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 _____	R-C 01/28/2026

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 From 01/23/2026 to 01/28/2026, Surveyors conducted 4 complaint investigations and 2 verification visits at Deforest Place, a CBRF in Deforest. Twelve deficiencies were identified. Nine 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, SOD Q1UN13, dated 09/15/2025 and SOD 59UD11, dated 10/21/2025. Four of 4 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 14	{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	{N 164}		

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

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{N 164}	Continued From page 1 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. On 12/05/2025, it was discovered that 30 of Resident 1's oxycodone were missing. On 12/09/2025, local law enforcement was called to assist with the investigation. The provider sent the department a report of the incident on 12/17/2025; 8 days after calling law enforcement. This is a repeat deficiency. See Statement of Deficiency (SOD) RTTY11, dated 09/21/2023 and SOD Q1UN13, dated 09/15/2025. Findings include: On 12/14/2025, the department received a complaint alleging that resident's narcotic medication was stolen. On 12/17/2025, the department received a self-report investigation documenting that Resident 1's oxycodone was stolen. On 12/22/2025, the department received a complaint alleging concerns with narcotic medication administration. On 01/23/2025, Surveyors conducted 2 verification visits and 4 complaint investigations. Surveyor reviewed an internal investigation documenting: "[Resident 1] used [his/her] last Oxycodone on 11/30/35[sic]. The writer re-ordered Oxycodone via Electronic Health Record system on 12/1/25. [Pharmacy] confirmed that they delivered the medication on 12/3/25 and that it was checked in	{N 164}		

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{N 164}	Continued From page 2 by [Caregiver Q] at 12:10 p.m. The pharmacy confirmed that they sent 60 pills, 2 cards. The cart in the cart states 2/2 and has 30 pills. 1 of 2 cards was discovered on the morning of 12/5 in the PRN drawer, rather than the Narcotic drawer. Pharmacy confirmed that they delivered 2 of 2 Oxycodone cards (60 pills) on 12/3/25. On 12/5 an internal investigation was launched, on 12/8 the internal investigation continued, and it was determined that 1 of 2 cards (30 pills) was unable to be located. Non-emergency local law enforcement was called 12/9 to assist with the investigation. This is still an open investigation". On 01/28/2026, at 10:56 a.m., Surveyor clarified that the facility contacted law enforcement on 12/09/2025 to assist with the investigation regarding Resident 1's missing Oxycodone and asked why the self-report was not completed until 12/17/2025. On 01/28/2026, at 12:34 p.m., Consultant B replied, "On 12/9, after contacting the police, I attempted to report this through the [misconduct reporting system] as misappropriation/potential misconduct. However, there was some confusion between the current licensee and the current owner/operator [Owner C] as to whose [misconduct reporting system] log in should be used. By 12/15, there was still some confusion, and I felt that this should have been urgently reported, so I contacted the DHS Office of Caregiver Quality to ask how to best proceed in this situation. They responded on the afternoon of the 16th stating that [Owner C] could create [his/her] own log-in. [S/he] was still having difficulty gaining access to the [misconduct reporting system] on the 17th, so we decided that	{N 164}		

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{N 164}	Continued From page 3 a self-report form would be the best course of action while we awaited the [misconduct reporting system] log in. We did not originally submit it under the "Law Enforcement Intervention" Reporting requirement, because we felt it more appropriately fell under Misappropriation/Misconduct."	{N 164}		
{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 deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025, SOD Q1UN13, dated 09/15/2025 and SOD 59UD11, dated 10/21/2025. Findings include: CURRENT NON-COMPLIANCE: From 01/23/2026 to 01/28/2026, Surveyors conducted 2 verification visits and 4 complaint investigations. The survey resulted in 12 deficiencies, 10 of which were repeat deficiencies, and 4 of 4 complaints were substantiated. The following concerns were identified:	{N 196}		

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{N 196}	Continued From page 4 Non-compliance with Special Orders: On 11/03/2026, the department issued SOD 59UD11, dated 11/21/2025. The SOD included an enforcement letter that included the following special orders: "Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall develop and implement corrective measures to ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for each resident with a copy of Statement of Deficiency (SOD) 59UD11 and a copy of this Notice and Order letter. The licensee shall retain documentation, 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 legal representative and case manager." On 01/23/2026 at approximately 8:20 a.m., Surveyor requested all documentation related to special orders, including notifications, from Consultant B and House Manager M. On 01/23/2026 at approximately 2:40 p.m., Consultant B provided Surveyor with documentation of email correspondence with the lead supervisor for a managed care organization that indicated the managed care organization was aware of SOD Q1UN13. Surveyor noted the email was not in regard to SOD 59UD11 as indicated in	{N 196}		

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{N 196}	Continued From page 5 the special orders and that the email was sent prior to the issuance of SOD 59UD11. Surveyor also shared that the email did not indicate notifications were completed to legal representatives. Consultant B acknowledged Surveyor's concerns and stated s/he did not have documentation to indicate notifications occurred as ordered. Consultant B stated the notifications would have been the responsibility of Administrator A. Deficiencies: - 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. *Repeat concern. - The provider did not follow special orders and did not ensure the facility complied with all laws governing its operation. *Repeat concern. - The provider did not ensure 3 of 4 residents reviewed received medications as prescribed in the dosage and intervals prescribed by a practitioner. *Repeat concern. - The provider did not ensure a schedule II medication was audited daily. *Repeat concern. - The provider did not ensure a schedule II medication was locked and securely fastened within a locked medication area. *Repeat concern. - The provider did not ensure services were provided to manage resident behaviors. *Repeat concern. - The provider did not ensure health monitoring services were provided for 1 of 4 residents reviewed. *Repeat concern. - The provider did not ensure medication	{N 196}		

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{N 196}	Continued From page 6	{N 196}		

administration services were provided to meet the needs of residents. *Repeat concern.
- The provider did not ensure food was stored and prepared in a safe manner. *Repeat concern.
- The provider did not ensure the facility was well maintained. *Repeat concern.
- The provider did not ensure rooms maintained a comfortable temperature.
- The provider did not ensure all residents were treated with dignity

COMPLIANCE HISTORY:

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.

Based on a review of the facility's compliance history since a change of ownership desk review was conducted on 05/21/2021, the department has conducted 17 regulatory visits, complaint investigations, licensing surveys, and verification visits. Nine of those visits resulted in deficiencies and/or enforcement action.

