STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 10/21/2025, Surveyors conducted 3 complaint investigations at DeForest Place, a CBRF in DeForest. Eleven deficiencies were identified. Three deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023, SOD RTTY11, dated 09/21/2023, SOD Q1UN12, dated 05/16/2025. Three of 3 complaints were substantiated. Census: 16	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a report was sent to the department within 3 working days when law enforcement was called to the facility as a result of an incident that jeopardized the health, safety or welfare of residents or employees. This is a repeat deficiency. See Statement of Deficiency (SOD) RTTY11, dated 09/21/2023.	N 164		

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

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N 164	Continued From page 1 Findings include: On 10/21/2025 at 7:40 a.m., Surveyor received police reports, requested by Surveyor. Surveyor identified the department had not received self-reports for the following occurrences of law enforcement responding to the facility for the health, safety or welfare of residents from 09/16/2025 to 10/21/2025: - 09/29/2025: Resident called for assistance. Made contact with staff member who advised s/he was the only person working and was putting all residents to bed. Law enforcement spoke with resident and informed him/her that staff would get to him/her when able. - 10/16/2025: Two residents called law enforcement stating they had not received medications as prescribed. Law enforcement learned that errors by staff caused a delay in residents receiving medications. - 10/30/2025: Assisted EMS as they responded to a call for service and were unable to locate staff. Staff member was located sleeping in the upstairs utility room. On 10/21/2025 at approximately 12:00 p.m., Administrator A provided Surveyor with self-reports for the 09/29/2025 and 10/16/2025 incidents. Surveyor did not receive a self-report for the 10/30/2025 call to locate staff. Surveyor requested documentation indicating Administrator A had submitted the self-reports to the department as Surveyor was unable to locate the records in department files. Administrator A checked his/her email and stated s/he forgot to send the reports. Cross Reference:	N 164		

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N 164	Continued From page 2 N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	N 164		
N 172	83.12(6) Documentation requirements for written report All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation of neglect was documented with the time, date, individuals involved and details of the occurrence. The provider did not document details of an investigation regarding Caregiver E sleeping during his/her NOC shift. Findings include: On 10/21/2025 at 7:00 a.m., Surveyor reviewed an emergency medical service (EMS) report, obtained by Surveyor, that stated EMS responded to the facility on 10/02/2025 at 9:01 a.m. to find Resident 5 on the floor between his/her bed and wheelchair. Resident 5 reported that s/he had been on the floor since the night before. Resident 5 was transported to the emergency room for assessment. On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 5's record and a self-report. Resident 5 was admitted to the	N 172		

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N 172	Continued From page 3	N 172		

provider's facility on 09/30/2025 with diagnoses including dementia, post-traumatic stress disorder, adjustment disorder, and mild cognitive impairment. Resident 5's individual service plan (ISP), dated 09/30/2025, indicated Resident 5 required assistance with bathing, partial assistance with dressing, a slide board or sit to stand lift for transfers and full assist with toileting. An incident report, dated 10/02/2025, stated Resident 5 was found on the floor around 9:00 a.m. when staff went to administer medications. A self-report, dated 10/02/2025, stated NOC shift staff had been termed.

On 10/21/2025 at approximately 12:00 p.m., Surveyor interviewed Administrator A regarding Resident 5's 10/02/2025 incident. Administrator A stated s/he conducted an investigation that concluded Caregiver E slept during his/her 10/01/2025 shift and did not assist Resident 5 or complete 2-hour checks on any of the residents. Caregiver E was terminated on 10/02/2025. Surveyor requested documentation of Administrator A's investigation.

On 10/21/2025 at approximately 12:45 p.m., Administrator A provided Surveyor with a handwritten paper, dated 10/02/2025, that stated "Investigation - DP Confirmed that [Caregiver E] was sleeping on shift (10/01/25). [Caregiver E] was terminated on 10/02/2025. [Caregiver E] was sleeping on couch in living room and didn't do 2-hour checks on anyone." Surveyor requested details of the investigation, including dates, times, what actions were taken and/or who was interviewed during the investigation. Administrator A stated s/he didn't document any details but after interviewing 4 residents remotely, s/he concluded Caregiver E slept through the shift and didn't check on anyone so Caregiver E was terminated.

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N 172	Continued From page 4 Cross Reference: N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	N 172		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat concern. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 10/02/2025, the Department issued a "Warning of Noncompliance" letter to the provider that identified the following concerns: 1. A high number of substantiated complaints. 2. Repeat citations of noncompliance. 3. Noncompliance resulting in outcome to residents. On 10/21/2025, Surveyors conducted 3 complaint investigations. All 3 complaints were substantiated. The investigations resulted in 11 deficiencies, 3 which were repeat deficiencies. The following concerns were identified: - The provider did not report to the department	N 196		

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occurrences of law enforcement responding the facility for the health and safety of residents.
- The provider did not thoroughly document an investigation of caregiver neglect.
- Two residents did not receive adequate treatment due to a 3rd shift caregiver sleeping.
- Residents did not receive medications as prescribed.
- The provider did not maintain a written staff schedule.
- The provider did not conduct daily audits of schedule II medications.
- The provider did not accurately document medication administration.
- The provider did not ensure adequate care was provided to meet the personal needs of residents.
- The provider did not maintain a record of a resident's emergency room visit.

