STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012647	A. BUILDING: _____ B. WING _____	R-C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE TREE CBRF	**324 ROBIN LN LUXEMBURG, WI 54217**

(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 12/15/2025, Surveyor conducted a verification visit at Pine Tree CBRF. Six (6) of 11 deficiencies were verified as corrected. Five (5) repeat deficiencies were identified. See Statement of Deficiency (SOD) 6XGU11, dated 08/19/2025. Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed. Census: 6	{N 000}		
{N 230}	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver E received orientation training in all required topics prior to performing job duties. This is a repeat deficiency. See Statement of	{N 230}		

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

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{N 230}	Continued From page 1 Deficiency (SOD) 6XGU11, dated 08/19/2025. Findings include: On 12/15/2025, Surveyor conducted a verification visit at the facility. At 12:50 PM, Surveyor reviewed Caregiver E's employee record to verify compliance with orientation training requirements. The record for Caregiver E, hired 10/27/2025, did not contain evidence of orientation training in 2 of 6 required topics. Training was not documented for prevention and reporting of resident abuse, neglect and misappropriation of resident property, and recognizing and responding to resident changes of condition. On 12/15/2025 at 1:00 PM, Surveyor interviewed Licensee A regarding Caregiver E's missing orientation training. Licensee A reviewed Caregiver E's training documentation and verified s/he was unable to locate additional orientation training in his/her record.	{N 230}		
{N 302}	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3.	{N 302}		

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{N 302}	Continued From page 2 The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was screened for clinically apparent communicable disease, including tuberculosis (TB), by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission. This is a repeat deficiency. See Statement of Deficiency (SOD) 6XGU11, dated 08/19/2025. Findings include: On 12/15/2025, Surveyor conducted a verification visit at the facility. On 12/15/2025 at 1:00 PM, Surveyor requested Resident 1's record from Licensee A to verify compliance Resident 1 was screened for clinically apparent communicable disease including TB. The following was identified: Resident 1 admitted to the facility on 03/20/2024 and was his/her own decision maker. Resident 1's record did not contain evidence s/he was screened for clinically apparent communicable disease, including tuberculosis. On 12/15/2025 at 1:10 PM, Surveyor interviewed Licensee A who confirmed s/he did not have documentation to show Resident 1 was screened	{N 302}		

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{N 302}	Continued From page 3 for clinically apparent communicable diseases including TB. Licensee A stated s/he tried to contact Resident 1's physician previously, but did not get the information. Licensee A reported, "I will reach out again." The provider did not ensure all residents were screened within 90 days before or 7 days after admission for clinically apparent communicable diseases including tuberculosis. Cross Reference: N0343 DHS 83.32(2)(a) