| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019196 | A. BUILDING: _____ B. WING _____ | C 02/19/2026 |

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| VITACARE LIVING CROSS PLAINS | 2620 MILITARY RD CROSS PLAINS, WI 53528 |

| (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 |
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| N 000 | Initial Comments<br><br>On 02/02/2026, with information gathered through 02/19/2026, Surveyor conducted a complaint investigation at VitaCare Living Cross Plains. Twelve deficiencies were identified.<br><br>Two of 12 deficiencies were repeat violations (see Statement of Deficiency (SOD) W10511).<br><br>Complaint was substantiated.<br><br>Census: 17 | N 000 | | |
| N 196 | 83.14(2)(a) Licensee ensures facility complies with laws<br><br>The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the licensee did not ensure the facility, and its operation complied with all laws governing a Community-Based Residential Facility (CBRF).<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 02/01/2024 and the licensee can provide care and services to 19 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.<br><br>On 02/02/2026, with information gathered through 02/19/2026, Surveyor conducted a complaint investigation. Twelve deficiencies, including this one, were identified: | N 196 | | |

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

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| N 196 | Continued From page 1 | N 196 | | |

N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0355 83.32(3)(k) Rights of Residents: Self-Determination
N0361 83.33(1)(c) Grievance Procedure: Coercion Prohibited
N0362 83.33(1)(d) Grievance Procedure: Written Summary
N0388 83.35(3)(c) Implement, Follow The Individual Service Plan
N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes. This is a repeat deficiency. See Statement of Deficiency (SOD) W10511, dated 07/15/2025
N0425 83.38(1)(a) Personal Care
N0427 83.38(1)(c) Leisure Time Activities
N0450 83.41(2)(c) Nutrition: Menus
N0489 83.44(2)(a) Rooms Clean and Free From Odors
Y3100 50.09(1)(f) Resident's Rights in Certain Facilities
Y3234 50.09(1)(e) Treatment

Review of facility records documented previous survey event identifying noncompliance, as follows:

-SOD 8O1011 - On 01/05/2026, with information gathered through 01/07/2026, Surveyor conducted a complaint investigation at VitaCare Living Cross Plains. Eight deficiencies were identified:
N0388 83.35(3)(c) Implement, Follow The Individual Service Plan
N0426 83.38(1)(b) Supervision
N0431 83.38(1)(g) Health Monitoring
N0432 83.38(1)(h) Medication Administration
N0444 83.40 Oxygen Storage
N0598 83.54(1)(d) Bedrooms: Closet, Drawer, Adequate Space

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| N 196 | Continued From page 2<br>N0648 83.59(3)(d) Clear, Unobstructed Pathway Maintained<br>Y3234 50.09(1)(e) Treatment<br><br>-SOD W10512 - On 10/30/2025, with information gathered through 11/18/2025, Surveyor conducted a standard licensure survey, a verification visit and 2 complaint investigations. Seven deficiencies were identified. One of 2 complaints was substantiated.<br><br>N0352 83.32(3)(h) Rights of Residents: Receive Medication<br>N0406 83.37(1)(g) Disposition of Medications<br>N0408 83.37(1)(i) PRN Psychotropic Medication<br>N0415 83.37(2)(d) Documentation of Medication Administration<br>N0481 83.43(1) Environment Safe, Clean and Comfortable<br>N0492 83.45(1)(a) Exterior Areas<br>N0499 83.45(3) Toxic Substances<br><br>-SOD W10511 - On 07/07/2025, with information gathered through 07/15/2025, Surveyor conducted a complaint investigation. Seven deficiencies were identified:<br><br>N0352 83.32(3)(h) Rights of Residents: Receive Medication<br>N0388 83.35(3)(c) Implement, Follow the Individual Service Plan<br>N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes<br>N0408 83.37(1)(i) PRN Psychotropic Medication<br>N0415 83.37(2)(d) Documentation of Medication Administration<br>N0481 83.43(1) Environment Safe, Clean and Comfortable<br>Y3234 50.09(1)(e) Treatment | N 196 | | |

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| N 196 | Continued From page 3<br>On 02/17/2026 at 5:20 AM, Surveyor emailed Regional Director B and Regional Director C requesting additional documentation.<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Licensee A stated these concerns are unacceptable and s/he expected better from his/her team, and s/he was in the process of hiring a dedicated management team. Licensee A stated s/he was not at the facility often as s/he relied on his/her management team. | N 196 | | |
| N 355 | 83.32(3)(k) Rights of Residents: Self-determination<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the provider did not support or promote the right of self-determination for 17 of 17 residents.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 53B111, dated 04/29/2025.<br><br>The provider would not allow residents to have other residents in their room.<br>The provider would not allow residents to sit at a table of their choice during meals.<br><br>Findings include: | N 355 | | |

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| N 355 | Continued From page 4<br><br>The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.<br><br>On 01/20/2026, the department received a concern that residents were not treated with dignity.<br><br>On 02/02/2026, at approximately 12:40 PM, Surveyor observed the noon meal. Surveyor noted the residents were not interacting with one another.<br><br>On 02/02/2026, at approximately 1:05 PM, Surveyor interviewed Resident 4. Resident 4 stated, "I want to sit with my friends during meals. We are now separated because we were supposedly 'gossiping.' As you know, not everyone here is capable of having a conversation with you so those of us who can gravitate towards each other. Then we are told we are gossiping. I am not a child."<br><br>On 02/02/2026, at approximately 2:00 PM, Surveyor interviewed Resident 5's Power of Attorney (POA) H. POA H stated, "I visit [Resident 5] several times a week, almost daily, and now there are assigned seats because supposedly residents and visitors are violating HIPAA (Health Insurance Portability and Accountability Act)." POA H explained that they only know what they hear staff talk about and having a conversation about an individual's likes and dislikes was not a violation of HIPAA. It was called having a conversation. The staff do not talk to the residents on a personal level, the residents enjoy having someone take an interest in their thoughts. | N 355 | | |