In total, the department has completed 4 surveys at the facility this year. The surveys have included 12 complaint investigations, a standard survey and 2 verification visits, which has resulted in 9 substantiated complaints and 61 deficiencies, 24 of which have been repeat deficiencies.

On 10/21/2025 at 2:00 p.m., Surveyors reviewed concerns identified during the 10/21/2025 visit with Administrator A, Consultant B, Owner C and House Manager D. Administrator A and Consultant B made note of Surveyors' concerns. Owner C, who participated via phone, asked if the provider would be issued new deficiencies or if the concerns identified on 10/21/2025 were reflected in the department's September visit to the facility.

Cross Reference:
N0164 DHS 83.12(4)(b)Reporting When Law Enforcement Is Called

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N 196	Continued From page 6 N0172 DHS 83.12(6) Documentation Requirements For Written Report N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0409 DHS 83.37(1)(j) Proof-Of-Use Record N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0425 DHS 83.38(1)(a) Personal Cares N0454 DHS 83.42(1) Resident Record Maintained	N 196		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 6 residents reviewed received medications as prescribed in the dosage and intervals prescribed by a practitioner. Resident 1 did not receive his/her Oxycodone Hcl PRN when requested due to caregivers not having access to the provider's medication cart on 10/16/2025.	N 352		

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N 352	Continued From page 7 Resident 10's Fentanyl patches were unavailable for administration. Resident 1 did not receive his/her Gabapentin in the intervals prescribed. Resident 10 did not receive his/her Oxycodone in the intervals prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023 and Q1UN12, dated 05/16/2025. Findings include: Example 1 - Lack of Access to Medication Cart: On 10/21/2025 at 7:00 a.m., Surveyor reviewed a police report, obtained by Surveyor. The report, dated 10/16/2025, stated law enforcement was called by Resident 1 and Resident 4 because they had not received prescription medications on time. The report documented Caregiver I and Administrator A informed law enforcement a caregiver had accidently taken the medication cart keys when s/he left for the day, leaving staff without keys to the medication cart. The report stated Caregiver J then reported to law enforcement via video call that s/he completed 12:00 p.m. medication pass, ended his/her shift at 1:00 p.m. and mistakenly took the medication cart keys when s/he left. The report documented Caregiver K arrived on scene with the keys and began medication pass at approximately 4:00 p.m. On 10/21/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/19/2022. Resident 1's physician orders	N 352		

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included Oxycodone Hcl 5 mg (Start Date: 09/11/2025) - Take 1-2 tablets every 6 hours for pain. Resident 1's individual service plan (ISP), dated 10/15/2025, indicated facility staff administered Resident 1's medications. Resident 1's medication administration record (MAR), indicated s/he was administered Oxycodone Hcl 5 mg PRN on 10/16/2025 at 8:47 a.m., 3:51 p.m. and 8:49 p.m.

On 10/21/2025 at 1:15 p.m., Surveyor interviewed Resident 1. Surveyor asked if s/he was affected by the provider's inability to pass medications from approximately 1:00 p.m. to 4:00 p.m. on 10/16/2025. Resident 1 replied, "Yes." Resident 1 explained that s/he had shoulder, back and right hip pain that required pain medications. Resident 1 stated on 10/16/2025 s/he wanted an Oxycodone Hcl 5 mg PRN for pain; however, facility staff were unable to administer him/her medications because staff didn't have keys to the medication cart. Resident 1 stated s/he and Resident 4 contacted law enforcement together.

Example 2 - Medication Unavailable:

On 10/21/2025 at 8:45 a.m., Surveyor interviewed Resident 10. Resident 10 indicated s/he had not gotten a Fentanyl patch in the last week and had talked to Administrator A about this. Resident 10 indicated s/he has been in pain since having back surgery 6 weeks ago.

On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 10's record for October 2025. Resident 10 was initially admitted to the facility on 12/26/2024 and readmitted on 10/15/2025 following surgery and a hospital stay. Resident 10's readmission order listed: Fentanyl 50 mcg/hr patch 72 hour / Apply 3 patches 1 time

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tonight. Change to 75 mcg patches at next dose. Resident's 10's MAR did not document administration of the Fentanyl patches since Resident 10 returned to the facility.

On 10/21/2025, Surveyor reviewed Resident 10's observation notes, which documented the following:

-10/15/2025 at 4:30 p.m.: Administrator A wrote called pharmacy. The pharmacy indicated they would reach out to the primary care provider because the Fentanyl patches required prior authorization.
-10/17/2025 at 3:30 p.m.: Consultant B contacted Resident 10's doctor about the medications on hold (including the fentanyl patch). Resident 10 had an appointment with his/her doctor on 10/21/2025 to discuss pain management.