SOD 576M11, dated 10/26/2021, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies.

SOD RP9811, dated 01/18/2022, consisted of a standard survey and a complaint investigation. As a result, 4 deficiencies of non compliance were issued. The complaint unsubstantiated. The

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{N 196}	Continued From page 7 deficiencies included: N0394 DHS 83.35(5)(b) Annual Evaluation of Evacuation Limitations N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by the RN N0507 DHS 83.46(1)(f) Combustibles N0526 DHS 83.47(2)(e) Other Evacuation Drills SOD HYN111, dated 03/14/2022, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD F9GG11, dated 03/21/2022, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD RP9812, dated 09/30/2022, consisted of a verification visit. As a result, 1 deficiency of non compliance was issued. The deficiency included N0507 DHS 83.46(1)(f) Combustibles. SOD SHTU11, dated 10/18/2022, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD RP9813, dated 03/17/2023, consisted of a verification visit. No deficiencies were issued. SOD 8XKQ11, dated 08/24/2023, consisted of a survey and complaint investigation. The complaint was unsubstantiated and the survey resulted in 6 deficiencies. The deficiencies included the following: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated	{N 196}		

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{N 196}	Continued From page 8 Annually Or On Changes N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0431 DHS 83.38(1)(g) Health Monitoring N0531 DHS 83.47(4)(a) Fire Extinguishers: Type and Inspection SOD 8XKQ12, dated 02/06/2024, consisted of a verification visit. No deficiencies were issued. SOD RTTY11, dated 09/21/2023 consisted of a complaint investigation. The complaint was unsubstantiated. The survey resulted in the following deficiency: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called. SOD 7S3X11, dated 04/11/2024, consisted of a complaint investigation. The complaint was substantiated but resulted in no deficiencies. SOD CS2Z11, dated 07/12/2024, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD Q1UN11, dated 01/06/2025 consisted of 2 complaint investigations. One complaint was substantiated. The survey resulted in the following deficiency: N0205 DHS 83.14(2)(j) Not Permit a Condition of Substantial Risk. SOD Q1UN12, dated 05/16/2025 consisted of a survey, verification visit, and 4 complaint investigations. Three of 4 complaints were substantiated. The survey resulted in 24 deficiencies, which included the following: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0219 DHS 83.17(1) Licensee Conduct Caregiver	{N 196}		

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{N 196}	Continued From page 9 Background Check N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0239 DHS 83.20(2)(a) Department-Approved Training Courses N0301 DHS 83.28(3) Provide Admission Agreement As Required N0302 DHS 83.28(4)(a)1. Resident Health Screening And Documentation N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limits N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0397 DHS 83.36(1)(b)2. Qualified Staff In Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0423 DHS 83.37(3)(g) Medication Storage: Controlled Substances N0427 DHS 83.38(1)(c) Leisure Time Activities N0432 DHS 83.38(1)(h) Medication Administration N0446 DHS 83.41(1)(b) Equipment N0450 DHS 83.41(2)(c)2. Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0509 DHS 83.46(1)(a) Ventilation Z0010 DHS 50.065(2)(bb) Determine Final Disposition Of Charge	{N 196}		

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{N 196}	Continued From page 10 SOD Q1UN13, dated 09/15/2025 consisted of a verification visit and 3 complaint investigations. Two of 3 complaints were substantiated. The survey resulted in 18 deficiencies, which included the following: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0355 DHS 83.32(3)(k) Rights Of Residents: Self-Determination N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0455 DHS 83.41(1)(a) Food Supply N0450 DHS 83.41(2)(c) Nutrition: Menus	{N 196}		

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{N 196}	Continued From page 11 N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0509 DHS 83.46(2)(a) Ventilation N0637 DHS 83.59(1) Proper Exit Locations, Sidewalks, Driveways SOD 59UD11, dated 10/21/2025 consisted of 3 complaint investigations. Three of 3 complaints were substantiated. The survey resulted in 11 deficiencies, which included the following: N0164 DHS 83.12(4)(b)Reporting When Law Enforcement Is Called N0172 DHS 83.12(6) Documentation Requirements For Written Report N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws 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 SOD 59UD12, dated 01/28/2026, consisted of 2 verification visits and 4 complaint investigations. Four of 4 complaints were substantiated. The survey resulted in 12 deficiencies, which included	{N 196}		

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{N 196}	Continued From page 12 the following: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0409 DHS 83.37(1)(j) Proof-of-Use Record N0423 DHS 83.37(3)(g) Medication Storage: Controlled Substances N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean And Comfortable N5202 DHS 83.46(1)(a) Comfortable Y3234 DHS 50.09(1)(e) Treatment In summary, during the past 6 years, the provider had surveys by the department resulting a total of 78 deficiencies, including 14 of 24 substantiated complaints.	{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	{N 352}		

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DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

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{N 352}	Continued From page 13 did not ensure 3 of 4 residents reviewed received medications as prescribed in the dosage and intervals prescribed by a practitioner. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023 and SOD Q1UN12, dated 05/16/2025. Resident 11 received a fentanyl patch that s/he was not prescribed on 2 occasions. Resident 11 received Xarelto when the medication should have been held, resulting in a delayed procedure. Resident 5 did not receive his/her Hydrocodone-Acetaminophen, Metoprolol and Amlodipine Besylate as prescribed. Resident 3 did not receive his/her Metformin twice daily as prescribed. Findings include: From 01/23/2026 to 01/28/2026, Surveyors conducted 4 complaint investigations alleging concerns with medication administration and 2 verification visits. The following concerns were identified: Example 1 - Resident 11: On 01/23/2026 at approximately 10:30 a.m., Surveyor reviewed Resident 11's record. Resident 11 admitted to the provider's facility on 07/21/2025. Resident 11's record documented the following concerns: - Resident 11's physician orders included Xarelto 20 mg (Start Date: 08/21/2025) - Take 1 tablet 1	{N 352}		

