| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015335 | A. BUILDING: _____ B. WING _____ | R-C 03/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HAMILTON PARK PLACE | 2525 HAMILTON STREET PORTAGE, WI 53901 |

| (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 03/20/2026, Surveyor conducted a verification visit and 1 complaint investigation at Hamilton Park Place.<br><br>Six deficiencies were identified.<br><br>Four of the 7 deficiencies were repeat violations. See Statement Of Deficiency (SOD) WHTX14, dated 09/27/2023, SOD SZPT11, dated 03/09/2020, SOD WHTX11, dated 05/25/2022, SOD WHTX14, dated 09/27/2023, SOD WHTX16, dated 07/12/2024, and SOD 56CN11, dated 12/10/2025.<br><br>Four of 8 deficiencies from SOD 56CN11, dated 12/10/2025 were substantially corrected.<br><br>The complaint was substantiated.<br><br>Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed.<br><br>Census: 23 | {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 record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF.<br><br>From 05/25/2022 to 03/26/2026, the provider did | {N 196} | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {N 196} | Continued From page 1 | {N 196} | | |

not comply with all the laws governing the CBRF as evidenced by 43 deficiencies identified, 26 of the 43 deficiencies were repeat deficiencies, 7 complaints were substantiated, Special Orders were issued by the Department with 7 Statement Of Deficiencies (SODs), and on 01/09/2026 the Department issued a No New Admit Order.

This is a repeat deficiency. See Statement Of Deficiency (SOD) WHTX14, dated 09/27/2023 and SOD 56CN11, dated 12/10/2025.

Findings include:

The facility is licensed as a Class CNA able to serve up to 29 residents within the client groups of advanced age, physically disabled, and irreversible dementia/Alzheimer's.

Example 1- SOD WHTX11, dated 05/25/2022:
On 05/25/2022, a standard survey and 1 complaint investigation were conducted. As a result of the survey, the complaint was substantiated and 8 deficiencies including 2 repeat deficiencies were identified in SOD WHTX11, dated 05/25/2022:
N0243 DHS 83.21(1)-(3) All Employee Training
N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes,
N0415 DHS 83.37(2)(d) Documentation Of Medication Administration
N0431 DHS 83.38(1)(g) Health Monitoring
N 0526 DHS 83.47(2)(d) Fire Drills
N0526 DHS 83.47(2)( e ) Other Evacuation Drills
N0546 DHS 83.48(4)(f) Smoke Detector in Non-Resident Living Areas

Special Orders issued 08/21/2022 with SOD

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| {N 196} | Continued From page 2<br><br>WHTX11, dated 05/25/2022 stated,<br>" ...Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall comply with requirements as specified by Wis. Admin. Code § DHS 83.38(1)(g). That is, the licensee shall monitor the physical, mental, and oral health of residents; and make arrangements for services unless otherwise arranged for by the resident. The licensee will develop (or review/revise) written procedures and provide staff training for all managers and caregivers to address how the provider will:<br>- assess risk factors contributing to skin integrity concerns including pressure injuries,<br>- implement pressure injury prevention and treatment,<br>- monitor and document changes in a resident's health,<br>- notify the physician, notify the resident's legal representative or family, notify the care manager (if any) when a resident experiences a change in health status or medical emergency,<br>- ensure timely medical assessments and emergency medical care,<br>- review and revise individualized service plans annually or when there is a change in a resident's needs, abilities or physical or mental condition, and<br>- implement standards of practice for medical records to ensure each resident's record is accurate, current, and complete ..."<br><br>Example 2- SOD WHTX12, dated 12/12/2022:<br>On 12/12/2022, 1 verification visit and 1 complaint investigation were conducted. As a result of the survey, 3 deficiencies including 2 repeat deficiencies were identified in SOD WHTX12, dated 12/12/2022:<br>N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication | {N 196} | | |

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| {N 196} | Continued From page 3<br>N0415 DHS 83.37(2)(d) Documentation Of Medication Administration<br>N0450 DHS 83.41(2)(c) Nutrition: Menus<br><br>Example 3- SOD WHTX13, dated 05/09/2023:<br>On 05/09/2023, 1 verification visit was conducted. As a result of the survey, 3 deficiencies including 2 repeat deficiencies were identified in SOD WHTX13, dated 05/09/2023:<br>N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication<br>N0408 DHS 83.37(1)(i) PRN Psychotropic Medication<br>N0415 DHS 83.37(2)(d) Documentation Of Medication Administration<br><br>SPECIAL ORDERS issued 07/13/2023 with SOD WHTX13 stated,<br>" ...Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee will comply with the requirements specified by Wis. Admin. Code § DHS 83.32(3)(h) and ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by a practitioner ...Diabetes Management, to include standards of practice for the assessment, care planning, and provision of services for residents with diabetes ..."<br><br>Example 4- SOD L5VC11, dated 07/13/2023:<br>On 07/13/2023, 1 complaint investigation was conducted. As a result of the survey, the complaint was substantiated and 1 deficiency was identified in SOD L5VC11, dated 07/13/2023:<br>N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs<br><br>Example 5- SOD WHTX14, dated 09/27/2023:<br>On 09/27/2023, 1 verification was conducted. As a result of the survey, 4 deficiencies including 3 | {N 196} | | |