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| N 355 | Continued From page 5<br><br>On 02/02/2026, at approximately 4:00 PM, Surveyor interviewed Assistant Executive Director (AED) D. Surveyor asked for clarification regarding the assigned seating requirement during meals. AED D stated that residents were making comments about the food and then other residents would automatically agree with them; "By separating them, food intake has increased."<br><br>On 02/09/2026, at approximately 1:00 PM, Surveyor interviewed Resident 7. Surveyor asked if s/he had any concerns about the seating arrangement during meals. Resident 7 stated, "I really enjoy being with [Resident 4] and [Resident 1], along with [POA H]. We love having conversations about anything. Like, I love horses, especially racehorses, and they will listen and join in the conversation. I don't understand why we are treated like children." Resident 7 said, "The other day, I don't remember who, commented about how there is limited toilet paper in [his/her] room, and we were scolded because we were gossiping. I don't understand it." Resident 7 asked Surveyor if s/he was allowed to have visitors in his/her room. Resident 7 said, "For instance, I wanted [Resident 10] to come into my room, [s/he] is new here and I was going to show [him/her] my collection of horse figurines and to just have a conversation without staff always interrupting you because they think you shouldn't talk about something. [Caregiver I] said 'absolutely not,' residents cannot go in each other's room. Then my speech therapist showed up today for my scheduled appointment and [Caregiver I] said [s/he] could not be in my room. Even my therapist cannot come into my room?"<br><br>On 02/09/2026, at approximately 2:30 PM, Surveyor interviewed Resident 1. Resident 1 | N 355 | | |

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| N 355 | Continued From page 6 | N 355 | | |

stated, "Yeah, we have assigned seats, but you know, I think I am just going to start sitting where I want."

On 02/18/2026, Surveyor reviewed Resident 7's record.

Resident 7 moved into the facility 07/08/2025.

Resident 7's "Master Care Plan," dated 01/28/2026, documented:
"Speech - No difficulty with language comprehension or expression."
"Speech is clear and easy to understand - Is able to make needs known."
"Behavior - No Concerns."
"Are there any restrictions to the resident's rights regarding visitors, social participation, personal and treatment privacy, and/or access to food, specify: - No."

On 02/19/2026, Surveyor reviewed Resident 5's hospice documentation submitted by his/her hospice provider, which stated:
"01/28/2026: Does not appear to be in any pain states [s/he] has no pain, no noted concerns in regards to surgical removal of teeth, it is noted that patient does have a bruise on [his/her] right chin. Staff state they do not understand why anyone came to see [him/her] [s/he] is fine [s/he] did eat ice cream. Stated that they would alert us with any changes and were concerned that [his/her] visit would wake the patient."

On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Licensee A stated that a general conversation is not gossip. Licensee A explained that residents and visitors/medical professionals are allowed to visit in a resident's apartment. Licensee A explained that staff need to remember

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| N 355 | Continued From page 7<br>that the facility was the resident's home and to be respectful of it. Licensee A stated additional guidance would be provided for staff. Licensee A stated s/he was not aware that assigned seating had been implemented. | N 355 | | |
| N 361 | 83.33(1)(c) Grievance procedure: coercion prohibited<br><br>Any form of coercion to discourage or prevent any individual from filing a grievance or in retaliation for having filed a grievance is prohibited.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility did not ensure residents were not discouraged from filing grievances against staff members or concerns in the facility.<br><br>Findings include:<br><br>The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.<br><br>On 01/20/2026, the department received a concern that residents were not treated with dignity.<br><br>On 02/02/2026, at approximately 1:05 PM, Surveyor interviewed Resident 4. Surveyor asked if s/he had any concerns regarding his/her cares s/he received. Resident 4 explained that there is a high turnover rate with staff and some of the staff were not friendly. Surveyor asked if Resident 4 had ever expressed his/her concerns | N 361 | | |

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| N 361 | Continued From page 8 | N 361 | | |

to management. Resident 4 stated, "You can tell management, but nothing is going to be done and then those staff members find out you stated something, and then they give you even more 'attitude.' Management will just tell you, 'That is just the way they are.'"

On 02/02/2026, at approximately 1:15 PM, Surveyor observed the provider's "Complaint / Grievance" policy hanging on the bulletin board next to the medication room. The policy stated: "All staff should encourage residents to voice concerns and ask questions. When an issue cannot be resolved by the front-line supervisor, or where there has been an allegation of disregard for a resident's rights, staff should encourage the resident to file a grievance with the Care and Concern Form. ... Any form of coercion to discourage or prevent a resident from filing a grievance or in retaliation for having filed a grievance is prohibited."

On 02/02/2026, at approximately 1:20 PM, Surveyor interviewed Resident 5's Power of Attorney (POA) H, who was visiting with Resident 5. Surveyor asked if Resident 5 or POA H had any concerns with the cares they received at the facility. POA H stated, "Where does one start. First, if they see me talking with you, I am sure the staff will have more attitude with [Resident 5]." Surveyor asked POA H to elaborate. POA H stated, "Well, for example. I have concerns because [Resident 5's] clothes are often missing, and [s/he] will be dressed in other resident's clothing. I brought the concern up to [Licensed Practical Nurse (LPN) E] and explained that I did not understand why this could happen since I label all of [Resident 5's] clothing. The next time I see [LPN E] [s/he] makes a scene in front of [Resident 5] and other resident's about how I like

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| N 361 | Continued From page 9 | N 361 | | |

to label all of [Resident 5's] clothing. Why would [s/he] have to do that. I just shouldn't say anything."

On 02/02/2026, at approximately 1:30 PM, Surveyor interviewed Assistant Executive Director (AED) D. AED D stated, "Are these the same concerns you brought up last time." AED D explained there were residents who always were voicing concerns about certain staff members but sometimes residents need to understand a staff members' personality. AED D explained that some staff members speak loudly or directly, but it did not mean the staff member meant anything negative by it.

On 02/09/2026, at approximately 1:00 PM, Surveyor interviewed Resident 7. Resident 7 asked if it was okay if s/he spoke negatively about a staff member to the Surveyor. Resident 7 expressed concerns regarding Caregiver I. Resident 7 stated, "[Caregiver I] treats you like a baby, talking to you in a sicky sweet voice and calling you something your grandma would call you when you were a child. Then [s/he] acts like [s/he] knows everything about everything. I won't let [him/her] assist me with showers anymore because [s/he] makes me cry. You are so vulnerable and then [s/he] will make inappropriate comments. At least I think they are. Like, I am sorry I need your help. I don't want to be here either. I always feel bullied by [him/her]." Surveyor asked if s/he filed a concern/grievance with management. Resident 7 explained that s/he had asked Caregiver I to fill one out, because Resident 7 was so mad. Caregiver I explained to Resident 7 that s/he would lose his/her job if s/he did that. Resident 7 stated, "They make you feel bad if you aren't happy with them."