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 _____	R-C 01/28/2026

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

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{N 352}	Continued From page 14 time daily. Physician orders also included an order to hold this medication on 11/16/2025 and 11/17/2025 for a suprapubic catheter placement on 11/18/2025. The record documented Xarelto was administered on 11/16/2025 and 11/17/2025. A progress note, dated 11/18/2025, documented that Resident 11's procedure needed to be rescheduled due to Resident 11's Xarelto being administered rather than held as ordered. Progress note, dated 11/18/2025, documented the procedure was rescheduled for 12/12/2025, 24 days after the originally planned procedure date. - A progress note, dated 11/17/2025, stated Resident 11 received a fentanyl patch instead of his/her nicotine patch. An incident report, dated 11/16/2025, stated Resident 11 was informed s/he was given a fentanyl patch instead of a nicotine patch on 11/15/2025. Resident 11 responded, "Oh, ok, maybe that's why I was feeling a little off." - Progress note, dated 12/08/2025: Resident was given another resident's fentanyl patch instead of his/her nicotine patch. The patch was on the resident for approximately 24-48 hours. On 01/23/2026 at 12:16 p.m., Surveyor interviewed LPN L about the medication error with the fentanyl patch. LPN L confirmed that Resident 11's nicotine patches were stored in the medication cart under a single lock and that Resident 10's fentanyl patches were stored under a double lock in the narcotics drawer. LPN L confirmed that Resident 10 was out of the building during both medication errors, so none of his/her medications should have been administered. LPN L stated that s/he is unsure of how this medication error happened twice with two different staff. Example 2 - Resident 5	{N 352}		

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 _____	R-C 01/28/2026

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

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{N 352}	Continued From page 15 On 01/23/2026 at approximately 10:30 a.m., Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider's facility on 09/30/2025. Resident 5's medication administration record (MAR), dated 11/16/2025 to 01/23/2026, documented the following occurrences when Resident 5 did not receive his/her medications as prescribed: Hydrocodone-Acetaminophen Resident 5's physician orders included Hydrocodone-Acetaminophen 5-325 mg (Start date not listed) - Take 1 tablet 3 times daily. Resident 5's record included an incident report, dated 01/19/2026, that indicated a medication audit determined this medication was documented as given on 01/13/2026 at 8:00 a.m.; however, the medication was still in the medication cart indicating Resident 5 did not receive the 01/13/2026 8:00 a.m. dose of Hydrocodone-Acetaminophen. The incident report documented that education was provided to the medication passer. Metoprolol Resident 5's physician orders included Metoprolol 100 mg (Start date not listed) - Take 1 tablet 1 time daily, hold if systolic BP is less than 100 and heart rate is less than 60. Resident 5's record documented a BP of 128/61 and pulse of 57 on 01/18/2026. The record documented Metoprolol was held; however, BP and pulse were not both under parameters to hold as indicated in the order. Amlodipine Besylate Resident 5's physician orders included Amlodipine Besylate 10 mg (Start Date not listed) - Take 1	{N 352}		

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	0018519	A. BUILDING: _____ B. WING _____	R-C 01/28/2026

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

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{N 352}	Continued From page 16 tablet 1 time daily, hold for systolic blood pressure (BP) less than 100. Resident 5's MAR, dated 11/16/2025 to 01/23/2026, documented a BP of 92/44 on 11/25/2025, indicating Amlodipine Besylate should be held; however, documentation indicated the medication was administered. On 01/23/2026 at approximately 3:00 p.m., Surveyors reviewed medication administration concerns with Consultant B, LPN L, House Manager M and Consultant P. Consultant B acknowledged concerns and stated LPN L had been a great help with correcting medication concerns. Example 3 - Resident 3 On 01/23/2026 at approximately 10:30 a.m., Surveyor reviewed Resident 3s record. Resident 3 was admitted to the facility on 11/20/2024 with diagnoses including type 2 diabetes mellitus with diabetic polyneuropathy. Resident 3's physician orders included Metformin hcl 500 mg (Start date not listed) to take 1 tablet twice daily on the November and December 2025 medication administration record (MAR). For the months of November and December, the MAR documented that the Metformin was only administered once daily at 8:00 a.m. On 01/23/2026 at 1:09 p.m., Surveyor interviewed Consultant B. Consultant B stated that the facility was aware of the error in medication administration and stated that the pharmacy transcribed the order wrong by only entering the time on the MAR 1 time rather than twice. Surveyor confirmed that the physician order on the MAR read twice daily and that the AM and PM dose of Metformin was	{N 352}		

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 _____	R-C 01/28/2026

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

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{N 352}	Continued From page 17 delivered to the facility. Consultant B stated yes that the facility had an extra medication card for Resident 3's Metformin for November and December and that's how they figured out the error.	{N 352}		
{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 record review and interview, the provider did not ensure Resident 1's Oxycodone HCl 5 mg was audited daily. This is a repeat deficiency. See Statement of Deficiency (SOD) 59UD11, dated 10/21/2025. Findings include: On 12/02/2025, the department received a complaint alleging that medications are not available for administration. On 12/07/2025, the department received a complaint alleging concerns about resident	{N 409}		

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

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{N 409}	Continued From page 18 medication. On 12/14/2025, the department received a complaint alleging that resident's narcotic medication was stolen. On 12/17/2025, the department received a self-report investigation documenting that Resident 1's oxycodone was stolen. On 12/22/2025, the department received a complaint alleging concerns with narcotic medication administration. On 01/23/2025, Surveyors conducted 2 verification visits and 4 complaint investigations. Surveyor reviewed an internal investigation documenting: "[Resident 1] used [his/her] last Oxycodone on 11/30/35[sic]. The writer re-ordered Oxycodone via Electronic Health Record system on 12/1/25. [Pharmacy] confirmed that they delivered the medication on 12/3/25 and that it was checked in by [Caregiver Q] at 12:10 p.m. The pharmacy confirmed that they sent 60 pills, 2 cards. The cart in the cart states 2/2 and has 30 pills. 1 of 2 cards was discovered on the morning of 12/5 in the PRN drawer, rather than the Narcotic drawer. Pharmacy confirmed that they delivered 2 of 2 Oxycodone cards (60 pills) on 12/3/25. On 12/5 an internal investigation was launched, on 12/8 the internal investigation continued, and it was determined that 1 of 2 cards (30 pills) was unable to be located. Non-emergency local law enforcement were called 12/9 to assist with the investigation. This is still an open investigation". Surveyor asked to review the record of Resident 1. Resident 1 was admitted to the provider on	{N 409}		

