication administration, and missed/refused doses; (b) administer medications to ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; (e) monitor for adverse side effects; (f) ensure medications are securely stored; (g) monitor for adverse side effects; (h) discontinue and dispose of medications; and (i) document and maintain proof of use record for schedule II drugs." On 11/12/2025, Surveyor reviewed the providers medication policy and confirmed that, although the policy existed, it was not followed, and the following issues persisted. RESIDENT 4 Resident 4 was admitted to the facility 10/07/2025	{N 432}		

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{N 432}	Continued From page 16 with diagnoses including: schizophrenia, physical deconditioning, chronic pain, acute conjunctivitis, dry eyes, and hypomagnesemia. On 11/12/2025, Surveyors reviewed Resident 4's medication administration record (MAR) for October and November 2025. In October of 2025, Resident 4's MAR showed 12 occasions where medications were circled and noted "not in cart," "out," or "don't have." Resident 4 did not receive his/her erythromycin ointment on 10/7 or 10/22; his/her Lansoprazole tablet on 10/8, 10/11, 10/12, and 10/15; and his/her cyclosporine ointment on 10/25, 10/26, 10/27, and 10/28. RESDIENT 5 Resident 5 was admitted to the facility 07/18/2024 with diagnoses including: Insulin dependent type 2 diabetes mellitus, altered mental status, heart failure, chronic pain, major depressive disorder, and pyelonephritis. On 11/12/2025, Surveyors reviewed Resident 5's medication administration record (MAR) for September, October, and November 2025. Resident 5's September MAR indicated that s/he did not receive his/her Miconazole 2% topical ointment 5 times (9/3 to 9/7). These dates were circled and noted "pharmacy did not deliver," or "do not have." Resident 5's September MAR showed s/he refused his/her Lidocaine 5% patch 26 out of 30 days. His/her October MAR showed s/he refused his/her Lidocaine 5% patch 23 out of 31 days. His/her November MAR showed s/he refused his/her Lidocaine 5% patch 9 out of the 12 days	{N 432}		

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{N 432}	Continued From page 17 this month. There was no documentation in Resident 5's record to show that the provider was notified regarding the frequent refusal of this medication. On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Surveyor asked Administrator A who staff reported to when medications ran low or were out of stock. Administrator A stated that staff have a reorder medication form they filled out. S/he was not aware of any issues regarding medications that had been out of stock or not delivered from pharmacy recently. Administrator A reported occasional difficulty with medical providers and pharmacy, which sometimes resulted in a delay in receiving medication. Surveyor interviewed Administrator A regarding refusal of medication from residents. Administrator A stated that they trained staff to reapproach the resident after they refused. S/he stated that they encouraged staff to return later and try again. S/he stated that if a resident continually refused medications, the caregiving staff should notify the RN. The RN would then provide the proper follow up with the resident's physician. Administrator A acknowledged that the frequent refusal of Resident 5's lidocaine patch should have been addressed. S/he stated they will follow up on that as soon as possible.	{N 432}		
{N 490}	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all bathrooms were clean and in	{N 490}		

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{N 490}	Continued From page 18	{N 490}		

working order.

This is a repeat violation. See Statement of Deficiency (SOD) 4TLG11, dated 12/10/2024.

Findings include:

On 11/07/2025, the Department received a complaint regarding bathroom concerns.

On 11/12/2025 at approximately 11:25 AM, Surveyor observed Resident 3's bathroom. The lid for the water tank on the back of the toilet was missing.

At approximately 11:30 AM, Surveyor interviewed Caregiver F regarding Resident 4's toilet. Caregiver F stated it had been like that since s/he started working, which had been over a year. S/he stated they had tried getting a new one but apparently it did not fit.

At approximately 2 PM, Surveyor observed Resident 4's bathroom with Caregiver E. Resident 4's shower floor was cracked in 2 different spots. Caregiver E demonstrated to surveyor how when stepping on one of the cracked areas, your foot sunk into the shower floor. Caregiver E stated they used the shower for Resident 3 and stated it had been like this for a while.