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| N 361 | Continued From page 10<br><br>On 02/09/2026, at approximately 2:05 PM, Surveyor interviewed Resident 8. Resident 8 stated, "You know, we aren't supposed to talk to you because you get everyone in trouble but I don't care, some changes need to be made, and some of these staff members are mean. I watch it, I see it."<br><br>On 02/13/2026, at approximately 10:45 AM, Surveyor interviewed POA H. POA H informed Surveyor that when s/he went in to assist Resident 5 the next day, staff were very rude towards him/her saying that s/he could not be in his/her room because they were providing cares. POA H stated, "I thought that was funny, since I am the one that normally provides [his/her] cares because they are too busy, but okay then." POA H continued to explain that [Caregiver F] and [Caregiver I] kept commenting about how they had to make sure Resident 5 was in the right clothing. POA H stated, "Then one of them pulls out a pair of sweatpants and is like '[POA H] you have clothes labeled for [Resident 5] and they have elastic in them. Didn't you say that was unacceptable.' They were so rude about it, mocking me, and I am trying to explain that elastic in the waistband is fine, it is around [his/her] ankles that isn't acceptable and [his/her] clothes that I provide do not have that." POA H stated, "I don't know which is worse, just show up every day and provide the cares for [Resident 5], fix what is done in error and just keep your mouth shut, because talking to staff or management, gets you retaliation."<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor explained the conversations s/he had with residents. Licensee A stated s/he was disappointed to hear that the | N 361 | | |

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| N 361 | Continued From page 11<br>residents or their family members felt retaliated against in their own home. Licensee A stated s/he would be re-educating staff on the importance of them understanding this is a home, the residents' home. | N 361 | | |
| N 362 | 83.33(1)(d) Grievance procedure: written summary<br><br>The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not create a written summary of the grievance, the findings and the conclusion to grievances for 1 of 2 residents.<br><br>Resident 5's Power of Attorney (POA) H expressed concerns with the provider regarding Resident 5 missing clothing and being dressed in other resident's clothing that affected his/her edema.<br>Caregiver F was involved in a verbal altercation with Resident 5's Hospice Certified Nursing Assistant (CNA) J and the provider did not write up a grievance form to follow up with POA H.<br><br>Findings include:<br><br>The provider is licensed to serve up to 19 residents in the client groups: physically disabled, | N 362 | | |

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advanced age and irreversible dementia/Alzheimer.

On 01/20/2026, the department received a concern that residents were not treated with dignity.

On 02/02/2026, at approximately 11:55 AM, Surveyor arrived at the facility and spoke with Assistant Executive Director (AED) D. Surveyor explained s/he was conducting a complaint investigation regarding staff interactions with residents.

On 02/02/2026, at approximately 1:00 PM, Surveyor observed the provider's "Complaint / Grievance" policy hanging on the bulletin board next to the medication room. The policy stated: "A grievance is defined in this facility to be a resident's concern or request not met by the facility that goes beyond the everyday needs/requests of the resident. A grievance would also be an allegation that a resident's rights were not being addressed/met by staff or any other person working within the facility in any fashion. A complaint is any statement noted to be a resident concern regarding any aspect of care or service rendered at this facility. ... All verbal and/or written complaints/grievances are to be submitted to the Executive Director, unless the grievance involves the Executive Director, then it should be reported to the Regional Director."

On 02/02/2026, at approximately 2:15 PM, Surveyor observed a discussion between AED D, Hospice Team Director (HTD) K, Hospice Social Worker (HSW) L, and POA H. POA H explained his/her concern that Resident 5 was often dressed in other resident's clothing which was frustrating, but when s/he was placed in

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sweatpants that had elastic in the pant leg around the ankle, which caused restrictions on his/her legs, causing additional swelling due to trapped excess fluid, and staff did not consider this as a problem, that was very concerning. AED D responded that s/he was not aware of the concern. POA H stammered, "How could you not know about it, I have talked with you each time it has happened." During the conversation, HTD K discussed a concern that had been communicated to him/her regarding the verbal altercation between hospice staff and the provider's staff regarding Resident 5. HTD K strongly stated that that type of behavior would not be tolerated. AED D agreed with HTD K.

On 02/02/2026, at approximately 3:15 PM, Surveyor interviewed POA H. Surveyor asked if s/he was aware of the verbal altercation between hospice staff and the provider's staff, prior to the discussion. POA H stated, "Oh yeah, hospice had talked with me about it, plus residents heard the altercation, so they were telling me about it. Supposedly, [Caregiver F] was swearing and making derogatory comments towards the Hospice CNA." Surveyor asked if the provider discussed the concern with him/her. POA H stated, "It is like anything else; they want to sweep it under the rug. They don't like me, and I try really hard to get along with everyone because I don't want anyone retaliating against [Resident 5], but when is enough enough."

On 02/02/2026, at approximately 3:25 PM, Surveyor interviewed AED D. Surveyor asked for clarification on the verbal altercation between the provider's staff and hospice staff. AED D responded, "What altercation?" Surveyor stated the concern hospice was referring to in the discussion that had just occurred. AED D stated,

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"Oh, that." Caregiver F walked into the office and AED D told Surveyor s/he should speak with Caregiver F. Surveyor asked Caregiver F if s/he was aware of an incident where hospice staff and provider staff had a verbal altercation. Caregiver F stated, "Yeah, I can tell you, it was me, [Hospice CNA J] shows up here, [s/he] is supposed to shower [Resident 5]. [S/he] will be here like 5 minutes and then goes and sits in [his/her] car. I called him/her out on it. I'm like are you giving [Resident 5] [his/her] shower. CNA J tells me '[Explicative] No!' So, I called [his/her] boss." Surveyor asked AED D if s/he filled out an official grievance form so Resident 5 and POA H could see how the concern was being addressed. AED D stated hospice did not file a grievance.

On 02/02/2026, at approximately 4:00 PM, Surveyor interviewed AED D. Surveyor asked for clarification on when the provider would fill out an official grievance form regarding a concern. AED D stated the forms were hanging on the wall and the resident could fill one out. Surveyor asked if AED D ever assisted a resident or a resident representative with filling out a grievance form, so there could be a form of tracking on how the grievance was resolved. AED D stated that s/he had not.

On 02/03/2026 at 8:34 AM, Surveyor interviewed Regional Director (RB) B. Surveyor discussed the concern on how residents and resident representatives appeared to not be assisted with filing a grievance. RB B stated that the forms were hung by the entrance, so they were readily available for anybody who wanted to file one. RB B stated they had completed that task after the previous conversation s/he had had with Surveyor. Surveyor asked if RB B felt that POA H should have been assisted with filing an official

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| N 362 | Continued From page 15<br>grievance regarding Resident 5's clothing and the verbal altercation between the care team. RB B stated s/he was not aware there was a verbal altercation, and s/he would have to do an internal investigation into the concern. Surveyor explained that s/he had interviewed AED D and Caregiver F regarding the concern, which they confirmed.<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor explained his/her concerns and asked for clarification as to when staff should assist a resident or resident representative with filling out a grievance form. Licensee A stated grievance forms are a way of protecting everyone involved. The form outlines what the concern is and how the provider resolved it, so when a concern is filed, we can show how we addressed the concern. Licensee A stated s/he would follow up with his/her staff.<br><br>N0361 83.33(1)(c) DHS Grievance Procedure: Coercion Prohibited | N 362 | | |
| N 388 | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the provider did not follow the resident's Individual Service Plan (ISP) as written for 6 of 6 residents reviewed.<br><br>Resident 2, who was an elopement risk, was not supervised during his/her smoke break.<br>Resident 3's oxygen was not utilized when s/he | N 388 | | |

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laid down in the afternoon.
Resident 5 was not toileted as outlined in his/her ISP.
Resident 8, Resident 9, and Resident 10 did not receive scheduled laundry services.