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

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{N 409}	Continued From page 19 10/19/2022 with diagnoses including anxiety disorder and disease of the spinal cord. Surveyor reviewed Resident 1's physician orders, including an order for oxycodone hcl 5 mg to take (1)-(2) every 6 hours as needed for pain. Surveyor reviewed the provider's daily narcotic audits from 12/01/2025 to 12/10/2025 of Resident 1's Oxycodone 5 mg, which documented the following: -12/01/2025 First Shift, Quantity = 0, Notes, "Count entered was 0, but count in system is 13." -12/01/2025 Second Shift, Quantity = 0, Notes, "Count entered was 0, but count in system is 13." -12/02/2025 First Shift, Quantity = Not Counted -12/02/2025 Second Shift, Quantity = 6, Notes, "Count entered was 6 but count in system is 13." -12/03/2025 - Pharmacy delivered 60 oxycodone at 12:10 p.m. which was signed as received by facility staff. -12/03/2025 Second Shift, Quantity = 0 -12/04/2025 First Shift, Quantity = 0 -12/04/2025 Second Shift, Quantity = 0 -12/04/2025 Third Shift, Quantity = 0 -12/05/2025 Second Shift, Quantity = 29, Notes, "Count entered was 29 but count in system is -1." -12/05/2025 Second Shift, Quantity = 29, Notes, "Count entered was 29 but count in system is -2." -12/05/2025 Second Shift, Quantity = 29, Notes, "Count entered was 29 but count in system is -2." -12/06/2025 Third Shift, Quantity = 28, Notes, "Count entered was 28 but count in system is -2." -12/06/2025 Third Shift, Quantity = 25, Notes, "Count entered was 25 but count in system is -5." -12/07/2025 Second Shift, Quantity = 23, Notes, "Count entered was 23 but count in system is -7." -12/07/2025 Third Shift, Quantity = Not Counted -12/08/2025 First Shift, Quantity = 22, Notes,	{N 409}		

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 _____	R-C 01/28/2026

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

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{N 409}	Continued From page 20 "Count entered was 22 but count in system is -8." -12/08/2025 First Shift, Quantity = 21, Notes, "Count entered was 21 but count in system is -9." -12/08/2025 Third Shift, Quantity = 20, Notes, "Count entered was 20 but count in system is -10." -12/09/2025 First Shift, Quantity = 19 -12/09/2025 Second Shift, Quantity = 18, Notes, "Count entered was 18 but count in system is 19." -12/10/2025 First Shift, Quantity = 15, Notes, "Count entered was 15 but count in system is 17." -12/10/2025 First Shift, Quantity = 16, Notes, "Count entered was 16 but count in system is 17." -12/10/2025 First Shift, Quantity = 15, Notes, "Count entered was 15 but count in system is 17." -12/10/2025 Second Shift, Quantity = 13, Notes, "Count entered was 13 but count in system is 15." Surveyor compared the audit sheet with Resident 1's December medication administration record (MAR) and noted the following discrepancies: -12/05/2025: MAR - 2 oxycodone given / Audit sheet - 1 oxycodone given -12/07/2025: MAR - 3 oxycodone given / Audit sheet - 2 oxycodone given -12/08/2025: MAR - 2 oxycodone given / Audit sheet - 3 oxycodone given -12/10/2025: MAR - 3 oxycodone given / Audit sheet - 5 oxycodone given On 01/23/2026, at 9:56 a.m., Surveyor interviewed LPN N. Surveyor asked if LPN N was responsible for medication administration for his/her entire shift, including narcotic medications on 12/03/2025. LPN N stated yes, s/he had the narc key. Surveyor asked if LPN N checked in Resident 1's oxycodone when it was delivered. LPN N stated no, s/he was the only person with the	{N 409}		

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	0018519	A. BUILDING: _____ B. WING _____	R-C 01/28/2026

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

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{N 409}	Continued From page 21 narcotic lock box key and did not see Resident 1's oxycodone or put it in the medication cart. Surveyor asked LPN N who was responsible for adjusting the narcotic counts in the facility's system when new narcotics, like Resident 1's oxycodone, was delivered by pharmacy. LPN N stated that Caregiver Q should have adjusted the counts when s/he checked in the medication. At approximately 2:15 p.m., Surveyor reviewed the proof of use records with Consultant B. Surveyor asked who was responsible for auditing the proof of use records on a daily basis. Consultant B stated s/he was currently auditing them. On 01/23/2026 at approximately 3:00 p.m., Surveyors reviewed the concerns regarding the daily audit of the proof of use record with Consultant B, LPN L, House Manager M and Consultant P. Consultant P stated that the provider has delegated the daily audit to staff, so caregivers are responsible for auditing the proof of use records at the beginning and end of their shifts. Surveyor asked who was overseeing the caregivers to ensure the audits were being completed correctly. Consultant P stated that the regulations states that the task can be delegated to caregivers and questioned why the provider should do follow up of medication theft if the provider would be cited by the department regardless. Consultant B stated that s/he is responsible for auditing the proof of use records, noting the concern in the documentation, and stating s/he does not always audit the proof of use records on Sundays.	{N 409}		
N 423	83.37(3)(g) Medication storage: controlled	N 423		

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 _____	R-C 01/28/2026

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 423	Continued From page 22 substances. Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's oxycodone was locked and securely fastened within the locked medication area upon delivery on 12/03/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 12/02/2025, the department received a complaint alleging that medications are not available for administration. On 12/07/2025, the department received a complaint alleging concerns about resident medication. On 12/14/2025, the department received a complaint alleging that resident's narcotic medication was stolen. On 12/17/2025, the department received a self-report investigation documenting that Resident 1's oxycodone was stolen.	N 423		

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 _____	R-C 01/28/2026

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 423	Continued From page 23 On 12/22/2025, the department received a complaint alleging concerns with narcotic medication administration. On 01/23/2025, the department conducted 2 verification visits and 4 complaint investigations. Surveyor asked to review the record of Resident 1. Resident 1 was admitted to the provider on 10/19/2022 with diagnoses including anxiety disorder and disease of the spinal cord. Surveyor reviewed Resident 1's physician orders, including an order for oxycodone hcl 5 mg to take (1)-(2) every 6 hours as needed for pain. Surveyor reviewed an internal investigation documenting: "[Resident 1] used [his/her] last Oxycodone on 11/30/35[sic]. The writer re-ordered Oxycodone via Electronic Health Record system on 12/1/25. [Pharmacy] confirmed that they delivered the medication on 12/3/25 and that it was checked in by [Caregiver Q] at 12:10 p.m. The pharmacy confirmed that they sent 60 pills, 2 cards. The card in the cart states 2/2 and has 30 pills. 1 of 2 cards was discovered on the morning of 12/5 in the PRN drawer, rather than the Narcotic drawer. Pharmacy confirmed that they delivered 2 of 2 Oxycodone cards (60 pills) on 12/3/25. On 12/5 an internal investigation was launched, on 12/8 the internal investigation continued and it was determined that 1 of 2 cards (30 pills) was unable to be located. Non-emergency local law enforcement were called 12/9 to assist with the investigation. This is still an open investigation". The investigations interview with Caregiver Q documented, "[Caregiver Q] worked at [facility] 12/3 and 12/4. [Caregiver Q] states that [s/he]	N 423		