On 10/21/2025 at 10:55 a.m., Surveyor interviewed Consultant B about Resident 10's Fentanyl patches not being available. Consultant B indicated they were waiting on a prior authorization to get approved for insurance coverage because the dose was increased from his/her previous order. Consultant B indicated s/he called Resident 10's doctor on 10/17/2025 and in the morning on 10/21/2025. Consultant B reviewed Resident 10's observation notes and indicated Administrator A should have also contacted Resident 10's doctor on 10/15/2025, but it didn't appear that s/he did.

Example 3 - Medication Intervals:

RESIDENT 1:

On 10/21/2025 at 8:26 a.m., Surveyor interviewed Resident 1. Resident 1 stated there was often

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only 1 staff member working in the afternoon, so medications were given late around suppertime. Resident 1 stated, "Everyone is sitting and waiting for their meds."

On 10/21/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1's record included a progress note, dated 10/15/2025, that stated Resident 1 voiced concern with medications being given late at a care conference held with family, facility staff and Resident 1's managed care organization. Resident 1's physician orders included Gabapentin 300 mg (Start Date: 08/28/2025) - Take 1 capsule 3 times daily for pain.

"These medications should be taken at evenly spaced times throughout the day and night; no more than 12 hours should pass between doses ... If you forget to take gabapentin capsules, tablets, or oral solution, take the missed dose as soon as you remember it. However, if it is almost time for the next dose or if you forget to take gabapentin extended-release tablets, skip the missed dose and continue your regular dosing schedule. Do not take a double dose to make up for a missed one." " (Source: Medline Plus, Gabapentin, May 15, 2020, https://medlineplus.gov/druginfo/meds/a694007.html (retrieval date - October 22, 2025).)

Resident 1's MAR, dated 09/01/2025 to 10/21/2025, indicated Gabapentin was due at 8:00 a.m., 4:00 p.m. and 8:00 p.m. Resident 1's record documented the following missed administrations or administration time significantly outside the interval the medication was due:

09/01/2025: 8:00 a.m. given at 10:14 a.m.
09/02/2025: 8:00 p.m. given at 10:25 p.m.

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N 352	Continued From page 11 09/10/2025: 4:00 p.m. given at 5:23 p.m. and 8:00 p.m. given at 9:07 p.m. 09/11/2025 4:00 p.m. given at 6:14 p.m. and 8:00 p.m. given at 8:15 p.m. 09/19/2025 4:00 p.m. given at 5:23 p.m. 09/29/2025 8:00 a.m. given at 9:25 p.m. 10/09/2025 4:00 p.m. given at 6:40 p.m. and 8:00 p.m. given at 9:30 p.m. 10/10/2025 8:00 a.m. given at 10:11 a.m. 10/11/2025 8:00 a.m. and 4:00 p.m. doses not given. 8:00 p.m. given at 11:31 p.m. 10/14/2025: 4:00 p.m. dose not given. 8:00 p.m. given at 6:51 p.m. 10/15/2025 4:00 p.m. given at 5:51 p.m. 10/18/2025 8:00 p.m. given at 9:26 p.m. 10/20/2025 8:00 a.m. given at 9:23 a.m. RESIDENT 10: On 10/21/2025 at 8:45 a.m., Surveyor interviewed Resident 10. Resident 10 indicated medications were not given timely and s/he did not receive pain medications as ordered. Resident 10 indicated s/he had been in pain since having back surgery 6 weeks ago. On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 10's record for October 2025. Resident 10 was initially admitted to the facility on 12/26/2024 and readmitted on 10/15/2025 following surgery and a hospital stay. Resident 10's MAR listed an order for Oxycodone HCL (IR (immediate release)) 15 mg (Start Date: 08/26/2025) - Take (1) tablet orally every 6 hours. Timing: 12:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m. Resident 10's MAR documented the following missed administrations or administration times significantly outside the interval the medication was due:	N 352		

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10/15/2025 6:00 p.m. given at 7:13 p.m.
10/16/2025 6:00 a.m. not given - No pass reason: Medication Unavailable / Waiting on Delivery / Pain level: 7
10/16/2025 12:00 p.m. given at 12:50 p.m.
10/16/2025 6:00 p.m. given at 4:15 p.m.
10/17/2025 12:00 a.m. given on 10/16/2025 at 8:55 p.m.
10/17/2025 6:00 a.m. given at 9:34 a.m.
10/17/2025 12:00 p.m. given at 1:54 p.m.
10/17/2025 6:00 p.m. given at 4:37 p.m.
10/18/2025 12:00 a.m. given on 10/17/2025 at 8:47 p.m.
10/18/2025 6:00 a.m. given at 9:17 a.m.
10/18/2025 12:00 p.m. given at 12:57 p.m.
10/18/2025 6:00 p.m. given at 3:50 p.m.
10/19/2025 12:00 a.m. given on 10/18/2025 at 9:17 p.m.
10/19/2025 6:00 a.m. given at 8:59 a.m.
10/19/2025 12:00 p.m. given at 1:51 p.m.
10/20/2025 12:00 a.m. given on 10/19/2025 at 9:14 p.m.
10/20/2025 6:00 a.m. given at 9:36 a.m.
10/20/2025 12:00 p.m. given at 2:17 p.m.
10/20/2025 6:00 p.m. Not given (No documentation as to why medication was not administered.)
10/21/2025 12:00 a.m. given on 10/20/2025 at 9:05 p.m.
10/21/2025 6:00 a.m. given at 8:11 a.m.