Findings include:

The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.

Findings include:

On 01/20/2026, the department received a concern that residents were not treated with dignity and provided adequate cares.

Example 1: Resident 2

On 02/16/2026, at approximately 8:15 AM, Surveyor arrived at the facility and observed Resident 2 sitting outside smoking. Surveyor recognized the resident from a previous complaint investigation and Resident 2 had been identified as an elopement risk. Resident 2 went into the facility at approximately 8:28 AM, when Resident 8 was exiting the building.

On 02/16/2026, at approximately 8:30 AM, Surveyor interviewed Caregiver G. Caregiver G explained that Resident 2 was to be supervised during smoke breaks and s/he was checking on him/her when s/he walked by the entrance door.

On 02/19/2026, Surveyor reviewed Resident 2's record.

Resident 2 moved into the facility 12/05/2025.

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| N 388 | Continued From page 17<br><br>Resident 2's "Master Care Plan," dated 12/26/2025, documented:<br>"Safety - Elopement Risk: Resident is a hour check due to high elopement. Elopement on 12/06/2025 and 12/08/2025."<br>"Safety - Safe Smoking: Resident requires supervision for all smoke breaks. Schedule is established and posted. Smoke times 8AM, 10AM, 2PM, 4PM, 7PM, 9PM. Resident is an elopement risk."<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor explained his/her observation. Licensee A stated s/he was disappointed that staff were not following Resident 2's ISP which was developed to ensure his/her safety. Licensee A explained that Resident 2 had eloped from the facility on prior occassions because s/he was not supervised outside while s/he was on smoke breaks. Licensee A stated the concern would be addressed with staff.<br><br>Example 2: Resident 3<br><br>On 02/02/2026, at approximately 2:00 PM, Surveyor, Assistant Executive Director (AED) D, and Caregiver F observed Resident 3 in his/her room, lying in his/her bed. Surveyor noted that Resident 3's oxygen concentrator was not turned on and Resident 3 was not utilizing his/her oxygen. AED D confirmed Resident 3 was to utilize his/her oxygen continuously and would follow up on why the concentrator had not been turned on.<br><br>On 02/02/2026, Surveyor reviewed Resident 3's record. | N 388 | | |

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Resident 3 moved into the facility, 02/26/2025, with diagnosis including chronic obstructive pulmonary disorder (COPD).

Resident 3's "Master Care Plan," dated 02/02/2026, documented:
"Respiratory Equipment: Needs assistance with oxygen. Wears 2 L (liters) of nasal cannula during the daytime continuously for oxygen saturation. Is on oxygen 4 L by nasal cannula at night for COPD. Staff will assist and make sure that [Resident 3] has this on at bedtime."
"Respiratory Function: Has order for O2 (oxygen). [S/he] is to have 2L-4L by nasal cannula for [his/her] COPD anytime [s/he] is sleeping and PRN (as needed)."
"Mobility - Transfer: Needs assistance with transferring. Sit to stand for all transfers. May only require a 1 staff assist with this at this time when week need two 2 asst with sit to stand.
"Social and Cognitive: Behavior - Agitation at times when needs not met timely."

On 02/02/2026, at approximately 3:00 PM, Surveyor interviewed Resident 3. Surveyor asked if Resident 3 utilized his/her oxygen during his/her nap time. Resident 3 stated s/he had not been asked if s/he wanted his/her oxygen on.

On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Licensee A stated that resident cares must always come first and staff would be re-educated.

Example 3: Resident 5

On 02/02/2026, at approximately 2:15 PM, Surveyor observed a discussion between AED D, Hospice Team Director (HTD) K, Hospice Social Worker (HSW) L, and POA H. POA H explained

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that when s/he visited with Resident 5 yesterday, staff did not check him for 5 ½ hours. POA H stated, "I thought [Resident 5] was on two-hour checks." EAD D confirmed that Resident 5 was on two-hour checks and that staff should have followed his/her ISP.

On 02/02/2026, Surveyor reviewed Resident 5's record.

Resident 5 moved into the facility 06/02/2025.

Resident 5's "Master Care Plan," dated 01/28/2026, documented:
"Toileting pattern: Resident is toileted every two hours and as needed. [Resident 5] wears Depends. Staff are to assist with changing [Resident 5's] incontinent products and preform peri care. Staff are to notify AED/ED (executive director) of any bowel/bladder or skin concerns."

Example 4: Laundry

On 02/02/2026, at approximately 2:10 PM, Resident 10 approached Surveyor and asked if s/he could help him/her. Resident 10 led Surveyor back to Resident 10's room where Surveyor observed a laundry basket overflowing with soiled clothing. Resident 10 asked if Surveyor could get someone to do his/her laundry. Surveyor noted Resident 10's room had the scent of soiled clothing.

On 02/02/2026, Surveyor observed the laundry schedule hanging on the wall in the med room which stated, "Residents with any soiled laundry, PLEASE take out of their room and wash immediately. Resident 10's name was not listed on the schedule.

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On 02/02/2026, Surveyor reviewed Resident 10's record.

Resident 10 moved into the facility 01/02/2026.

Resident 10's "Master Care Plan," dated 01/28/2026, documented:
"Laundry: Staff to provide laundry services weekly and as needed."

On 02/02/2026, at approximately 4:00 PM, Surveyor interviewed AED D. AED D looked at the laundry schedule and stated it was outdated.

On 02/09/2026, at approximately 2:10 PM, Surveyor was interviewing Resident 8 in his/her bedroom when s/he commented that it had been a while since his/her laundry had been completed. Surveyor observed Resident 8's laundry basket filled with soiled clothing.

On 02/09/2026, at approximately 2:30 PM, Surveyor interviewed Resident 9 in his/her bedroom. Surveyor asked if there were any areas s/he would like to see improved regarding his/her cares. Resident 9 stated s/he would like his/her laundry completed. Resident 9 stated laundry was usually not completed on a regular schedule. Surveyor observed Resident 9's laundry basket filled with soiled clothing.