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 _____	R-C 01/28/2026

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 423	Continued From page 24	N 423		

signed for medications around lunch time, that [s/he] did not look at what they were and that [s/he] placed them on the counter in the back of the nurses station. [Caregiver Q] stated [s/he] did not look at the delivery sheet and [s/he] did not open the medications. [Caregiver Q] stated [s/he] did not put them away in the medication cart. [Caregiver Q] states when [s/he] came back on the morning of 12/4, [s/he] saw medications sitting on the back counter. [S/he] reports putting away insulin and a PRN acetaminophen card..."

The investigations interview with LPN N documented, "Was training with [Consultant B] and does not remember seeing medication laying out or being delivered."

On 01/23/2026, at 9:56 a.m., Surveyor interviewed LPN N. Surveyor asked LPN N what his/her job responsibilities were on 12/03/2025. LPN N stated that s/he started training on 12/01/2025 and was going to be training with Consultant B on 12/03/2025, however, when s/he got in Caregiver Q was training with Administrator A so LPN N was asked to take over the medication cart. Surveyor asked if LPN N was responsible for medication administration for his/her entire shift, including narcotic medications. LPN N stated yes, s/he had the narc key. Surveyor asked if LPN N checked in Resident 1's oxycodone when it was delivered. LPN N stated no, s/he was the only person with the narcotic lock box key and did not see Resident 1's oxycodone or put it in the medication cart. LPN N stated that s/he found out that the oxycodone was missing at the end of his/her shift on 12/03/2025.

On 01/28/2026, at 12:34 p.m., Consultant B

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 _____	R-C 01/28/2026

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

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N 423	Continued From page 25 stated, "On 12/5 [Resident 1] told me that the Oxycodone had not arrived yet. I did not think this was odd because it often does take a few days to process, and has taken 4-5 days in the past. I called the [pharmacy] on 12/5 to get an update on the order, and that was when they stated the Oxycodone had been delivered on 12/3 and signed by [Caregiver Q]. I connected with [Caregiver Q] to see if [s/he] had signed any medications in. [S/he] stated [s/he] did but that [s/he] did not look at the requisition sheet and did not open the bag (this is against company policy) and that [s/he] set them on the back counter in the locked nurses station (unfortunately, we have no way of knowing if this is true, as our cameras do not show the nurses station, and only the medication room itself, and nobody else who was onsite saw the medications be delivered that day, including me). [Caregiver Q] states that when [s/he] came in the next day (12/4) the medications were still on the back counter (again could not confirm this as no staff members remember/admitted to seeing them) and that [s/he] put the medications away that morning (12/4). [S/he] told us that [s/he] put away 1 bubble pack card and 1 insulin package (in the med fridge). [S/he] is seen on the med room cameras putting away 1 bubble pack into the med cart and 1 insulin box into the fridge..." On 12/03/2025, the provider did not ensure Resident 1's oxycodone was separately locked within the locked medication area resulting in Resident 1's oxycodone pills missing from 12/03/2025 to 12/04/2025 and then identified 1 of 2 cards (30 oxycodone pills) stolen on 12/05/2025.	N 423		
N 431	83.38(1)(g) Health monitoring.	N 431		

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 _____	R-C 01/28/2026

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 431	Continued From page 26 As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of 1 of 4 residents reviewed had their health monitored and changes documented in their records. The monitoring of Resident 11's wound care was not documented. This is a repeat deficiency. See Statement of	N 431		

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 _____	R-C 01/28/2026

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

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N 431	Continued From page 27 Deficiency (SOD) 8XKQ11, dated 08/24/2023 and SOD Q1UN13, dated 09/15/2025. Findings include: On 01/23/2026 at 7:00 a.m., Surveyor reviewed primary care documentation, obtained by Surveyor. A note, dated 12/17/2025, requested increased nursing visits due to Resident 11's foot becoming wet in the shower, the provider not changing the dressing and Resident 11's toes being so macerated they were nearly necrotic. On 01/23/2026 at approximately 10:30 a.m., Surveyors reviewed Resident 11's record. Resident 11 admitted to the provider's facility on 07/21/2025. A progress note, dated 01/08/2026, stated home care wound care would be discontinued on 01/09/2026 and that provider's nurse and trained staff would perform wound care starting 01/12/2026. The note documented that wound care would be provided Monday, Wednesday, Friday. The record included wound care instructions, dated 01/12/2026, that stated to keep toes clean, warm and dry at all times, wash wounds with antibacterial soup and water once daily with dressing changes, dry well, apply betadine/iodine to black areas on toes on left foot, leave open to air if kept dry and sitting around or cover with gauze and compression sleeve. The order stated to monitor for signs/symptoms of infection, including the following: fever, chills, change in color/consistency of wound drainage, increase in redness around wound and/or red streaking from wound, unexplainable swelling around the wound opening, unusual order, unexplainable increase in the size of the wound, pain or tenderness. Surveyor noted the wound documentation did not	N 431		

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 _____	R-C 01/28/2026

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

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N 431	Continued From page 28 document the appearance of the wound. The provider's record documented wound care completion on the following dates: - 01/09/2026: Wound care completed on left lower extremity. Tolerated well. - 01/12/2026: Wound care on left lower extremity completed. - 01/14/2026: Wound care completed. Noticed no changes. - 01/16/2026: Wound care completed on lower left toes, per house manager. - 01/20/2026: Wound care completed on left lower extremity - No change. - 01/21/2026: Wound care completed on lower left extremity. No changes noted. On 01/23/2026 at 12:35 p.m., Surveyor interviewed LPN L regarding Resident 11's wound care. Surveyor asked who was assessing and monitoring the wound. LPN L stated s/he was unable to assess the wound since s/he was not an RN, but that s/he and House Manager M were responsible for monitoring the wound and completed wound care. Surveyor requested documentation regarding the appearance of the wound. LPN L stated s/he did not document the appearance of the wound since there had been no changes. Surveyor asked how changes would be noted when 2 different individuals were completing wound care 3 times per week, so 1 of the individuals could go several days without seeing the wound. LPN L did not comment, but stated Resident 11's toes were necrotic and going to fall off. Surveyor asked how staff other than LPN L or House Manager M would be aware of changes if they needed to complete a change due to the bandage being wet, soiled or falling off when there	N 431		