On 10/21/2025 at 1:23 p.m., Surveyor interviewed Resident 10. Resident 10 confirmed s/he did not get pain medication overnight. Resident 10 indicated s/he woke up in pain overnight but did not want to call a caregiver.

On 10/21/2025 at 2:00 p.m., Surveyor reviewed concern with Administrator A, Consultant B, Owner C and House Manager D that medications

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N 352	Continued From page 13 were not administered in the intervals as prescribed. Administrator A and Consultant B made note of Surveyor's concern.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, 2 of 6 residents reviewed did not receive prompt and adequate treatment that was appropriate to their needs. Resident 2 sustained a fall on 10/01/2025 and was not assisted by the provider's staff because staff were sleeping. The NOC caregiver, Caregiver E, was found sleeping by law enforcement. Resident 5 was found on the floor on 10/02/2025 and reported being on the floor all night. The NOC caregiver, Caregiver E, was terminated for sleeping his/her shift. Findings include: On 10/21/2025, Surveyors conducted a complaint investigations alleging care concerns. The following concerns were identified: Example 1 - Resident 2:	N 353		

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N 353	Continued From page 14 On 10/21/2025 at 7:00 a.m., Surveyor reviewed police and emergency medical service (EMS) reports, obtained by Surveyor, that documented the following: - On 10/01/2025 at 4:11 a.m., EMS personnel arrived to the facility and were let in by another resident. EMS personnel went to Resident 2's room, where Resident 2 was found on the floor with his/her back to the bed and a large trail of feces leading from the bed to where Resident 2 sat. Resident 2 reported that s/he had slid out of bed trying to get to the bathroom. EMS personnel assisted Resident 2 to his/her wheelchair. EMS personnel did not locate or interact with staff while present, leaving at approximately 4:43 a.m. Resident 2 had stated staff may have been sleeping out in their car. - On 10/01/2025 at approximately 4:00 a.m., law enforcement arrived to the facility to assist EMS personnel, who were unable to locate staff in the facility. Law enforcement located Caregiver E sleeping in a utility/storage room covered with a blanket. Caregiver E reported to law enforcement that s/he must have fallen asleep. On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 03/05/2021 with diagnosis of right sided hemiparesis secondary to a cerebral vascular accident. Resident 2's individual service plan (ISP), dated 10/08/2025, documented that s/he required physical assistance for bathing, dressing, grooming and toileting. Resident 2's ISP documented that s/he used a wheelchair for mobility. Resident 2's record did not include documentation of the 10/01/2025 incident resulting in EMS and law enforcement presence.	N 353		

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N 353	Continued From page 15 On 10/21/2025 at 1:00 p.m., Surveyor interviewed Resident 2 and Resident 6 together. Resident 6 stated s/he often heard call lights go off at the facility, checked to see who was calling and checked on the resident him/herself. Resident 6 stated if the residents need help, s/he would find the caregiver or wake the caregiver on shift, stating caregivers were often sleeping. Resident 6 stated on 10/01/2025, s/he was unable to locate a caregiver, so s/he called 911 him/herself and let EMS into the facility. Resident 2 was unable to recall how long s/he was on the floor, but confirmed a caregiver was not present in his/her room for the duration of time EMS personnel were with Resident 2. On 10/21/2025 at 2:00 p.m., Surveyor reviewed concern with Administrator A, Consultant B, Owner C and House Manager D that Resident 2 slid from bed on 10/01/2025 and did not receive assistance from Caregiver E, who was working the overnight shift. Surveyor shared that Resident 2 received assistance from Resident 6 and EMS personnel while Caregiver E slept. Administrator A and Consultant B took note of Surveyor's concern. None of the individuals present during the discussion made a comment regarding the incident. Example 2 - Resident 5: On 10/21/2025 at 7:00 a.m., Surveyor reviewed an EMS report, obtained by Surveyor, that stated EMS responded to the facility on 10/02/2025 at 9:01 a.m. to find Resident 5 on the floor between his/her bed and wheelchair. Resident 5 reported that s/he had been on the floor since the night before and was sent to the emergency room for assessment.	N 353		

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N 353	Continued From page 16 On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 5's record and a self-report. Resident 5 was admitted to the provider's facility on 09/30/2025 with diagnoses including dementia, post-traumatic stress disorder, adjustment disorder, and mild cognitive impairment. Resident 5's individual service plan (ISP), dated 09/30/2025, indicated Resident 5 required assistance with bathing, partial assistance with dressing, a slide board or sit to stand lift for transfers and full assist with toileting. Resident 5's record included a progress note, dated 10/02/2025, that stated Resident 5 sustained a fall and was transported to the hospital. Records indicated Resident 5 remained hospitalized as of 10/21/2025. An incident report, dated 10/02/2025, stated Resident 5 was found on the floor around 9:00 a.m. when staff went to administer medications. The report stated PM shift and NOC shift had checked on all residents together and Resident 5 refused assistance getting to bed stating s/he was not ready for bed. The report stated NOC shift checked on Resident 5 around 3:00 a.m., but that NOC shift staff had been removed from the schedule until further notice. A self-report, dated 10/02/2025, stated NOC shift staff had been termed. On 10/21/2025 at approximately 12:00 p.m., Surveyor interviewed Administrator A regarding Resident 5's 10/02/2025 incident. Administrator A stated s/he conducted an investigation that concluded Caregiver E slept during his/her 10/01/2025 shift and did not assist Resident 5 or complete 2-hour checks on any of the residents. Caregiver E was terminated on 10/02/2025. Administrator A stated Resident 5 was hospitalized with failure to thrive and planned to return to the facility once a hoyer lift was delivered.	N 353		