On 02/09/2026, Surveyor reviewed the laundry scheduled obtained on 02/02/2026. Resident 8's name was not on it. Resident 9's laundry was scheduled for Thursdays and today was Monday.

On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor discussed concerns regarding timely completion of resident laundry. Licensee A stated s/he would discuss the concern

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| N 388 | Continued From page 21<br>with staff as it appeared resident laundry was not being completed as scheduled. | N 388 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 2 resident records reviewed were updated when there was a change in condition.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) W10511, dated 07/15/2025.<br><br>Resident 2's ISP was not updated to provide guidance for staff regarding his/her sexually inappropriate behavior.<br><br>Findings include:<br><br>On 01/20/2026, the department received a concern that residents were not treated with | N 389 | | |

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dignity and provided adequate care.

The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.

On 02/02/2026, at approximately 2:15 PM, Surveyor observed a discussion between Assistant Executive Director (AED) D, Hospice Team Director (HTD) K, Hospice Social Worker (HSW) L, and POA H. POA H asked how staff knew what cares were to be provided to a resident. AED D stated that staff were to review the individualized service plan on every shift.

On 02/09/2026, at approximately 1:00 PM, Surveyor interviewed Resident 7. Resident 7 described becoming aware of a sexual interaction between Resident 2 and Resident 5.

On 02/13/2026, at approximately 10:45 AM, Surveyor interviewed Resident 5's Power of Attorney (POA) H. Surveyor asked if s/he had been informed there was an incident between Resident 5 and Resident 7. POA H stated s/he had been information of a sexual encounter between Resident 5 and Resident 7. POA H stated, "I informed them that this cannot be happening, that [Resident 5] doesn't understand why [Resident 7] is drawn to [him/her], and they said they were addressing it and redirecting [Resident 7] away from [Resident 5], which never happens."

On 02/19/2026, Surveyor reviewed Resident 7's record.

Resident 7 moved into the facility 12/05/2025.

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| N 389 | Continued From page 23<br><br>Resident 7's "Master Care Plan," dated 12/16/2025, documented:<br>"Social and Cognitive - Behavior: Sexually inappropriate. Touching of [wo/men] in appropriate places to groin area." "Verbal aggression: Yelling out and swearing when needs not met."<br>"Social and Cognitive - Mental Illness: Personality disorder: Neurocognitive Disorder,"<br>The Master Care Plan did not identify guidelines for staff on how to provide cares regarding Resident 7's social and cognitive behaviors.<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor discussed what guidelines are spelled out in a resident's individualized service plan and how the guidelines should be clear in expectations. Licensee A stated s/he would discuss the concern with staff and provide additional training to Licensed Practical Nurse E, who was responsible for updating the plans. | N 389 | | |
| N 425 | 83.38(1)(a) Personal care.<br><br>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:<br><br>Personal care.<br><br>Personal care services shall be designed and provided to allow a resident to increase or maintain independence. | N 425 | | |

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| N 425 | Continued From page 24 | N 425 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 residents received assistance with personal cares to increase or maintain independence.

Resident 5 did not receive timely assistance to prepare for a medical appointment and did not receive soft foods after dental surgery.
Resident 7 did not receive timely assistance to prepare for a speech therapy appointment.

Findings include:

The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.

On 01/20/2026, the department received a concern that residents were not treated with dignity and provided adequate care.

Example 1: Resident 5

On 02/02/2026, at approximately 2:15 PM, Surveyor observed a discussion between Assistant Executive Director (AED) D, Hospice Team Director (HTD) K, Hospice Social Worker (HSW) L, and Power of Attorney (POA) H. POA H expressed his/her frustration that the provider was aware that Resident 5 had a follow up appointment from his/her dental surgery scheduled for 01/30/2026 and when s/he arrived to take him/her to the appointment s/he had not been dressed and groomed for the day. POA H

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| N 425 | Continued From page 25 | N 425 | | |

explained that s/he became very stressed trying to get Resident 5 ready for an appointment that should have been the staff members' responsibility and all staff would say is we had an emergency that morning and didn't have time to get Resident 5 ready. AED D responded that during shift change the staff should be communicating with one another to ensure cares were not missed and s/he was sorry for the inconvenience. POA H stated, "Then everyone knows that [s/he] is having dental surgery, and they give [him/her] chicken nuggets for supper and toast for breakfast, when [his/her] gums are raw. I brought food for [him/her] so staff wouldn't have to worry about it and they didn't provide it. It is like they could not even comprehend that [s/he] had dental surgery." AED D explained that they did not have a physician order stating that Resident 5 was on a special diet. POA H asked, "As the power of attorney, do I not have the right to make healthcare decisions for [him/her] and anybody who has had dental surgery, all your teeth removed, would want to eat 'rough' foods." AED D stated s/he understood.

On 02/02/2026, at approximately 3:40 PM, Surveyor interviewed POA H. Surveyor asked POA H to elaborate on how s/he knew what Resident 5 was served on 01/27/2026, after his/her dental surgery. POA H stated s/he had come back to the facility to bring additional supplies for Resident 5 and see how s/he was doing since the surgery and there s/he was sitting with chicken nuggets on his/her plate. POA H stated, "I went to the staff and was like [s/he] just had dental surgery, [s/he] should not be eating chicken nuggets. I just get a blank stare."

On 02/02/2026, Surveyor reviewed Resident 5's record.

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| N 425 | Continued From page 26<br><br>Resident 5 moved into the facility 06/02/2025.<br><br>Resident 5's progress notes documented: "01/28/2026 3:00 PM - Good mood considering [s/he] had all of [his/her] teeth pulled day before. Drank and ate ice cream because of teeth getting pulled."<br>There was no note for 01/27/2026 when Resident 5 had dental surgery.<br><br>On 02/02/2026, at approximately 4:20 PM, Surveyor interviewed AED D. AED D stated s/he had not received a physician order regarding what foods Resident 5 would be restricted from. Surveyor asked AED D what foods AED D would have eaten after having major dental surgery. AED D stated s/he understood, and the staff should have been more observant of what Resident 5's potential needs would have been. AED D confirmed that POA H was upset when s/he came to visit Resident 5 and observed him/her being served the chicken mcnuggets.<br><br>On 02/19/2026, Surveyor reviewed Resident 5's hospice documentation submitted by his/her hospice provider, which stated: "01/30/2026: [POA H] and this writer had had an extensive conversation about appropriate dietary choices post-surgery for patient. Inspection was done of mouth. It is swollen, stitches are intact at this time. I did check the freezer for apple sauce, jello and ice cream. ... educated staff that [s/he] should not be eating toast oranges apples eggs and sandwiches. ... this writer waited until shift change to touch base with afternoon shave shift about dietary needs post-surgery."<br><br>Example 2: Resident 7 | N 425 | | |