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 _____	R-C 01/28/2026

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

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N 431	Continued From page 29 was no documentation of the wound appearance. LPN L stated staff would need to call him/her. On 01/23/2026 at approximately 3:00 p.m., Surveyors reviewed concern with the monitoring of Resident 11's wound with Consultant B, LPN L, House Manager M and Consultant P. Consultant P, who attended the conversation via phone, stated s/he spoke with a wound specialist who confirmed the facility was doing everything they needed to do for Resident 11's wound care. Consultant P stated there was documentation in Resident 11's record of what his/her wound looked like when home health ended and there had been no changes so no further documentation was required. Surveyor requested documentation of Resident 11's wound appearance when home health ended from Consultant B. Consultant B reviewed Resident 11's record and stated s/he was unable to produce documentation of what Resident 11's wound looked like when home health ended or what the wound currently looked like.	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs.	N 432		

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 _____	R-C 01/28/2026

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 432	Continued From page 30	N 432		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure medication administration was provided to meet the needs of 3 of 4 residents reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025 and SOD Q1UN13, dated 09/15/2025.

Resident 11 missed administrations of his/her nicotine patch, xarelto, toujeo insulin, spiriva inhaler and polyethylene glycol due to the medications being unavailable.

Resident 1 missed administrations of his/her breo ellipta inhaler and was unable to receive oxycodone PRN due to the medications being unavailable.

Resident 3 missed administrations of his/her acetaminophen and olanzapine due to the medications being unavailable for administration.

Findings include:

From 01/23/2026 to 01/28/2026, Surveyors conducted 4 complaint investigations alleging concerns with the provider's medication management.

RECORD REVIEW

On 01/23/2026 at approximately 10:30 a.m., Surveyors reviewed resident records and identified the following occurrences when residents did not

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 _____	R-C 01/28/2026

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 432	Continued From page 31 receive medications due to lack of availability: Example 1 - Resident 11: Resident 11 admitted to the provider's facility on 07/21/2025. Resident 11's record, including the medication administration record (MAR), dated 11/16/2025 to 01/23/2026, documented the following medication concerns: Nicotine Patch: Resident 11's physician orders included Nicotine 21 mg/24 hour patch (Start Date: 08/21/2025) - Apply 1 patch 1 time daily. The MAR documented his/her Nicotine patch as unavailable 12/02/2025 to 12/18/2025. A progress note, dated 12/17/2025, stated a re-order request was submitted on 12/02/2025 and resubmitted again on 12/17/2025. The record did not indicate follow up occurred from 12/03/2025 through 12/16/2025. A follow up incident report, dated 12/17/2025, stated Resident 11 reported having extra cigarettes throughout the month. Xarelto: Resident 11's physician orders included Xarelto 20 mg (Start Date: 08/21/2025) - Take 1 tablet 1 time daily. Resident 11's record documented Xarelto was unavailable on 12/13/2025 ad 12/14/2025. A notation, dated 12/13/2025, documented the medication was removed from the medication cart and not put back into the medication cart for administration. Toujeo: Resident 11's physician orders included Toujeo Solo 300 unit/ml (Start Date: 09/02/2025) - Inject 15 units 1 time daily. Resident 11's record	N 432		

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 _____	R-C 01/28/2026

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 432	Continued From page 32	N 432		

documented the following medication errors regarding Resident 11's Toujeo:
- Toujeo was not documented as administered on 12/14/2025 and 12/15/2025. A progress note, dated 12/16/2025, stated the insulin was discontinued by pharmacy in error and would be resumed on 12/16/2025 or 12/17/2025.
- Only 6 units were administered to resident on 01/19/2026, rather than 15 units as ordered. The notation stated additional insulin would be delivered to the facility later that afternoon.

Spiriva Respimat:
Resident 11's physician orders included Spiriva Respimat 2.5 mcg inhaler (Start Date: 08/21/2025) - Inhale 2 puffs 1 time daily. Resident 11's MAR documented his/her Spiriva Respimat inhaler as unavailable from 11/18/2025 to 11/24/2024 and 01/04/2026 through 01/06/2026.

Polyethylene Glycol:
Resident 11's physician orders included Polyethylene Glycol 17 grams (Start Date: 08/21/2025) - Mix 17 grams in 4-8 oz liquid and drink 1 time daily. Resident 11's MAR documented his/her Polyethylene Glycol 17 grams as unavailable from 11/18/2025 to 11/24/2024.

Example 2 - Resident 1:

Resident 1 was admitted to the provider's facility on 10/19/2022 and discharged 01/08/2026. Resident 1's record, including the MAR, dated 11/16/2025 to 01/23/2026, documented the following medication concerns:

Breo Ellipta 100-25 mcg inhaler:
Resident 1's physician orders documented his/her

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 _____	R-C 01/28/2026

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 432	Continued From page 33 Breo Ellipta 100-25 mcg inhaler (Start Date: 09/17/2025) - Take 1 puff daily was unavailable for administration from 11/16/2025 to 11/26/2025. Oxycodone Hcl: A police report, dated 12/09/2025 and obtained by Surveyor, stated law enforcement was contacted regarding 30 tablets of Oxycodone 5 mg that the provider believed had been stolen. The report stated approximately 2 days had passed from the time the medication was delivered to the facility and the time the provider learned the medication was missing. Resident 1's physician orders included Oxycodone Hcl 5 mg (Start Date: 10/07/2025) - 1 to 2 tablets every 6 hours as needed for pain. Resident 1's MARs, dated 11/16/2025 to 01/08/2026, documented 99 administrations of Oxycodone with Resident 1 being out of the facility 7 of those days. Surveyor noted Resident 1 took 2-3 Oxycodone PRNs nearly every day and did take Oxycodone Hcl PRN with him/her while out of the facility. The MAR documented 0 administrations of Oxycodone PRN from 12/01/2025 to 12/04/2025 while Resident 1 was at the facility. On 01/28/2026 at 12:34 p.m., Consultant B stated that Resident 1's oxycodone was delivered on 12/03/2025 but the caregiver did not check in the medications per the policy. On 12/04/2026, the oxycodone were added to the medication cart, but were put in the PRN drawer rather than with the narcotics, so the facility was not aware that Resident 5's oxycodone was available for administration until 12/05/2025. Example 3 - Resident 3:	N 432		