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| {N 196} | Continued From page 4<br>repeat deficiencies were identified in SOD WHTX14, dated 09/27/2023:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws<br>N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication<br>N0408 DHS 83.37(1)(i) PRN Psychotropic Medication<br>N0415 DHS 83.37(2)(d) Documentation Of Medication Administration<br><br>SPECIAL ORDERS issued 12/11/2023 with SOD WHTX14 stated,<br>" ...1. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee shall comply with the requirements specified by Wis. Admin. Code § DHS 83.14(2)(a) and ensure that the CBRF and its operation comply with this chapter and with all other laws governing the CBRF and its operation. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) WHTZ14.<br>The licensee's corrective measures, at a minimum, shall include the development (or review) of written procedures and staff training (as appropriate) to address:<br>Medication Management: including how the facility will document medication orders, medication administration, missed/refused doses; and ensure residents receive medications at the intervals and dosages prescribed ...Diabetes Management: Including standards of practice for the assessment, care planning, and provision of services for residents with diabetes ..."<br><br>Example 6- SOD WHTX15, dated 03/21/2024:<br>On 03/21/2024, a standard survey and 1 verification visit were conducted. As a result of the survey, 5 deficiencies including 2 repeat | {N 196} | | |

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| {N 196} | Continued From page 5<br>deficiencies were identified in SOD WHTX15, dated 03/21/2024:<br>N0219 DHS83.17(1) Licensee Conduct Caregiver Background Check,<br>N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication<br>N0408 DHS 83.37(1)(i) PRN Psychotropic Medication<br>N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented<br>Z0010 50.065(2)(bb) Determine Final Disposition Of Charge<br><br>SPECIAL ORDERS issued 04/19/2024 with SOD WHTX15 stated,<br>" ...1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall provide medication administration appropriate to the resident's needs and ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. In consultation with a registered nurse (RN), the licensee shall develop and implement corrective measures for the deficiencies issued under Wis. Admin. Code §§ DHS 83.32(3)(h) and 83.37(1)(i) as identified in Statement of Deficiency (SOD) WHTX15. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis. Stat. ch. 50) and knowledge of the client groups served by Hamilton Park Place. Consultation will include the development (or review) of written procedures to address: Medication Management and Administration, including how the provider will:<br>- Implement standards of practice for insulin management ...<br>- Monitor and document the rationale for use, detailed description of the behavior, and effectiveness of the use of PRN psychotropic | {N 196} | | |

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| {N 196} | Continued From page 6<br>medications as a behavioral intervention.."<br><br>Example 7- SOD WHTX16, dated 07/12/2024:<br>On 07/12/2024, 1 verification visit and 3 complaint investigations were conducted. As a result of the survey, 2 complaints were substantiated and 4 deficiencies including 3 repeat deficiencies were identified in SOD WHTX16, dated 07/12/2024:<br>N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication<br>N0388 DHS 83.35(3)( c )Implement, Follow The Individual Service Plan<br>N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes<br>N0408 DHS 83.37(1)(i) PRN Psychotropic Medication<br><br>SPECIAL ORDERS issued 08/26/2024 with SOD WHTX16 stated,<br>"Based on the results of the Department's 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 Hamilton Park Place: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide legal representative and case manager (if any) of Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13 with a copy of Statement of Deficiency WHTX16 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #1. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request." | {N 196} | | |

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| {N 196} | Continued From page 7<br><br>Example 8- SOD WHTX17, dated 11/06/2024:<br>On 11/06/2024, 1 verification visit and 3 complaint investigations were conducted. As a result of the survey, 1 complaint was substantiated and 1 deficiency, a repeat deficiency was identified in SOD WHTX17, dated 11/06/2024:<br>N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication<br><br>SPECIAL ORDERS issued 02/11/2025 with SOD WHTX17 stated<br>" ...1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br>WITHIN 45 DAYS of receipt of this notice, the licensee will develop and implement corrective measures to address the medication administration deficiency identified in Statement of Deficiency WHTX17.<br>All managers and resident care staff with responsibilities for medication administration and management will receive training regarding the provider's corrective measures..."<br><br>Example 9- SOD 56CN11, dated 12/10/2025:<br>On 11/14/2025, 1 complaint investigation and a standard survey were conducted, and on 11/26/2025 1 complaint investigation was conducted. As a result of the survey, 1 complaint was substantiated and 8 deficiencies, including 7 repeat deficiencies were identified in SOD 56CN11, dated 12/10/2025:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws<br>N0219 DHS 83.17(1) Licensee Conduct | {N 196} | | |