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| N 425 | Continued From page 27<br><br>On 02/09/2026, at approximately 1:00 PM, Surveyor interviewed Resident 7. Resident 7 stated, "I was irritated. Today, my speech therapist arrived. I didn't realize I had an appointment, and staff had not assisted me in getting up for the morning yet, so my speech therapist had to wait."<br><br>On 02/19/2026, Surveyor reviewed Resident 7's record.<br><br>Resident 7 moved into the facility, 07/08/2025, with diagnoses including<br>Resident 7 was represented by Power of Attorney of Healthcare (POA) M.<br><br>Resident 7's "Master Care Plan," dated 01/28/2026, documented:<br>"Needs assistance to manage health care decisions."<br>"Mobility - Transfer: Needs staff assistance for all of [his/her] transfers. Needs an assistive device to transfer - Gait belt."<br>"Mobility - Bed: Needs staff assistance of one with getting in bed and repositioning."<br>"Dressing Needs - Needs staff assistance of one with dressing. Staff will assist with dressing [his/her] upper and lower half and assist with putting on [his/her] socks and shoes."<br>"Hygiene/Grooming/Oral - Needs staff assistance of one, staff will comb [Resident 7's] hair and assist with brushing [his/her] teeth."<br><br>On 02/09/2026, at approximately 2:00 PM, Surveyor interviewed AED D. AED D stated s/he could not explain why staff did not have Resident 7 ready for his/her medical appointment but s/he should have been.<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed | N 425 | | |

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| N 425 | Continued From page 28<br>Licensee A. Surveyor discussed the concerns expressed by residents and their representatives. Licensee A stated staff should be communicating between shift changes to ensure care needs are met. Licensee A stated s/he would be discussing staff processes with management. | N 425 | | |
| N 427 | 83.38(1)(c) Leisure time activities.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not arrange for services adequate to meet the needs of the residents in leisure time activities.<br><br>Findings include:<br><br>The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.<br><br>On 01/20/2026, the department received a | N 427 | | |

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| N 427 | Continued From page 29 | N 427 | | |

concern that residents were not treated with dignity.

On 02/02/2026, from approximately 11:55 AM to 4:30 PM, Surveyor was onsite. During this timeframe, activities were not conducted with the residents. Several residents sat in the dining room or living room, but staff did not conduct an activity.

On 02/02/2026, Surveyor reviewed the activity calendar that stated, "10:00 Snack, 11:00 Daily Chronicle, 2:00 Resident Council, 3:00 Exercise."

On 02/02/2026, at approximately 1:05 PM, Surveyor interviewed Resident 4. Surveyor asked what activities Resident 4 participated in at the facility. Resident 4 stated there are no activities to participate in unless Surveyor meant watching tv in the living room or putting together one of the puzzles the provider has sitting out. Surveyor reviewed the list of activities for the day with Resident 4. Resident 4 asked what 'Resident Council' meant. Surveyor explained what a resident council was. Resident 4 stated there is no such thing as a resident council here.

On 02/02/2026, at approximately 2:15 PM, Surveyor observed a discussion between Assistant Executive Director (AED) D, Hospice Team Director (HTD) K, Hospice Social Worker (HSW) L, and Power of Attorney (POA) H. There was a discussion about activities at the facility. POA H commented that the staff usually did not provide any form of activity for the residents, assuming this was due to the staff shortage. HTD K suggested to AED D that perhaps Hospice could step in and assist with providing activities and suggested to POA H, since s/he visits almost daily, that perhaps s/he might want to take the

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| N 427 | Continued From page 30<br>lead with bingo.<br><br>On 02/02/2026, at approximately 3:40 PM, Surveyor interviewed Resident 6. Surveyor asked what activities Resident 6 liked to participate in that were provided at the facility. Resident 6 responded, "What activities."<br><br>On 02/09/2026, at approximately 1:00 PM, Surveyor interviewed Resident 7. Surveyor asked what activities Resident 7 liked to participate in that were provided at the facility. Resident 7 stated, "I am one of the lucky ones, I have employment outside of the facility, so I am gone must weekdays and they don't provide anything on the weekends. Other residents often comment that there is nothing to do unless you want to watch tv."<br><br>On 02/09/2026, at approximately 2:30 PM, Surveyor interviewed Resident 8 and Resident 9. Surveyor asked what activities they liked to participate in that were provided at the facility. Resident 8 and Resident 9 stated there really were no activities provided. Resident 8 then stated, "We can make our own game." Resident 8 then proceeded to engage Surveyor and Resident 9 in a memory game; Resident 9 appeared to really enjoy it.<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor discussed the concern regarding the lack of activities and/or interaction of staff with the residents. Licensee A stated the concern would be discussed with staff. | N 427 | | |
| N 450 | 83.41(2)(c) Nutrition: menus.<br><br>Menus. 1. The CBRF shall make reasonable | N 450 | | |

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| N 450 | Continued From page 31<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not make weekly menus available to residents.<br><br>Findings include:<br><br>The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.<br><br>On 02/02/2026, at approximately 11:55 AM, Surveyor arrived at the facility and observed residents sitting in the dining room, waiting for lunch. Residents were asking what was for lunch. Resident 1 walked over to the whiteboard where the menu was to be posted. Resident 1 stated, "Well, that isn't going to be helpful. I have no idea what is for lunch."<br><br>On 02/02/2026, at approximately 12:10 PM, Surveyor interviewed Resident 3. Resident 3 was entering the dining room area. Surveyor asked if s/he knew what was for lunch. Resident 3 looked at the white board and stated, "No."<br><br>On 02/02/2026, at approximately 12:33 PM, Caregiver F filled out the menu whiteboard, when the residents were being served lunch. | N 450 | | |

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| N 450 | Continued From page 32<br><br>On 02/02/2026, at approximately 1:05 PM. Surveyor interviewed Resident 4. Surveyor asked if Resident 4 received a monthly menu to review. Resident 4 stated, "We never get a monthly menu, let alone a daily menu. As you saw today, lunch was served 45 minutes late, because they were short on staff and probably didn't know what they were going to make until the last minute."<br><br>On 02/02/2026, at approximately 4:00 PM, Surveyor interviewed Assistant Executive Director D. Surveyor stated the concern with the menu being available to the residents in a timely manner had been discussed during previous visits. Assistant Executive Director D stated s/he understood but today was not a good day due to a staff member calling in.<br><br>On 02/09/2026 at 12:57 PM, Surveyor entered the facility and noticed the menu whiteboard was blank. Licensed Practical Nurse E observed Surveyor looking at the whiteboard and stated s/he knew it had not been filled out but s/he was doing the best that s/he could.<br><br>On 02/16/2026 at 8:18 AM, Surveyor entered the facility and noticed the menu whiteboard was blank. | N 450 | | |
| N 489 | 83.44(2)(a) Rooms clean and free from odors.<br><br>The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure that all rooms were clean and free | N 489 | | |

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| N 489 | Continued From page 33 | N 489 | | |

from odor.

