

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 08/09/2023, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Anchor Communities, a CBRF located in Fox Lake, WI As a result, 4 violations of Chapter DHS 83 was issued. The complaint was substantiated.	N 000		
N 141	83.09 Biennial report and fees. Biennial report and fees. Every 24 months, on a date determined by the department, the licensee shall submit a biennial report on the form provided by department, and shall submit payment of the license continuation fees. This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a biennial report on the form provided by the Department or submit payment of the biennial license continuation fee for 2022-2023. Findings include: On 07/27/2023, Surveyor conducted a desk review of facility payment of fees. Example 1: Biennial Fees On 10/28/2022, Licensee A was mailed correspondence from the Department letting them know their biennial licensing fee of \$1092.50 due on 01/01/2023.	N 141		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 141	Continued From page 1 Per the Department's facility file, the last documented submission of the biennial report and licensing fee was on 12/09/2020 and payment for the 2022-2023 fee was never received leaving an outstanding balance of \$1092.50. On 08/09/2023 at 10:00 AM, Surveyor interviewed Administrator D who stated s/he did not know if Licensee A had submitted a biennial report or biennial licensing fee, "because I just took this job in June 2023, but I will ask Licensee A about this." Surveyor showed Administrator D the list of fees that had gone unpaid. Administrator D stated, "If your records show that these fees have not been paid, then they have not been paid. I will speak with Licensee A and they will be paid and the biennial report will be submitted as soon as possible." CROSS REFERENCE: 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 141		
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 record review, the provider did not ensure that the CBRF and its operation complied with all laws governing the CBRF. Licensee A has not responded to documentation requests by the Department.	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 196	Continued From page 2 On 05/17/2023, a complaint investigation was conducted regarding facility financial capability. The investigation revealed that Licensee A had received multiple notices from the power company, utility company to pay the bill or have power/utilities shut off. The bills were paid eventually, but not until after Licensee A had received notice that power would be shut off. On 05/17/2023 at 10:00 AM, Surveyor interviewed Former Administrator B. Former Administrator B confirmed that the facility had received multiple "pay or shut off" notices by the power/utility companies. Former Administrator B also stated that s/he had received complaints from caregivers that their respective pay checks had been late or funds held by the bank due to insufficient funds from Licensee A. Former Administrator B stated that the balance for the corporate credit card in Licensee A's name is often unpaid and they are left without funds for items such as supplies and groceries. Former Administrator B stated that s/he had used his/her own credit card to purchase groceries and had to be reimbursed at a later time by Licensee A. On 05/17/2023 at 10:30 AM, Surveyor interviewed Caregiver C. Caregiver C confirmed that his/her paychecks were often late due to insufficient funds. Caregiver C stated that s/he received notices from his/her bank that the, "paycheck funds are being held until the check clears." Surveyor asked Caregiver C who issues the paychecks. Caregiver C stated that Licensee A is the one that writes the checks. On 06/07/2023, a letter was sent to Licensee A by the Department requesting documentation related to financial ability to maintain the facility.	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 196	Continued From page 3 Requested response time was 20 days (06/27/2023) The requested documentation requested was as follows: · Available cash reserves or lines of credit to operate for 60 days · Status of all utility accounts (gas, electricity, telephone) - currently paid or in arrears · Proof that business, homeowners and vehicle insurance premiums are current · The status of all current debts (monies owed) and loans (written or otherwise) · Information regarding savings and checking accounts and any other financial accounts, including current account balances and accounts that may be in arrears · Staff payroll is current or in arrears (including bonus program or policy) · Copies of county contractual agreements, if any · Status of lease agreements and/or mortgage payments - currently paid or in arrears · Contracts or agreements to ensure needed services are available for residents, i.e., food contracts, medical supply or service contracts, pharmacy agreement, etc. · Status of property, income, and employee withholding taxes - currently paid or in arrears · Most current balance sheets · Status of workers Compensation and unemployment compensation premiums As of 06/27/2023, there was no response from Licensee A. On 06/29/2023, Surveyor sent Licensee A an email informing him/her that the Department had not seen a response to the 06/07/2023 letter.	N 196			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 196	Continued From page 4 On 06/29/2023, Licensee A sent Surveyor an email stating that s/he would send in requested documents by 07/15/2023. On 11/09/2022, a NOTICE OF REVISIT FEE was issued to Anchor Communities. The revisit fee payment was due within (10) days of receipt of the NOTICE OF REVISIT FEE letter. On 08/09/2023, Surveyor conducted a record review to determine timely compliance with submission of the revisit fee and found that no revisit fee issued on 11/09/2022 had been received by the Department. On 06/29/2023, the NOTICE OF REVISIT FEE was issued to Anchor Communities. The revisit fee payment was due within (10) days of receipt of the NOTICE OF REVISIT FEE letter. On 08/09/2023, Surveyor conducted a record review to determine timely compliance with submission of the revisit fee and found that no revisit fee issued on 06/29/2023 had been received by the Department. As of 10/23/2023, no requested documents had been provided. CROSS REFERENCE: 83.09 Biennial Report and Fees	N 196			