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| {N 196} | Continued From page 8<br><br>Caregiver Background Check<br>N0277 DHS 83.25 Continuing Education<br>N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation<br>N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication<br>N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessments<br>N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes<br>N0408 DHS 83.37(1)(i) PRN Psychotropic Medication<br><br>Notice and Order issued 01/09/2026 with SOD 576CN11 included a no new admission order and special orders and stated " pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Hamilton Park Place NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency 56CN11 are corrected, compliance is verified by the Department, and this Order is rescinded in writing ...SPECIAL ORDERS ...<br>pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Hamilton Park Place: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide Resident 1's, Resident 2's, and Resident 4's legal representative and case manager (if any) of with a copy of Statement of Deficiency 56CN11 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with this Order. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each | {N 196} | | |

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| {N 196} | Continued From page 9<br>legal representative and case manager ..."<br><br>Example 10- SOD 56CN12, dated 03/26/2026 (this survey):<br>On 03/26/2026, 1 complaint investigation and a verification visit were conducted. As a result of the survey, the complaint was substantiated and 6 deficiencies, including 4 repeat deficiencies were identified in SOD 56CN12, dated 03/26/2026:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws<br>N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation<br>N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessments<br>N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes<br>N0326 DHS 83.31(4) (a) Notice of Facility Initiated Discharges<br>N0328 DHS 83.31 (4)(c) Involuntary Discharge Notice Requirements<br><br>On 03/26/2026 at 10:00 AM, Surveyor discussed concerns with Owner/Licensee O, Administrator Q and Assistant Administrator R. Owner/Licensee O stated (former) Executive Director A and (former) Resident Health Director B had reassured him/her they were correcting the issues and were no longer employed at facility. Owner/Licensee A stated due to Administrator Q's and Assistant Administrator R's training and experience s/he was confident they would resolve the issues appropriately and promptly.<br><br>Cross Reference:<br>N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation<br>N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessments | {N 196} | | |

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| {N 196} | Continued From page 10<br>N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes<br>N0326 DHS 83.31(4) (a) Notice of Facility Initiated Discharges<br>N0328 DHS 83.31 (4)( c) Involuntary Discharge Notice Requirements | {N 196} | | |
| {N 302} | 83.28(4)(a) Resident health screening and documentation<br><br>Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse screened each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis (TB).<br><br>Resident 5 was not screened for TB within 90 days before or 7 days after admission. | {N 302} | | |

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| {N 302} | Continued From page 11<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) SOD 56CN11, dated 12/10/2025.<br><br>Findings include:<br><br>On 03/20/2026 at approximately 9:30 AM, Surveyor requested Resident 5's record including TB test results from Administrator Q.<br><br>On 03/20/2026, Surveyor reviewed Resident 5's record. S/he was admitted 01/12/2026.<br><br>The record contained a Physician Admission Orders form dated 12/30/2025 which identified Resident 5 was free of communicable disease. The form stated "Resident must have a PPD [TB test] with in [sic] 30 days of admission" with areas to fill in the date given, date read and results. Date given, date read and results were blank.<br><br>On 03/20/2026 at 2:48 PM, Surveyor discussed concern of no TB test with Administrator Q and Assistant Administrator R. Administrator Q stated they requested the TB test results from Resident 5's physician on 03/20/2026. Administrator Q stated s/he would forward the TB test results to Surveyor by noon on 03/23/2026.<br><br>As of 03/24/2026 at 9:15 AM, Surveyor had not received Resident 5's TB test results.<br><br>Cross Reference:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws | {N 302} | | |
| N 326 | 83.31(4)(a) Notice of facility initiated discharges | N 326 | | |

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| N 326 | Continued From page 12<br>Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, Resident 4's legal representative was not provided a 30-day written advance notice of involuntary discharge.<br><br>Findings include:<br><br>On 02/12/2026, the Department received a complaint alleging inappropriate involuntary discharge.<br><br>Findings include:<br><br>On 02/13/2026 at 3:24 PM, Surveyor interviewed Family Member J who stated Resident 4 was at a skilled nursing facility (SNF) for rehab following brain surgery on 12/01/2025, was planning to return to the CBRF, and his/her managed care organization was paying the CBRF to hold Resident 4's bed. Family Member J stated on 02/09/2026, s/he received an email from (former) Resident Health Director F stating they were | N 326 | | |