On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Administrator A stated s/he wished someone would have said something regarding Resident 4's shower floor. Administrator A stated s/he will get maintenance on it. Administrator A stated they were implementing a new process that involved a communication log for staff to document maintenance concerns. S/he stated the

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{N 490}	Continued From page 19 caregiving staff were often busy and noted that it could be easy to forget to express environmental concerns if administration was not in the building at the time it was discovered. Administrator A believed the communication log was important and hoped it would be effective. Administrator A stated that Resident 3 had been taking off the lid to his/her toilet bowl and throwing it on the ground. Administrator A stated they will get a new lid as soon as possible.	{N 490}		
N 503	83.46(1)(b) Portable space heaters prohibited. The use of portable space heaters is prohibited except for Underwriters Laboratories listed electric heating equipment that is listed for permanent attachment to the wall. Portable space heaters shall have an automatic thermostatic control and shall be physically attached to a wall. This Rule is not met as evidenced by: Based on observation and interview, the provider did not prohibit the use of portable space heaters. Findings include: On 11/12/2025, at approximately 10:55 AM, Surveyor observed a portable space heater in Resident 1's room. The space heater was plugged in and producing heat. Surveyor interviewed Resident 1. Resident 1 stated that for "weeks and weeks" his/her heat had not been working. Resident 1 stated that his/her family member brought him/her a portable space heater to use. Resident 1 stated the provider told him/her that a space heater was not	N 503		

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N 503	Continued From page 20 safe, however, s/he stated s/he was cold and needed the warmth. On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Administrator A stated s/he told Resident 1's family that the space heater was not allowed. Administrator A stated they were working to ensure Resident 1's heat gets fixed and would address the space heater. Cross References: N0504 DHS 83.46(1)(c) Heating System Maintenance	N 503		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating 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 observation and interview, the provider did not maintain the heating system in a safe and properly functioning condition. Findings include:	N 504		

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N 504	Continued From page 21 On 11/07/2025, the Department received a complaint regarding the heat not working in the building. On 11/12/2025, at approximately 10:55 AM, Surveyor entered Resident 1's room. Surveyor could feel a chill in the air. Surveyor interviewed Resident 1. Resident 1 stated that for "weeks and weeks" his/her heat had not been working. S/he stated his/her family member had to bring in a space heater so s/he could be warm. Resident 1 stated that s/he had called heating companies him/herself to come fix the heat. S/he stated that no one will come fix the heat because the provider will not pay for it. At approximately 11:40 AM, Surveyor interviewed Caregiver E about Resident 1's heat. Caregiver E stated Resident 1's room was the only room where the heat did not work. S/he stated it had been like that for "a while." S/he stated a HVAC (heating, ventilation, and air conditioning) company did come out and fix it, however, it only worked for 2 days and then stopped working again. On 11/13/2025 at approximately 1 PM, Surveyor reviewed Resident 1's record. Resident 1 had diagnoses that included: chronic anticoagulation, hypertension, and lymphedema of both lower extremities. Surveyor reviewed Resident 1's progress notes. An entry on 10/21/2025 at 5:14 AM read: "Resident came out around 3:30a stating it was so cold in [his/her] room. Heater is not working. Staff helped resident cover up with more blankets. Team lead already knows per resident	N 504		

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N 504	Continued From page 22 and other staff member." An entry on 10/21/2025 at 3:22 PM read: "Writer spoke with heating contact. Will come tomorrow to take a look at heater. Plastic will go on windows tomorrow. Please advise to resident of visitors tomorrow for the heating." An entry on 10/28/2025 at 10:02 AM read: "Resident is unhappy about heating in the building and was calling places all morning about it. Was asking staff about it [sic] but staff was unsure of an update on what was going on with it. [S/he's] extremely unhappy and doesn't understand how this is even legal." On 11/18/2025 at 10 AM, Surveyor interviewed Administrator A. Administrator A stated they had someone out and they had fixed the heater itself. However, the issue continued. Administrator A stated they had contacted someone to come out and look at the duct work, however, that company had not yet been able to get out. Administrator A stated they had put plastic on the windows. S/he stated they were aware of the issue and have been actively trying to address it. Cross References: N0503 DHS 83.46(1)(b) Portable Space Heaters Prohibited.	N 504		