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N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written schedule for staffing was maintained. Findings include: On 10/21/2025 at 8:30 a.m., Surveyor requested the provider's written staff schedule from 09/16/2025 through 10/21/2025. On 10/21/2025 from approximately 11:00 a.m. to 1:00 p.m., Surveyor was provided 3 different staff schedules by Administrator A and Consultant B. Surveyor noted discrepancies between the schedules provided, the employee list provided, resident medication administration record and staff currently working at the facility on day of Surveyor's presence. On 10/21/2025 at approximately 1:00 p.m., Surveyor discussed concern with Administrator A that s/he had not been provided an accurate staff schedule. Administrator A stated s/he had not been responsible for scheduling up until recently when there was a change in house manager. Administrator A stated scheduling was something the provider was working on. On 10/21/2025 at 2:00 p.m., Surveyor reviewed concern with Administrator A, Consultant B,	N 399		

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N 399	Continued From page 18 Owner C and House Manager D that the provider did not have record of the employee schedule. Consultant B confirmed Surveyor's concern and stated s/he and Administrator A were unable to figure out how to pull the schedule from the program used.	N 399		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 schedule II medications reviewed were audited on a daily basis. Resident 1's Oxycodone HCl 5 mg was not audited daily. Resident 10's Oxycodone HCl 20 mg were not audited daily. Findings include: RESIDENT 1: On 10/21/2025 at approximately 10:00 a.m.,	N 409		

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N 409	Continued From page 19 Surveyor reviewed Resident 1's record and medication administration record (MAR) for October 2025. Resident 1 admitted to the facility on 10/19/2022. Resident 1's physician orders include Oxycodone HCl 5 mg (Start Date: 09/11/2025) - Take 1-2 tablets every 6 hours for pain as needed. On 10/21/2025 at 9:10 a.m., Surveyor reviewed the provider's daily audits from 10/07/2025 to 10/20/2025 of Resident 1's Oxycodone 5 mg, which documented the following: -10/11/2025: Had no entry that included the amount of tablets available, given, or remaining and had no signatures. -10/12/2025: Had no entry that included the amount of tablets available, given, or remaining and had no signatures. -The entry on 10/10/2025 at 4:30 p.m. indicated 19 tablets remained. Entries for 10/11/2025 and 10/12/2025 did not indicate any tablets were administered. An entry for 10/13/2025 at 10:00 a.m. listed 12 tablets available, leaving 7 tablets unaccounted for. -10/17/2025: Had no entry that included the amount of tablets available, given, or remaining and had no signatures. On 10/21/2025 at 9:15 a.m., Surveyor interviewed House Manager D about the facility's auditing process. House Manager D confirmed that some days were missing and indicated narcotic counts should be done every shift. House Manager D stated s/he was unsure who audited the sheets to ensure they were done accurately. House Manager D took the audit sheets out of the room. When Surveyor returned to the medication cart later, there were new audit sheets in place.	N 409		

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N 409	Continued From page 20 On 10/21/2025 at approximately 10:15 a.m., Surveyor compared the audit sheet with Resident 1's MAR and noted the following discrepancies: -10/13/2025: MAR - 2 oxycodone given / Audit sheet - 3 oxycodone given -10/14/2025: MAR - 2 oxycodone given / Audit sheet - 3 oxycodone given -10/15/2025: MAR - 2 oxycodone given / Audit sheet - 3 oxycodone given -10/16/2025: MAR - 3 oxycodone given / Audit sheet - 1 oxycodone given -10/17/2025: MAR - 2 oxycodone given / Audit sheet - No entries -10/18/2025: MAR - 1 oxycodoen given / Audit sheet - 2 oxycodone given -10/19/2025 MAR - 1 oxycodone given / Audit sheet - 2 oxycodone given RESIDENT 10: On 10/21/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 10's record. Resident 10 was initially admitted to the facility on 12/26/2024 and readmitted on 10/15/2025 following a hospital stay. Resident 10's physician orders include Oxycodone HCl 20 mg tab (Start Date: 10/15/2025) Take (1) tablet orally every four hours as needed for pain. On 10/21/2025 at 9:10 a.m., Surveyor reviewed the provider's daily audits of Resident 10's Oxycodone from 10/15/2025 to 10/21/2025, which documented the following: -The entry on 10/17/2025 at 2:10 p.m. indicated 30 tablets remained. The entry on 10/18/2025 at 4:00 p.m. indicated 26 tablets were available, leaving 4 tablets unaccounted for. On 10/21/2025 at 9:15 a.m., Surveyor interviewed House Manager D about the facility's auditing	N 409		