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| N 326 | Continued From page 13<br>discharging Resident 4 and family needed to pick up his/her belongings by the end of that week.<br><br>On 02/13/2026 at 3:27 PM, Family Member J forwarded an email string to Surveyor.<br>Email dated 02/09/2026 at 11:59 AM from Resident Health Director B to Family Member B, Resident 4's MCO team, Owner/Licensee O and Owner P.<br>The email stated " ...I am writing in regards to [Resident 4] and [his/her] extended absence from our facility. I have spoken to [Resident 4] via Zoom and also the staff at the [skilled nursing facility]. [His/her] level of care is above what we are able to provide. We ask that [his/her] family please remove [his/her] belongings by end of this week from [his/her] room please ..."<br><br>On 03/26/2026 at 10:00 AM, Surveyor discussed concerns regarding Resident 4's involuntary discharge with Owner/Licensee O, Administrator Q and Assistant Administrator R. Owner/Licensee O stated Executive Director A and Resident Health Director B no longer work for the facility.<br><br>Cross Reference:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws<br>N0328 DHS 83.31 (4)( c) Involuntary Discharge Notice Requirements | N 326 | | |
| N 328 | 83.31(4)(c) Involuntary discharge notice requirements.<br><br>Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth | N 328 | | |

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| N 328 | Continued From page 14<br>the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, an involuntary discharge notice to Resident 4's legal representative did not include a statement that a review of the involuntary discharge notice could be reviewed by the Department and did not include the contact information for the Department's regional director or the regional office of the Board On Aging and Long Term Care's Ombudsman program.<br><br>Findings include:<br><br>On 02/12/2026, the Department received a complaint alleging inappropriate involuntary discharge.<br><br>On 02/13/2026 at 3:27 PM, Family Member J | N 328 | | |

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| N 328 | Continued From page 15<br><br>forwarded an email dated 02/09/2026 at 11:59 AM from Resident Health Director B to Family Member B, Resident 4's MCO team, Owner/Licensee O and Owner P.<br><br>The email stated " ...I am writing in regards to [Resident 4] and [his/her] extended absence from our facility. I have spoken to [Resident 4] via Zoom and also the staff at the [SNF]. [His/her] level of care is above what we are able to provide. We ask that [his/her] family please remove [his/her] belongings by end of this week from [his/her] room please ..."<br><br>The notice did not include a statement that a review of the involuntary discharge notice could be reviewed by the Department and did not include contact information for the Department's regional director or contact information for the regional office of the Board On Aging and Long Term Care's Ombudsman program.<br><br>On 03/26/2026 at 10:00 AM, Surveyor discussed concerns regarding Resident 4's involuntary discharge with Owner/Licensee O, Administrator Q and Assistant Administrator R. Owner/Licensee O stated (former) Executive Director A and (former) Resident Health Director B no longer work for the facility.<br><br>Cross Reference:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws<br>N0326 DHS 83.31(4) (a) Notice of Facility Initiated Discharges | N 328 | | |
| {N 381} | 83.35(1)(a) Pre-admission and ongoing assessments. | {N 381} | | |

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| {N 381} | Continued From page 16<br>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure all resident's needs were assessed when there was a change in needs, abilities, or condition.<br><br>Side rail assessments were not completed for 4 of 4 residents reviewed.<br><br>Resident 1's, Resident 5's, Resident 6's, and Resident 7's assessments did not include description of medical symptom or condition warranting use of side rails, alternative interventions to side rails tried and reason(s) why alternative interventions were not successful and their individual service plans (ISP) did not identify need for side rails or when side rails should be in up position, describe trials of less restrictive interventions, include education provided to resident and/or resident's legal representative regarding risks of side rail use or plans to reduce side rail use and monitor bed, mattress and side rails for safety.<br><br>This is a repeat deficiency. See Statement Of | {N 381} | | |

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| {N 381} | Continued From page 17<br>Deficiency (SOD) 56CN11, dated 12/10/2025.<br><br>Findings include:<br><br>The facility is licensed as a Class C (nonambulatory) CBRF able to serve up to 29 residents within the client groups of physically disabled, advanced age and irreversible dementia/Alzheimer's.<br>According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment...2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patients assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts | {N 381} | | |

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| {N 381} | Continued From page 18<br>to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach... Bed Rail Safety Guidelines If it is determined that bed rails are required and that other environmental or treatment considerations may not meet the individual patient's assessed needs, or have been tried and were unsuccessful in meeting the patient's assessed needs, then close attention must be given to the design of the rails and the relationship between rails and other parts of the bed. 1. The bars within the bed rails should be closely spaced to prevent a patient's head from passing through the openings and becoming entrapped. 2. The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering. 3. Care should be taken that the mattress does not shrink over time or after cleaning. Such shrinkage increases the potential space between the rails and the mattress. 4. Check for compression of the mattress' outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail. 5. Ensure that the mattress is appropriately sized for the selected bed frame, as not all beds and mattresses are interchangeable. 6. The space between the bed rails and the mattress and the headboard and the mattress | {N 381} | | |

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| {N 381} | Continued From page 19<br>should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails. 7. Latches securing bed rails should be stable so that the bed rails will not fall when shaken. 8. Older bed rail designs that have tapered or winged ends are not appropriate for use with patients assessed to be at risk for entrapment. Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings 11 9. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items (See Appendix 1: Glossary) should be ongoing. " (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 03/24/2026)).<br><br>On 03/20/2026 at 10:54 AM, Surveyor observed Resident 1 sitting on a chair in his/her room and bilateral ¼ siderails in the up position on Resident 1's bed.<br>On 03/20/2026 at 10:58 AM, Surveyor observed Resident 5 in bed. Bilateral ½ side rails were in the up position.<br>On 03/20/2026 at 10:59 AM, Surveyor observed Resident 7 in bed. Bilateral ½ side rails were in the up position.<br>On 03/20/2026 at 11:06 AM, Surveyor observed Resident 6 in bed. A scoop mattress was in place and bilateral ½ side rails were in the up position.<br><br>On 03/20/2026 at approximately 9:30 AM, Surveyor requested Resident 5's record and at 12:22 PM requested his/her side rail assessment from Administrator Q, and on 03/20/2026 at 12:22 | {N 381} | | |

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| {N 381} | Continued From page 20<br>PM, Surveyor requested Resident 1's, Resident 6's, and Resident 7's records including side rail assessments from Administrator Q.<br><br>Example 1- Resident 1<br>Resident 1 was admitted 09/29/2025. Diagnoses included vascular dementia with agitation and anxiety disorder.<br><br>Comprehensive Assessment dated 01/26/2025 (summarized):<br>In the area of Walking/Ambulation: Transferred with 1 person assist with a gait belt and verbal assistance, required hands-on assistance with getting up, sitting down/laying down, and used a wheelchair.<br>In the area of Falls- High risk for falls.<br>In the area of Physical Disabilities- Required 1 person assist with positioning in bed, wheelchair, standing and other furniture.<br>The comprehensive assessment did not identify need for/use of side rails.<br><br>ISP, not signed or dated (summarized):<br>In the area of General Questions- " ...List any adaptive equipment: Uses a wheelchair ..."<br>In the area of Mobility and Transferring- Required hands-on assistance with getting up, using walking devices, and sitting down/laying down.<br>In the area of Physical Disabilities- Required 1 person assist with positioning.<br>The ISP did not identify use of side rails.<br><br>Hospice Assessment and Plan of Care dated 09/29/2025-<br>The assessment and plan of care did not identify need for/use of side rails.<br><br>Fax cover sheet from provider to hospice dated 03/03/2026- " ...Please fax over order that: okay | {N 381} | | |

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| {N 381} | Continued From page 21<br>for [patient] to have side rails ..."<br>Resident 1's record did not contain an MD order for Resident 1's side rails.<br><br>Example 2- Resident 5<br>Resident 2 was admitted 01/12/2026. Diagnoses included polyneuropathy, unspecified and severe hypoxic ischemic encephalopathy.<br><br>Comprehensive Assessment dated 12/31/2025 (summarized):<br>In the area of Walking/Ambulation- Required assistance of 1 person using a gait belt and verbal cues for walking, hands on assistance with getting up, sitting and laying down.<br>In the area of Fall Risk- Low fall risk<br>In the area of Physical Disabilities- Required 1 person assist with positioning in bed, wheelchair, and other furniture.<br>The assessment did not address need for/use of side rails, and the record did not contain a side rail assessment.<br><br>ISP, not signed or dated (summarized):<br>In the area of Mobility and Transferring- Independent<br>In the area of Fall Risk- "Bed rails As Needed Every Day ...The resident is still deemed a low risk for falls ..."<br>In the area of Physical Disabilities- Required 1 assist with positioning<br>The ISP did not identify when side rails should be in up position, describe trials of less restrictive interventions, include education provided to resident and/or resident's legal representative regarding risks of side rail use or plans to reduce side rail use and monitor bed, mattress and side rails for safety.<br><br>Physician order dated 03/04/2026 stated " ...Okay | {N 381} | | |