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 _____	R-C 01/28/2026

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 432	Continued From page 34 Resident 3 was admitted to the provider's facility on 11/20/2024. Resident 3's physician orders included acetaminophen 500 mg to take 2 tablets 3 times daily (8:00 a.m., 5:00 p.m., and 9:00 p.m.) and olanzapine 2.5 mg tablet to take 1 tablet once daily in the morning. Resident 3's medication administration record (MAR) documented that Resident 3's 9:00 p.m. acetaminophen was not available for administration 7 times in December 2025 and that Resident 3's olanzapine was not available for administration for 3 days from 12/19/2026-12/21/2026. INTERVIEW On 01/23/2026 at 8:12 a.m., Surveyor interviewed LPN L. LPN L stated s/he was hired around Thanksgiving and audited the provider's medication administration from home nightly. On 01/23/2026 at approximately 3:00 p.m., Surveyors reviewed medication administration concerns with Consultant B, LPN L, House Manager M and Consultant P. Consultant B acknowledged concerns and stated LPN L had been a great help with correcting medication concerns. Consultant P questioned why the provider should do follow up of medication theft if the provider would be cited by the department regardless. CROSS REFERENCE N0423 DHS 83.37(3)(g) Medication Storeage: Controlled Substances	N 432		

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 _____	R-C 01/28/2026

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 433	Continued From page 35	N 433		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services were provided to manage a resident's behavior that was harmful to others. A visitor assisted with management of an altercation between Resident 12 and Caregiver K. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN13, dated 09/15/2025. Findings include: On 01/23/2026 at approximately 7:00 a.m., Surveyor reviewed a police report, dated 11/30/2025, that stated law enforcement was called to the provider's facility for report of a resident attacking a worker. The report documented that upon arrival, law enforcement was greeted by 2 staff members, identified as Caregiver K and Individual R. The report documented the following, "[Caregiver K] reported the yelling became more aggressive toward [him/her], prompting [Individual R]'s attention. [Caregiver K] reported [Resident 12] grabbed the	N 433		

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 _____	R-C 01/28/2026

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 433	Continued From page 36	N 433		

front of [his/her] shirt, near [his/her] right shoulder, and tried to pull [him/her] down. [Caregiver K] showed [the officer] [his/her] shirt. [Officer] noted [his/her] hooded zip up sweatshirt was pulled down from [his/her] shoulder, and [his/her] t-shirt in that region appeared "roughed up" and wrinkly as if somebody had grabbed it recently. [Caregiver K] reported [Individual R] attempted to get in between of [Caregiver K] and [Resident 12] to break it up, however was unable to control [Resident 12]. [Caregiver K] then reported [Resident 12] grabbed a chair from the kitchen dining area, which [officer] observed was laying on its side, and threw it at [Caregiver K]. [Caregiver K] reported the chair did not strike [him/her] however it struck [Individual R] as [s/he] attempted to block it from hitting [Caregiver K].

On 01/23/2026 at approximately 10:00 a.m., Surveyor reviewed a self-report, dated 12/01/2025, regarding Resident 12. The report documented that Resident 12 was temporarily placed at the facility for respite and had diagnoses of depression, bipolar and behavioral outbursts. The report stated resident became extremely irritated and angry with a staff member after discussion about going into other residents rooms and taking food and soda. The report stated the resident picked up and threw a dining room chair in the living room, ripped a broom out of staff's hands and swung it at staff. The report included a statement from Caregiver K, taken via text message 12/01/2025 at 11:30 a.m., that stated the following, "On November 30, 2025 at 4:40 p.m. resident came and asked for [his/her] medication. I stated to the resident that that[sic] [s/he] does not have any medication scheduled so after I said that the resident got quiet [s/he] turned [his/her] head. The visitor had seen the

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 _____	R-C 01/28/2026

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 433	Continued From page 37	N 433		

residence[sic] face, and [s/he] told [him/her] to explain to me how [s/he] felt about the situation. The resident was upset about all the other residents, claiming that [s/he] was stealing out of all their rooms so [s/he] was crying, so the resident confronted the visitor and told the visitor that [s/he] was upset with the staff member resident it [sic] and then began to get loud and start screaming and yelling at me. I thin[sic] end up, trying to redirect the resident and try to calm [him/her] out, but resident jut kept getting loud so then eventually the resident ended up smacking my right hand. That's when the visitor jumped in between me and the resident. The resident kept screaming and screaming and screaming at me and [s/he] started and eventually [s/he] charged at me in[sic] the visitor. The visitor was still holding me, guarding me in front of me between us, but the resident attempted to start hitting me and punching me. Then the resident took a chair and threw it at us hating[sic] the resident hitting the visitor the resident and then went to go pick up a broom and swung and hit my left hand visitor, then visitor then kept trying to break us up as the resident attended[sic] to grab my shirt and sweaters trying to swing me around the resident kept hitting me and hitting me while the staff member was while the visitor was trying to break us up and redirect the resident eventually we moved to the sunroom and we were able to be separated. The visitor then was able to separate us and have the resident sit on the couch and directed me to call law-enforcement for additional support."

On 01/23/2026 at approximately 11:00 a.m., Surveyors requested Caregiver K and Individual R's employee records from House Manager M. House

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 _____	R-C 01/28/2026

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 433	Continued From page 38 Manager M stated s/he was not familiar with Individual R, but would check records. Surveyors referenced the 11/30/2025 police report that referenced Individual R as an employee. On 01/23/2026 at approximately 11:20 a.m., House Manager M followed up with Surveyors and stated Individual R was not an employee of the facility. House Manager M provided the facility schedule, which indicated Caregiver K was the only individual working from 3:00 p.m. to 12:00 a.m. on 11/30/2025. House Manager M stated Individual R was at the facility working on Caregiver K's vehicle when the 11/30/2025 incident occurred. House Manager M stated Individual R may have stated s/he was an employee to law enforcement in fear of getting in trouble for being present. On 01/23/2026 at approximately 3:00 p.m., Surveyors discussed concern with Consultant B, LPN L, House Manager M and Consultant P that a visitor of an employee was involved with a resident to staff altercation. Consultant P stated the provider was not responsible for visitors. Surveyor stressed concern that the visitor was present for an employee and that the visitor was interacted/involved with a resident. Consultant P did not make a further comment.	N 433		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods	N 452		