Findings include:

On 01/20/2026, the department received a concern that residents were not treated with dignity and provided adequate cares.

On 02/09/2026, at approximately 2:00 PM, Surveyor walked down the hall where Resident 3's, Resident 8's and Resident 10's rooms resided. Surveyor detected a strong urine like scent emanating throughout. Surveyor walked into Resident 3's room where a urinal with residue coated the sides and bottom. Surveyor could see shoe prints on the floor. Surveyor walked into the bathroom where soiled clothing that smelled strongly of a urine like scent, was stacked in the shower.

On 02/09/2026, at approximately 2:03 PM, Resident 8 observed Surveyor walking out of Resident 3's bedroom and stated, "Come in my room, it smells better there." Surveyor entered Resident 8's room and noted the room smelled pleasant. Resident 8 stated, "I don't know why [Resident 10's] room smells now, [s/he] isn't even here, [s/he] is in the hospital. Been there a few days."

On 02/09/2026, at approximately 2:15 PM, Surveyor exited Resident 8's room and walked past Resident 10's room. Resident 10's room was locked but Surveyor could detect a strong urine-like scent emanating from it.

On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor commented on the condition of the home environment with Licensee A and stated this was a continual problem.

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| N 489 | Continued From page 34<br>Surveyor has discussed the concern with staff on previous visits. Licensee A stated this was unacceptable as the facility was the resident's home and they should not have to live in that type of environment. | N 489 | | |
| Y3100 | 50.09(1)(f) Resident's Rights In Certain Facilities<br><br>(f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to:<br>1. Privacy for visits by spouse or domestic partner. If both spouses or both domestic partners under ch. 770 are residents of the same facility, the spouses or domestic partners shall be permitted to share a room unless medically contraindicated as documented by the resident ' s physician, physician assistant, or advanced practice nurse prescriber in the resident ' s medical record.<br>2. Privacy concerning health care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident ' s care shall require the resident ' s permission to authorize their presence.<br>3. Confidentiality of health and personal records, and the right to approve or refuse their release to any individual outside the facility, except in the case of the resident ' s transfer to another facility or as required by law or 3rd-party payment contracts and except as provided in s. 146.82 (2) and (3). | Y3100 | | |

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| Y3100 | Continued From page 35 | Y3100 | | |

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure residents had the right not to be recorded and filmed without consent.

Findings include:

The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.

On 02/02/2026, at approximately 3:30 PM, Surveyor interviewed Assistant Executive Director C and Caregiver E. Caregiver E proceeded to explain and stated the video feed could be reviewed to determine how Caregiver E acted towards Certified Nursing Assistant (CNA) J.

On 02/02/2026, at approximately 4:00 PM, Surveyor observed a camera in the kitchen and in the medication room, which were accessible to residents. Surveyor noted the door to the medication room was open and residents had gone in and out of the medication room during the survey process to ask staff questions or receive medication. Surveyor noted the kitchen was an open concept and residents could easily ambulate in and out of the kitchen. The camera in the kitchen was hung on the wall, above the archway where food was plated and placed on the counter. The living room was in line with the camera where residents gathered to watch

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| Y3100 | Continued From page 36<br>television.<br><br>On 02/09/2026, at approximately 2:00 PM, Surveyor observed the medication door was open and residents were able to ambulate in and out of the room.<br><br>On 02/16/2026, at approximately 8:15 AM, Surveyor observed the medication door was open and residents were able to ambulate in and out of the room. Surveyor interviewed Caregiver F. Surveyor asked if Caregiver F was aware of the cameras in the facility and were residents in view of the camera. Caregiver F stated, "Yes, residents can be seen on the cameras, along with staff members."<br><br>On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor discussed the concern. Licensee A stated s/he would have to review the location of the cameras as the cameras were primarily placed to monitor behaviors of the staff. | Y3100 | | |
| Y3234 | 50.09(1)(e) Treatment<br><br>(1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to:<br><br>(e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. | Y3234 | | |

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality by all employees of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.

This is a repeat deficiency. See Statement of Deficiency (SOD) W10511, dated 07/15/2025.

Residents and resident representatives voice concerns regarding staff treatment of residents.

Findings include:

The provider is licensed to serve up to 19 residents in the client groups: physically disabled, advanced age and irreversible dementia/Alzheimer.

On 01/20/2026, the department received a concern that residents were not treated with dignity and provided adequate care.

On 02/02/2026, at approximately 12:15 PM, Surveyor interviewed Resident 3. Resident 3 explained that Licensed Practical Nurse (LPN) E would talk "gruff" with the staff in front of the residents. Resident 3 explained that several staff at the facility were "rough around the edges."

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| Y3234 | Continued From page 38<br><br>On 02/02/2026, at approximately 1:05 PM, Surveyor interviewed Resident 4. Resident 4 explained that today was his/her shower day, and s/he was supposed to receive it at 1:30 PM, but s/he didn't think that would happen since they are short staffed. Resident 4 stated, "I will wait, because I will not allow Caregiver I to assist me." Resident 4 explained s/he was so devastated on how Caregiver I treated him/her during a shower. Resident 4 is paralyzed on the left side and unfortunately requires assistance. Resident 4 explained how embarrassing and degraded s/he felt while s/he was sitting in a shower, naked and Caregiver I was "harping" about how Resident 4 needed to be more flexible with his/her shower times. Resident 4 stated, "[S/he] just kept going on and on, it was so belittling. [S/he] will keep on and on, like beating a dead horse, trying to use [his/her] power to change my mind." Resident 4 explained there are shouting matches between staff and residents and staff with staff. Resident 4 stated, "It is all very disturbing. I didn't grow up around arguments." Resident 4 explained that Caregiver I was always yelling at residents about how they were violating HIPAA (Health Insurance Portability and Accountability Act). This even occurred during church service. Resident 4 stated a resident had passed away and the staff do not acknowledge the passing, discuss feelings with residents. Resident 4 stated, "[S/he] was our friend and then we are not allowed to grieve through it with our pastor. Nope. [Caregiver I] starts yelling at us saying we are violating HIPAA."<br><br>On 02/02/2026, at approximately 2:00 PM, Surveyor interviewed Resident 5's Power of Attorney (POA) H. POA H stated s/he visited Resident 5 several times a week, almost daily, and had noticed that assigned seating was being | Y3234 | | |

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implemented during meals. POA H explained staff informed him/her the assigned seats was due to residents and visitors gossiping and violating HIPAA. POA H stated residents and visitors only know what they overhear from staff. POA H stated, "Having a conversation about an individual's likes and dislikes was not a violation of HIPAA. It was called having a conversation. The staff do not talk to the residents on a personal level, the residents enjoy having someone take an interest in their thoughts."