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| {N 381} | Continued From page 22<br>for facility to use bed rails for patient safety."<br><br>Hospice Admission Plan of Care dated 01/12/2026:<br>In the area of Immediate Needs: " ...Fall concerns identified?: Yes: Educate caregiver to perform frequent visual checks on patient, Reinforce [sic] bed in low position and wheels locked at all times ...[name of hospice agency] to provide appropriate [durable medical equipment] to minimize fall risk ..."<br>The hospice care plan did not identify need for/use of side rails.<br><br>Example 3- Resident 6<br>Resident 6 was admitted 05/13/2025. Diagnoses included unspecified intellectual disabilities, spastic diplegic cerebral palsy, and epilepsy, unspecified, not intractable without status epilepticus.<br><br>On 03/24/2026 at 2:25 PM, Surveyor received a Comprehensive Assessment and Level of Care Determination for Resident 6 dated 03/24/2026 via email from Assistant Administrator B that did not identify use of side rails.<br><br>On 03/27/2026 at 5:03 PM, Surveyor received a Comprehensive Assessment dated 01/28/2026 via email from Assistant Administrator R (summarized):<br>In the area of Transferring- 1 person assist with mechanical lift<br>In the area of Fall Risk- No risk of falls<br>In the area of Pain Management- Requires assistance with bed positioning devices.<br>In the area of Physical Disabilities- 1 person assist with positioning in bed, wheelchair, or other furniture.<br>The assessment did not identify need for/use of | {N 381} | | |

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| {N 381} | Continued From page 23<br>side rails.<br><br>ISP, not signed or dated (summarized):<br>In the area of General Questions- " ...List any adaptive equipment: Use of Hoyer Lift ..."<br>In the area of Mobility and Transfers- "Independent"<br>In the area of Fall Risk- "Not Applicable"<br>In the area of Mobility Transferring- "Not Applicable"<br>The ISP did not identify need for/use of side rails.<br><br>Physician order dated 03/20/2026 stated " ...Patient to have bedrails to assist with positioning and transfers ..."<br><br>Hospice Plan of Care dated 05/15/2025:<br>In the area of Fall Prevention- "Educate/ reinforce facility staff on keeping call light within reach of patient ...bed in lowest possible position."<br>In the area of Mobility- "Transfer using 2 people ...using mechanical lift sit to stand ..."<br>The hospice care plan did not identify need for/use of side rails.<br><br>Example 4- Resident 7<br>Resident 7 was admitted 05/10/2023. Diagnoses included generalized weakness and fibromyalgia.<br><br>On 03/24/2026 at 2:25 PM, Surveyor received a Comprehensive Assessment and Level of Care Determination for Resident 7 dated 03/24/2026 via email from Assistant Administrator B that did not identify use of side rails.<br><br>On 03/27/2026 at 5:03 PM, Surveyor received a Comprehensive Assessment dated 11/24/2025 via email from Assistant Administrator R (summarized):<br>In the area of Eating- Alternated eating in room | {N 381} | | |

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| {N 381} | Continued From page 24<br>and eating in Broda chair in dining room (required supervision while eating due to choking risk).<br>In the area of Mobility/Transferring- 1 assist mechanical lift<br>In the area of Fall Risk- Minimal risk for falls<br>In the area of Physical Disabilities- 2 person assist for repositioning in bed, wheelchair, or other furniture.<br>The assessment did not identify need for/use of side rails.<br><br>ISP, not signed or dated (summarized):<br>In the area of General Questions- Adaptive equipment Hoyer lift, Broda chair and hospital bed.<br>In the area of Mobility and Transfers- "Independent"<br>In the area of Fall Risk- "Not Applicable"<br>In the area of Physical Disabilities- Low risk for falls, team to assist with repositioning in bed, wheelchair/device, standing or in other facility/home furniture.<br>The ISP did not identify use of side rails.<br><br>Physician order dated 03/20/2026 stated " ...Patient to have bedrails to assist with positioning and transfers ..."<br><br>Hospice Plan of Care dated 01/27/2026 (summarized):<br>In the area of Equipment and Supplies- High-low full electric bed, side rails<br>In the area of Fall Prevention- Educate facility staff on increasing frequency of visual checks on patient ..."<br>In the area of Mobility- 2 person assist transfer with Hoyer lift<br><br>On 03/20/2026 at 10:59 AM, Surveyor | {N 381} | | |