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N 452	Continued From page 39 requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was prepared and stored under sanitary conditions for the prevention of food borne illnesses. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025 and SOD Q1UN13, dated 09/15/2025. Findings include: On 01/23/2026 at 8:00 a.m., Surveyor toured the provider's kitchen. Surveyor observed a Ziploc bag of pizza slices that was not dated and an open package of ham deli meat, dated 01/01/2026, in the provider's refrigerator. Surveyor observed a package of chicken thawing in the kitchen sink. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States."	N 452		

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N 452	Continued From page 40 (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) According to Foodsafety.gov, sliced deli meat is good in the refrigerator for 3 to 5 days. (Source: FoodSafety.gov website, Cold Food Storage, September 19, 2023, https://www.foodsafety.gov/food-safety-charts/cold-food-storage-chart (retrieval date - January 21, 2026).) "Perishable foods should never be thawed on the counter, or in hot water and must not be left at room temperature for more than two hours. Even though the center of the package may still be frozen as it thaws on the counter, the outer layer of the food could be in the "Danger Zone," between 40 and 140 °F - temperatures where bacteria multiply rapidly. When thawing frozen food, it's best to plan ahead and thaw in the refrigerator where it will remain at a safe, constant temperature - at 40 °F or below." (Source: USDA Food Safety and Inspection Service, The Big Thaw - Safe Defrosting Methods, June 15, 2013, https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/big-thaw-safe-defrosting-methods (retrieval date - January 23, 2026).) On 01/23/2026 at 8:00 a.m., Surveyor interviewed Caregiver O regarding food in the refrigerator. Caregiver O stated the pizza was staff's personal food. Caregiver O did not comment on the deli meat. On 01/23/2026 at 11:35 a.m., Surveyor observed Caregiver N preparing the chicken for lunch.	N 452		

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N 452	Continued From page 41 Surveyor asked if the chicken had thawed in the sink. Caregiver N replied, "Yes," and stated the overnight shift placed the chicken in the sink to thaw and be ready for lunch.	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe, clean, comfortable and homelike environment was provided. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025 and SOD Q1UN13, dated 09/15/2025. Findings include: On 01/23/2026 at approximately 7:55 a.m., Surveyors entered the facility and observed 3 bags of garbage and 2 boxes sitting on the floor inside the main entrance to the facility. On 01/23/2026 at approximately 8:30 a.m., Surveyors toured the provider's facility and identified the following concerns: - Flooring in the bathroom nearest Room 14 was pulling up by the toilet.	N 481		

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N 481	Continued From page 42 - Bleach stains were observed on the carpeting throughout the facility. - There was an approximate 10-inch tear in the carpeting outside Resident 5's room. - There was an approximate 10-inch tear in the carpeting outside the elevator. - Hallway doors and walls had heavy, black scuff marks. - Hallway corners had broken and chipped off drywall. - Resident 9's shared bathroom had dark gray staining down the toilet bowl and around the ring of water. - A side exit, identified as an emergency exit by a lit sign but not identified on the evacuation plan as an emergency exit, was covered with snow. There was not a clear path to leave the facility from the exit. On 01/23/2026 at 11:48 a.m., Surveyor observed a caregiver put 2 bags of garbage on the floor near the front entrance to the facility. The 2 bags of garbage remained on the floor of the facility until the Surveyors exited the facility. On 01/23/2026 at approximately 3:00 p.m., Surveyors discussed environmental concerns with Consultant B. Consultant B stated Owner C had a contractor come out to rectify some environmental concerns but believed s/he was having a different contractor redo some of the previous contractor's work and address other concerns in the spring.	N 481		
N 502	83.46(1)(a) Comfortable and safe temperatures A CBRF shall maintain comfortable and safe temperatures. The CBRF shall provide tempered	N 502		

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N 502	Continued From page 43 air at all times to eliminate cold air drafts. The heating system shall be capable of maintaining temperatures of 74º F. in areas occupied by residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a comfortable temperature was maintained in common area which had the potential to affect each resident who utilized the facilities hallways, dining room and sunroom. Findings include: On 01/23/2026 at approximately 8:00 a.m., Surveyors toured the provider's facility. Surveyor observed the following: -The sun room/meeting room was 63.4º F -The dining room was 69.4º F -The second floor main hallway was 71.4º F -The living room was 68.1º F with the fire place on. At 8:49 a.m., Surveyor interviewed Resident 5 and noted the room felt cold. Surveyor asked Resident 5 if his/her room temperature was comfortable. Resident 5 replied, "It's cold in here. Always cold." At 10:34 a.m., the sunroom/meeting room was 67.7º F On 01/23/2026 at approximately 3:00 p.m., Surveyors reviewed the concerns regarding the facility maintaining a temperature of 74º F with Consultant B, LPN L, House Manager M and	N 502		

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N 502	Continued From page 44 Consultant P. House Manager M stated that the temperature inside the facility is probably lower because it is so cold outside.	N 502		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure all residents were treated with dignity. Resident 11's catheter bag was left exposed and leaking into a clear Ziploc bag while Resident 11 mobilized throughout the facility. Findings include: On 01/23/2026 at 7:00 a.m., Surveyor reviewed	Y3234		

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Y3234	Continued From page 45 primary care documentation, obtained by Surveyor. A note, dated 11/21/2026, stated Resident 11 voiced concern to his/her provider that his/her catheter was not well cared for. Resident 11 reported that staff did not change the bag. On 01/23/2026 at 8:22 a.m., Surveyor observed Resident 11 in his/her wheelchair with a catheter bag, leaking into a clear Ziploc freezer bag, attached to his/her wheelchair. Resident 11's individual service plan (ISP), dated 01/20/2026, documented that staff assisted with management of Resident 11's catheter bag. On 01/23/2026 at approximately 2:00 p.m., Surveyor observed Resident 11 with the clear Ziploc bag over his/her catheter; however, urine was no longer leaking into the Ziploc bag. On 01/23/2026 at approximately 3:00 p.m., Surveyors reviewed concern that Resident 11's catheter bag was covered with only a Ziploc bag with Consultant B, LPN L, House Manager M and Consultant P. LPN L stated the provider was working with the managed care organization on an alternate solution.	Y3234		