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7	N 200			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 200	Continued From page 5 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the Department within 7 days after there is a change in administrator. Administrator D has been in place since 06/20/2023. Findings include: On 08/09/2023, Surveyor requested documentation from Administrator D regarding a change in administrator for the facility. Surveyor stated that the Department had Former Administrator B as the Administrator for the facility. Administrator D stated, "Former Administrator B left 06/04/2023 and I took over a short time later." Administrator D stated that s/he did not inform the Department of the change as "Licensee A should have done that in June 2023 when I took over." CROSS REFERENCE: N-196- 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 200			
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 348	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 was free from mistreatment. Resident 1 was incontinent and was not changed for at least 5 hours. Findings include: On 07/23/2023, the Department received a complaint that alleged caregiver mistreatment of resident that occurred on 07/17/2023. On 08/09/2023 at 9:00 AM, Surveyor arrived at the facility to conduct a complaint investigation. On 08/09/2023 at 9:30 AM, Surveyor interviewed Assistant-Administrator G (AA-G). AA-G stated that s/he was called by Caregiver D at approximately 10:30 PM on 07/17/2023 regarding Resident 1 being extremely upset. AA-G stated that when s/he arrived at the facility at approximately 10:40 PM on 07/17/2023, s/he interviewed Resident 1. Resident 1 told AA-G that s/he had asked Former Caregiver F to change him/her after dinner (approximately 5:30 PM) on 07/17/2023. AA-G stated that Resident 1 stated that Former Caregiver F screamed at him/her and told Resident 1 to "just change yourself!" AA-G stated that Resident 1 is blind and is a fall risk and Resident 1's Individual Service Plan (ISP) directs caregivers to assist Resident 1 with toileting and changing clothes. AA-G stated that Caregiver E told him/her that when s/he got to work on 07/17/2023 at 10:00 PM, Resident 1's brief was soaked to the point that it was literally dripping urine all over Resident	N 348			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 348	Continued From page 7 1's clothes, legs and on the floor. AA-G stated that s/he attempted to speak with Former Caregiver F by phone and also to get a written statement. Former Caregiver F did not call AA-G back. Former Caregiver F sent a text message that stated Former Caregiver F would not be coming back to the facility to address the accusations. AA-G stated that Former Caregiver F employment was terminated as of 07/18/2023. AA-G stated that s/he believed Resident 1 because, "S/he is a reliable reporter and usually does not get upset, so when I saw him/her crying and yelling, it really stood out that something bad happened to him/her." On 08/09/2023 at 10:15 AM, Surveyor reviewed Resident 1's ISP dated 04/24/2023. Resident 1 was admitted 09/18/2018 with diagnoses that include but are not limited to: serous retinal detachment right eye, blindness one eye, low vision other eye, unspecified atherosclerosis of native arteries of extremities bilateral legs, weakness, history of falling. Resident 1 is own person, makes own decisions. Resident 1's ISP indicates that Resident 1 is a fall risk due to blindness and requires full assistance for toileting and changing of clothes to minimize the risk of falls. ISP directs staff to assist Resident 1 with all aspects of toileting and clean up which includes: hands on assistance with undressing/dressing, washing/wiping and any physical assistance necessary. On 08/09/2023 at 10:45 AM, Surveyor interviewed Resident 1. Resident 1 stated that s/he remembered what happened "like it was yesterday. I asked that staff to change me after dinner and s/he just yelled at me and told me to do it myself! I can't see very well and lose my balance a lot so I need help. That staff continued	N 348			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 348	Continued From page 8 to yell at me and left me in my soiled clothes from dinner time until the next staff came in at night." Surveyor asked Resident 1 asked if s/he Former Caregiver F for help. Resident 1 stated s/he asked right after dinner. Surveyor asked Resident 1 when s/he did get help from staff. Resident 1 stated that a different staff that came in at night helped him/her. "I don't know what time it was because I don't see very well, but it was dark out." Surveyor observed Resident 1's demeanor to change from happy to angry/sad during the course of the conversation. Resident 1 stated that s/he did not deserve to be treated like that and said, "you tell that [expletive] that s/he is not welcome back!" On 08/09/2023 at 11:10 AM, Surveyor interviewed Caregiver E. Caregiver E stated that s/he arrived at work on 07/17/2023 at approximately 10:00 PM. Caregiver E stated that Former Caregiver F told him/her, "I think Resident 1 might be wet, s/he is really mad at me because I didn't have time to get to him/her." Caregiver E stated that s/he then walked towards Resident 1's room and could hear Resident 1 yelling. Caregiver E stated that Resident 1 stated that Former Caregiver F refused to change him/her and was screaming at him/her. Caregiver E stated that Resident 1 said, "S/he told me I had to change myself. I can't! S/he left me in wet clothes for hours!" Caregiver E stated that when s/he changed Resident 1's clothes, the brief was so full of urine that, "it was literally dripping all over the place, that doesn't happen in 2 hours, more like 5 hours. Resident 1 told me s/he started asking to be changed right after dinner which is around 5:30 PM so s/he was likely Resident 1 was sitting in soiled clothing for almost 5 hours." Caregiver E stated that Resident 1 started to cry. Caregiver E stated, "Resident 1 never cries, so when I saw that, I	N 348		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER ANCHOR COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 FOREST ST FOX LAKE, WI 53933		
(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 348	Continued From page 9 knew something happened and I called AA-G right away to report it."	N 348			