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| {N 381} | Continued From page 25<br><br>interviewed Med Tech S who stated Resident 5's side rails were initiated on admission and were to be in the up position any time s/he was in bed, unless s/he was eating or drinking in bed. Med Tech S stated Resident 7's side rails were initiated prior to 12/19/2025 (Med Tech S's hire date) and were to be in the up position anytime s/he was in bed to prevent rolling out of bed.<br><br>On 03/20/2026 at 11:09 AM, Surveyor interviewed Lead Caregiver G who stated they had physician orders for every resident who had side rails. Lead Caregiver G stated Resident 1's side rails were to prevent rolling out of bed and Resident 1 held them for support while getting in and out of bed, Resident 5 grabbed onto the side rails to help him/her sit up in bed and held onto them while sitting at edge of bed, Resident 6's side rails were for safety since s/he was a fall risk and were to be in the up position whenever s/he was in bed, and Resident 7's side rails were for safety and s/he held onto the rail to assist with rolling in bed.<br><br>On 03/20/2026 at 1:11 PM, Surveyor returned to Resident 6's room with Administrator Q. Surveyor tested the stability of the side rail on the room side of the bed by shaking it horizontally from room side of bed to wall side of bed, and the side rail moved approximately ½ inch to 1 inch. Surveyor tested for gap between the mattress and side rail and observed a gap measuring approximately 3 ½" between the mattress and side rail. Administrator Q stated the side rail probably was not tightened when a new mattress was put on the bed a couple days prior to 03/20/2026 and s/he would have maintenance staff tighten it. Administrator Q showed Surveyor the scoop mattress (mattress with soft guards on either side of the mattress) on Resident 6's bed and stated the scoop mattress was to prevent | {N 381} | | |

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| {N 381} | Continued From page 26 | {N 381} | | |

Resident 6 from falling out of bed.

On 03/20/2026 at 1:15 PM, Surveyor returned to Resident 1's room with Administrator Q stated Resident 1's side rails were used for positioning to aid in sitting up. Administrator Q stated hospice usually initiated side rails.

On 03/20/2026 at 1:28 PM, Surveyor returned to Resident 5's and Resident 7's room with Administrator Q who stated all 4 residents with side rails needed their side rails and no side rail assessments had been completed for any of the 4 residents.

On 03/20/2026 at 2:48 PM, Surveyor discussed concern of no side rail assessments with Administrator Q and Assistant Administrator R. Administrator Q stated s/he would have the facility or hospice nurse complete the side rail assessments the week of 03/22/2026. Administrator Q verbalized an understanding when Surveyor discussed and side rail alternatives such as transfer handles, low beds, floor mats, and special mattresses and the dangers of side rails.

On 03/26/2026 at 10:00 AM, Surveyor discussed concern of no side rail assessments with Owner O, Administrator Q and Assistant Administrator R. Owner O stated s/he did not know if other positioning devices were trialed. Owner O stated when the last Statement of Deficiency (SOD) was issued (SOD 56CN11, dated 12/10/2025 and issued on 01/09/2026) (former) Executive Director A and (former) Resident Health Director B were to complete side rail assessments and obtain physician orders or physical therapy orders for the side rails. Administrator Q stated they had no documentation alternative positioning devices

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| {N 381} | Continued From page 27<br>were trialed, since 03/20/2026 they determined side rails were not appropriate for Resident 6 and were removed.<br><br>Cross Reference:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws<br>N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes | {N 381} | | |
| {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 observation, record review and interview, the provider did not ensure: 1. the individual service plan (ISP) was updated when there was a change in resident's needs for 2 of 2 residents reviewed and 2. the ISP was reviewed with the resident or resident's legal representative or that the resident or their legal representative signed the ISP, acknowledging their involvement in, understanding of and agreement with the | {N 389} | | |

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| {N 389} | Continued From page 28<br>individual service plan for 5 of 5 residents reviewed.<br><br>Resident 1's ISP did not address need for or use of pull tab alarm and Resident 6's ISP did not address need for or use of a scoop mattress.<br><br>Resident 1's, Resident 4's, and Resident 6's ISPs were not signed by their legal representatives, and Resident 5 and Resident 7 had not signed their ISPs.<br><br>This is a repeat deficiency. See Statement Of Deficiency (SOD) WHTX11, dated 05/25/2022, SOD WHTX16, dated 07/12/2024, SOD 56CN11, dated 12/10/2025.<br><br>Findings include:<br><br>On 03/20/2026 at 1:11 PM with Administrator Q, Surveyor observed Resident 6 in bed on a scoop mattress and bilateral side rails attached to bed in the up position. Administrator Q stated the scoop mattress was to prevent Resident 6 from falling out of bed.<br><br>On 03/20/2026 at 1:15 PM while in Resident 1's room with Administrator Q, Surveyor observed Resident 1 sitting in a chair. A pull tab alarm was in use. Administrator Q stated the pull tab alarm was used to alert staff of Resident 1's attempts to transfer without assistance.<br><br>On 03/20/2026, Surveyor reviewed records of Resident 6, Resident 1, Resident 4, Resident 5, Resident 6 and Resident 7.<br><br>Example 1- Resident 6<br>Resident 6 was admitted 05/13/2025. Diagnoses included unspecified intellectual disabilities, | {N 389} | | |