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N 409	Continued From page 21 process. House Manager D confirmed that some days were missing and indicated narcotic counts should be done every shift. House Manager D stated s/he was unsure who audited the sheets to ensure they were done accurately. House Manager D took the audit sheets out of the room. When Surveyor returned to the medication cart later, there were new audit sheets in place. On 10/21/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 10's medication administration record (MAR) for October 2025. The MAR indicated only 1 Oxycodone 20 mg tablet was given between 10/15/2025 and 10/21/2025, on 10/16/2025 at 9:10 a.m. There was no entry matchng this date and time on the audit sheet.	N 409		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 6 residents reviewed	N 415		

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N 415	Continued From page 22	N 415		

had the administration of their medications documented in the record.

The provider did not have record of Resident 5's medication administration.
The provider did not have record of medications administered to Resident 1, Resident 2 and Resident 4 on 10/12/2025.

This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023.

Findings include:

On 10/21/2025, Surveyors conducted a complaint investigation related to medication administration. The following concerns were identified:

Example 1 - Resident 5:

On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider's facility on 09/30/2025 with diagnoses including dementia, post-traumatic stress disorder, adjustment disorder, and mild cognitive impairment. Resident 5's record indicated the facility's staff managed his/her medications. Resident 5's physician orders included the following medications: cranberry tablet, fish oil capsule, Fluticasone-Salmeterol inhaler, Gabapentin, Hydrocodone-Acetaminophen, Ibuprofen, Ketoconazole shampoo, Albuterol inhaler, Amlodipine, Baclofen, Belsomra, Bumetanide, Cetirizine, Cholecalciferol, Metoprolol Succinate, Miralax, Myrbetriq, Omeprazole, Renacidin irrigation, Senna-Docusate, Acetaminophen, Sertraline, SM muscle rub, Tizanidine and Trazadone. Resident 5's record did not include a medication administration record (MAR).

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N 415	Continued From page 23 On 10/21/2025 at approximately 1:00 p.m., Consultant B stated s/he was unable to locate a MAR for Resident 5. Consultant B stated caregivers were to document Resident 5's medication administration on a paper MAR and s/he was unable to locate the documentation. Example 2 - 10/12/2025: On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed resident records and identified the following documentation concerns on 10/12/2025: - Resident 1 was admitted to the provider's facility on 10/19/2022. Resident 1's individual service plan (ISP), updated 10/15/2025, indicated the provider managed and administered Resident 1's medications. Resident 1's MAR, dated 09/16/2025 to 10/21/2025, had blank entries for each medication due on 10/12/2025 (8:00 a.m., 4:00 p.m. and 8:00 p.m.). Medications included Guaifenesin, Iprat-Albuterol inhaler, Vitamin B-1, Senna, Polyethylene Glycol, Oyster Shell, Melatonin, Gabapentin, Breo Ellipta inhaler, Fluticasone spray, Eliquis, Duloxetine, Stool Softener and Alendronate Sodium. - Resident 2 was admitted to the provider's facility on 03/05/2021. Resident 2's ISP, updated 10/08/2025, indicated the provider managed and administered his/her medications. Resident 2's MAR dated 09/16/2025 to 10/21/2025, had blank entries for each medication due on 10/12/2025 (8:00 a.m., 12:00 p.m., 4:00 p.m., 5:00 p.m. and 8:00 p.m.). Medications included Systane eye drops, Folic Acid, Amantadine, Aspirin, Atorvastatin, Azelastine spray, Calcitriol, Carvedilol, Chlorhexidine rinse, Ciclopirox, Dialyvite, Fluticasone spray, Vitamin B-12,	N 415		

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N 415	Continued From page 24 Systane gel, Sevelamer Carbonate, Olanzapine, eye lubricant, Ipratropium spray, Hydroxyurea, Hydrocortisone cream and Gabapentin. - Resident 4 was admitted to the provider's facility on 02/05/2021. Resident 4's ISP, updated 10/08/2025, indicated the provider managed and administered his/her medications. Resident 4's MAR, dated 09/16/2025 to 10/13/2025, had blank entries for each medication due on 10/12/2025 (8:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., and 9:00 p.m.). Medications included Azelastine spray, Donepezil, Lamotrigine, Lorazepam, Memantine HCl, Trazodone HCl, Hydroxyzine HCl, Vitamin B-6, Sertraline HCl, Fluticasone spray, Centrum multivitamin liquid, Arthritis cream, Acetaminophen, and Lansoprazole. On 10/21/2025 at approximately 1:00 p.m., Surveyor interviewed Administrator A and shared concern that residents did not receive medication on 10/12/2025. Administrator A stated s/he had been made aware of the concern the week prior and looked into the concern. Administrator A stated residents did in fact receive their medications on 10/12/2025; however, the 2 caregivers that worked 7:00 a.m. to 11:00 p.m. that day did not document all of the medication administration.	N 415		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, not all medications administered by the provider were	N 419		

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securely stored.