On 02/02/2026, at approximately 2:08 PM, Hospice Team Director (HTD) K, Hospice Social Worker (HSW) L, Resident 5's Power of Attorney (POA) H and Surveyor observed Assistant Executive Director (AED) D aggressively push Resident 6 out of the med room in his/her wheelchair and proceeded to slam the door. HTD K and HSW L expressed shock over the incident by shaking their heads and commenting that was unacceptable behavior. POA H stated that was how the staff normally acted towards residents. POA H stated, "I think the staff are tired and there are not enough of them, so the residents take the brunt of their frustration." Surveyor walked over to Resident 6, who was sitting at a dining room table, and asked if s/he was okay. Resident 6 stated, "I just wanted some pain medication. Sorry." Resident 6 then laid his/her head on the table.

On 02/02/2026, at approximately 2:15 PM, Surveyor observed a discussion between AED D, HTD K, HSW L, and POA H. POA H was in the process of explaining his/her concerns which included: Staff and management interacting loudly and rudely among the residents; residents and visitors being yelled at for having a conversation amongst themselves; staff don't

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acknowledge visitors when they arrive, cannot even say hello. Surveyor observed AED D roll his/her eyes and then POA H called AED D out for rolling his/her eyes and being condescending with his/her responses.

On 02/02/2026, at approximately 4:15 PM, Surveyor attempted to interview AED D. Surveyor asked for clarification on what the reasoning was for aggressively removing Resident 6 from the med room. AED D stated s/he did not understand what the Surveyor was asking. Surveyor discussed the observation that occurred and the response that HTD K, HSW L and POA H expressed. AED D just shook his/her head.

On 02/02/2026, Surveyor reviewed the staff roster and determined Caregiver I was employed on 08/13/2025.

On 02/09/2026, at approximately 1:00 PM, Surveyor interviewed Resident 7. Resident 7 stated, "Well, if we don't accept our showers when the staff member offers, then you aren't getting one. There is no such thing as saying, I would like it before I go to bed." Resident 7 stated, "Staff are loud and are always yelling at each other."

On 02/09/2026, at approximately 2:05 PM, Surveyor interviewed Resident 8. Resident 8 explained that if a resident hears another resident calling out and notify staff, residents are scolded for violating HIPPA or not minding their business. Resident 8 stated, "We all take care of each other here, we look out for each other, how can that be wrong." At approximately 2:08 PM, Surveyor could hear Caregiver I approach Resident 8's room, singing, "[Resident 8] [Resident 8], I have your Hydro (hydrocodone)" in a loud manner.

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Caregiver I knocked on Resident 8's door and repeated it again as s/he entered the room. Surveyor observed Caregiver I hand Resident 8 his/her pill cup which Caregiver I held onto with his/her bare hands, finger inside the cup. Caregiver I stated, "I always sing to [Resident 8]." Surveyor commented s/he could hear Caregiver I singing Resident 8's medications before s/he entered the room. Caregiver I chuckled and said, "Yeah." Resident 8 took the medication and Caregiver I exited the room. Surveyor exited the room shortly after and observed residents ambulating in the hallway. Surveyor re-entered Resident 8's room and asked how s/he felt that Caregiver I announced his/her medications loud enough for others to hear. Resident 8 stated, "You get used to it, they do whatever they want around here. They say we are gossiping but the information we know is cause they are usually yelling about it."

On 02/09/2026, at approximately 2:25 PM, Surveyor attempted to interview Executive Assistant Director (EAD) D and Caregiver I, who were sitting in the common area. EAD D asked Surveyor if s/he had completed all of his/her interviews. Surveyor stated there were concerns regarding staff accusing residents of violating HIPAA guidelines, but the Surveyor had observed staff violating HIPAA guidelines. EAD D stated there were residents who were always upset about something. Caregiver I did not elaborate on sharing medication information in the common area of the facility.

On 02/13/2026, at approximately 10:45 AM, Surveyor interviewed POA H. POA H explained that s/he felt like during the meeting with [AED D] that s/he wasn't even being listened to. POA H stated s/he tried to explain how LPN E rudely

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speaks to residents and family members and that s/he will yell at staff in front of residents, but management does not want to hear it. POA H explained that there was an instance, a staff member actually sat down and conversed with a resident who was struggling, and LPN E yelled at the staff member for not doing their job. POA H stated, "Interacting with residents is a part of the job!" POA H stated when the staff member was done chatting with the resident, [s/he] got up and asked if any of the residents needed assistance before proceeding to clean a room. LPN E yelled at them again because they had delayed cleaning a room. POA H stated, "What is sad, I actually observed [Regional Director C] telling [LPN E] and [AED D] during a staff meeting that residents come first but that isn't what happens." POA H continued to explained that Caregiver I will interrupt conversations if s/he thinks s/he was not being informed of something. PAO H stated s/he expressed his/her concerns to AED D and s/he made light of it, saying that is "Just the way [s/he] is."

On 02/19/2026, Surveyor reviewed Resident 5's hospice documentation submitted by his/her hospice provider, which stated:
"01/22/2026 - completed routine visit to pt (patient) at facility. upon arrival, pt sitting in dining room eating [his/her] lunch. [S/he] says [s/he] is not in any pain, but [s/he] is bothered because staff is being loud while washing dishes. Provided support to [him/her] through conversation. [Regional Director C] requested a dementia training for [his/her] staff."
"01/30/2026 - [POA H] and this writer had had an extensive conversation about staff dynamics."

On 02/19/2026 at 3:30 PM, Surveyor interviewed Licensee A. Surveyor explained the

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| Y3234 | Continued From page 43<br>conversations s/he had with residents and resident representatives. Licensee A stated s/he was disappointed to hear that the residents or their family members felt disrespected by staff in their own home. Licensee A stated s/he would be re-educating staff on the importance of them understanding this is a home, the residents' home. Surveyor explained his/her observation of Resident 8's med pass. Licensee A stated caregivers should never discuss a resident's medications out loud when in a setting that others can hear. Licensee A said this was not the provider's standard of practice and would address the concerns immediately. | Y3234 | | |