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| {N 389} | Continued From page 29 | {N 389} | | |

spastic diplegic cerebral palsy, and epilepsy, unspecified, not intractable without status epilepticus. Resident 6's face sheet identified s/he had a guardian of person (legal representative).

ISP, not dated or signed (summarized):
In the area of General Questions- Adaptive Equipment: Hoyer lift
In the area of Fall Risk- "Not Applicable"
In the area of Mobility/Transferring- "Not Applicable"
In the area of Physical Disabilities- 1 person assist with positioning
The ISP did not identify need for or use of scoop mattress.

Hospice Plan of Care dated 05/15/2025:
In the area of Equipment and Supplies- "N/A" [not applicable]
In the area of Safety Measures- "N/A"
In the area of Fall Prevention- "Educate/ reinforce facility staff on keeping call light within reach of patient ...bed in lowest possible position."
In the area of Mobility- "Transfer using 2 people ...using mechanical lift sit to stand ..."
The hospice care plan did not identify need for or use of a scoop mattress.

Example 2- Resident 1
Resident 1 was admitted 09/29/2025. Diagnoses included vascular dementia with agitation and anxiety disorder. Resident 1's face sheet identified s/he had a Power of Attorney for Health Care agent (legal representative).

ISP, not dated or signed (summarized):
In the area of General Questions- Adaptive equipment: wheelchair
In the area of Mobility and Transferring- 1 person

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| {N 389} | Continued From page 30 | {N 389} | | |

assist with gait belt and verbal assistance
In the area of Fall Risk- " ...high fall risk because of [sic] they forget their limitations, gait is unsteady, forget [sic] to let someone help transfer ..."
In the area of Behavior/Clinical- " ...history of confusion, anxiety and hallucinations ...1. Approach in a calm manner. 2. Turn on church station and pray with [him/her]. 3. Offer to call [family member] ..."
The ISP did not identify attempts to self-transfer or need for or use of pull tab alarm.

Hospice Assessment and Plan of Care dated 09/29/2025-
In the area of Safety- " ...INSTRUCT PATIENT/CAREGIVER ON FALL PRECAUTIONS INCLUDING USING ROLLATOR WALKER WHEN AMBULATING ..."
The Hospice Assessment and Plan of Care did not identify need for or use of pull tab alarm.

Example 3- Resident 4
Resident 4 was admitted 05/07/2025 and discharged on 02/08/2026.
His/her face sheet identified s/he had a Power of Attorney for Health Care agent (legal representative).
Resident 4's ISP was not signed or dated.

Example 4- Resident 5
Resident 5 was admitted 01/12/2026. S/he made his/her own health care decisions (no legal representative for health care identified on face sheet).
His/her ISP was not signed or dated.

Example 5- Resident 7
Resident 7 was admitted 05/10/2023. S/he made his/her own health care decisions (no legal

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| {N 389} | Continued From page 31<br>representative for health care identified on face sheet).<br>His/her ISP was not signed or dated.<br><br>On 03/20/2026 at 2:48 PM, Surveyor discussed concern ISPs not updated when changes occurred with Administrator Q and Assistant Administrator R. Administrator Q stated Resident 1's pull tab alarm was initiated prior to Administrator Q's start of employment on 02/23/2026, because Resident 6 became agitated and restless in bed the scoop mattress was initiated to prevent falls out of bed. Administrator Q facility staff followed the hospice care plans and the hospice care plan and facility ISP should match.<br><br>On 03/26/2026 at 10:00 AM, Surveyor discussed concern of ISP's not updated with Owner/Licensee O, Administrator Q and Assistant Administrator R. Administrator Q stated they would ensure the ISP's are kept updated. Owner O stated when the last Statement of Deficiency (SOD) was issued (SOD 56CN11, dated 12/10/2025 and issued on 01/09/2026) (former) Executive Director A and (former) Resident Health Director B reassured Owner O the ISPs were updated.<br><br>Cross Reference:<br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws<br>N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessments | {N 389} | | |