Medications were stored in a medication cart inside a room in the nurses' station. The door to the nurses' station was propped open and the medication cart was unlocked.

Resident 9 required staff to administer his/her medications. There were unsecured medications in Resident 9's room.

Findings include:

The facility is licensed to provide services for up to 20 residents within the client groups: advanced aged, terminally ill, and/or irreversible dementia/Alzheimer's.

Example 1 - Unsecured Medication Cart:

On 10/21/2025 at 12:25 p.m., Surveyor observed the medication cart in a room inside the nurses' station. The door to the nurses' station was propped open and the door to the adjoining room with the medication cart was open. The medication cart contained a locking mechanism, which was not engaged. Surveyor opened the medication cart and observed residents' scheduled prescription medications.

Surveyor observed residents moving freely throughout the facility during the time frame of 8:00 a.m. to 2:00 p.m.

On 10/21/2025 at 12:35 p.m., Surveyor interviewed Administrator A. Administrator A indicated the door to the nurses' station automatically locked and was only propped open during the survey because staff were making photocopies. Administrator A stated s/he would

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N 419	Continued From page 26 expect the medication cart to be locked at all times. Example 2 - Resident Medications: On 10/21/2025 at approximately 8:10 a.m., Surveyor observed Resident 9's room. Resident 9 was seated in his/her bed with a medication cup in front of him/her. The medication cup had several pills in it. No staff were present in the room. Resident 9 took the medications while Surveyor was in the room. Resident 9 indicated staff usually stayed in the room while s/he took medications. On 10/21/2025, Surveyor reviewed Resident 9's record. Resident 9 was admitted on 09/25/2023. Resident 9's individualized service plan (ISP), dated 10/15/2025, identified Resident 9 required staff to manage and administer his/her medications. On 10/21/2025 at 2:00 p.m., Surveyor reviewed concern with Administrator A, Consultant B, Owner C, and House Manager D that Resident 9 was taking medications unsupervised. Administrator A and Consultant B made note of Surveyor's concern.	N 419		
N 425	83.38(1)(a) Personal care. 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:	N 425		

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N 425	Continued From page 27 Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure residents received personal care services adequate to meet their needs. Residents did not receive routine bathing assistance. Caregivers did not respond to call lights. Resident 10 did not receive adequate assistance from staff with personal cares on 10/21/2025. Findings include: On 10/21/2025, Surveyors conducted 3 complaint investigations alleging care concerns at the facility. The following concerns were identified: Example 1 - Bathing: INTERVIEWS: On 10/21/2025 at 8:25 a.m., Surveyor interviewed Resident 7. Resident 7 stated s/he was concerned with the lack of care being provided. Resident 7 stated s/he was supposed to have a shower Monday, Wednesday and Friday, but had gone some weeks without a shower at all. Resident 7 stated staff will tell him/her, "[Resident	N 425		

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N 425	Continued From page 28 7], it's busy," when s/he went without a shower. On 10/21/2025 at 8:26 a.m., Surveyor interviewed Resident 1. Resident 1 indicated s/he was supposed to get a shower on Friday (10/17) but was unable to because only 1 staff member was working and had to take care of all the residents. Resident 1 stated s/he was hoping to get a shower today. On 10/21/2025 at 8:35 a.m., Surveyor interviewed Caregiver F. Caregiver F stated residents frequently didn't receive assistance with showers as scheduled, especially if scheduled in the evenings. Caregiver F identified Resident 7, Resident 1 and Resident 9 as often missing showers. Caregiver F stated s/he tried to do the missed showers him/herself. On 10/21/2025 at 8:45 a.m., Surveyor interviewed Resident 3, who was observed with greasy hair. Resident 3 stated s/he often missed his/her shower, stating "This staff is the laziest people I have ever met. They make their own hours." Resident 3 stated s/he was supposed to have a shower the day prior to Surveyor's visit, but didn't get one. RECORD REVIEW: On 10/21/2025 at approximately 10:30 a.m., Surveyor reviewed resident records, which documented the following: - Resident 7 was admitted to the provider's facility on 01/06/2017. Resident 7's individual service plan (ISP), last updated 10/13/2025, stated s/he required standby assistance for bathing and preferred showers on Monday, Wednesday and Fridays after dinner. Resident 7's record, dated	N 425		

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09/09/2025 to 10/21/2025, documented that showers occurred on 09/10/2025, 09/22/2025, 09/25/2025, 10/03/2025, 10/06/2025, 10/08/2025, 10/09/2025 and 10/14/2025. Records indicated Resident 7 did not receive shower assistance 3 times per week and went 12 days without a shower from 09/10/2025 to 09/22/2025.
- Resident 3 admitted to the provider's facility on 11/20/2024. Resident 3's ISP, not dated, documented that s/he required physical assistance with showers and preferred them on Monday mornings. Resident 3's record, dated 09/09/2025 to 10/21/2025, documented that s/he refused a shower on 09/09/2025 and received a shower on 09/22/2025 and 10/06/2025, indicating s/he had gone 2 weeks without a shower.
- On 10/21/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1's ISP, updated 10/15/2025, indicated s/he required standby assistance with bathing and preferred showers on Tuesday and Friday mornings. Resident 1's record, dated 09/09/2025 to 10/21/2025, documented showers occurred on 09/09/2025, 09/23/2025, 10/03/2025, 10/09/2025 and 10/14/2025, indicating Resident 1 went 2 weeks without staff providing assistance with a shower.

Call Lights:

INTERVIEW:

On 10/21/2025 at 8:10 a.m., Surveyor interviewed Resident 8. Resident 8 stated s/he didn't think his/her call pendant worked because staff never responded.

On 10/21/2025 at 8:25 a.m., Surveyor interviewed Resident 7. Resident 7 stated caregivers were not responsive to call lights. Resident 7 stated the

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N 425	Continued From page 30 weekend prior to Surveyors' visit call lights were going off from 7:00 a.m. to 8:00 a.m. with no response. On 10/21/2025 at 8:35 a.m., Surveyor interviewed Caregiver F, who stated at times s/he arrived to work in the AM and would find NOC shift staff sleeping. On 10/21/2025 at 8:45 a.m., Surveyor interviewed Resident 3. Resident 3 stated s/he used his/her call light, but staff wouldn't respond at all sometimes. Resident 3 stated s/he often had to go out to find staff for assistance and would find staff sleeping in the recliner in the living room. Resident 3 identified Caregiver G as a caregiver that often slept. On 10/21/2025 at 12:50 p.m., Surveyor interviewed Resident 6. Resident 6 stated s/he often would hear call lights going off and respond to them him/herself. Resident 6 stated when s/he heard a call light, s/he would respond to find out what the resident wanted and then locate or wake up staff to assist residents. Resident 6 stated staff often slept in a recliner in the living room and that management had been informed of the concerns. Resident 6 was able to tell Surveyor Resident 3 and Resident 7's typical morning routines, including the times they called for assistance. OBSERVATION: On 10/21/2025 at 8:11 a.m., Surveyor pushed Resident 8's call light. On 10/21/2025 at 8:15 a.m., Surveyor went to the nurse's station to determine if caregivers were aware Resident 8's call light had been engaged at	N 425		

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8:11 a.m. Surveyor asked House Manager D if s/he was aware Resident 8's call light had been pushed. House Manager D looked at the call light monitor which would show who had called for assistance and saw another room number on the screen. House Manager D was initially unable to tell Resident 8 had called. House Manager D, Caregiver H and Surveyor then pushed buttons on the call light monitor and learned one would have to arrow back to see multiple calls otherwise only the most recent call for assistance shows on the monitor. House Manager D acknowledged calls could be missed if the call light was not heard or seen when initially going off.

On 10/21/2025 at approximately 1:00 p.m., Surveyor reviewed care concerns with Administrator A. Administrator A stated, "There's probably a lot going on here that I don't know about. It's ridiculous." Administrator A stated Caregiver G was going to be terminated soon, s/he had made several new hires, and was working on a plan with management to conduct "pop up visits" at the facility.

Example 3 - Assistance for Resident 10:

OBSERVATION:

On 10/21/2025 at 10:07 AM, Surveyors observed Resident 10 telling Administrator A that staff had rushed him/her to get ready for an appointment and told him/her to wheel him/herself downstairs. Resident 10 also stated that s/he did not get breakfast.

INTERVIEW:

On 10/21/2025 at 1:23 PM, Surveyor interviewed Resident 10 after s/he returned from the

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N 425	Continued From page 32 appointment. Resident 10 stated staff did not know s/he had an appointment that morning and rushed him/her to get ready because Resident 10's ride was at the facility. Resident 10 said a caregiver pushed him/her so fast down the hallway that his/her leg got caught under the wheelchair. Resident 10 told the caregiver, and the caregiver replied, "Well push yourself then," and left Resident 10 in the hallway. Resident 10 confirmed s/he did not get breakfast before leaving for his/her appointment that morning. On 10/21/2025 at 2:00 p.m., Surveyor reviewed personal care concerns, including lack of assistance with bathing, lack of response to call lights and lack of assistance with personal cares with Administrator A, Consultant B, Owner C and House Manager D. Administrator A and Consultant B made note of Surveyors' concerns.	N 425		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and	N 454		

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N 454	Continued From page 33 resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually	N 454		

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N 454	Continued From page 34 spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 residents reviewed had their record maintained. The provider did not have documentation of Resident 2's emergency room visit on 09/21/2025. Findings include: On 10/21/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 03/05/2021 with diagnosis of right sided hemiparesis secondary to a cerebral vascular accident. Resident 2's record included an incident report, dated 09/21/2025, that stated s/he was sitting in the front room and informed staff s/he couldn't breathe and was experiencing discomfort. The report indicated emergency medical services (EMS) was called and resident was transferred to the hospital. Resident 2's record did not include documentation of an "After Visit Summary" or any summary of what occurred at the emergency room. On 10/21/2025 at approximately 12:00 p.m., Administrator A stated s/he didn't have record of Resident 2's "After Visit Summary." Administrator A stated residents returned to the facility often without any summary of their visit and that s/he would need to work on getting electronic access to the residents' electronic records.	N 454		

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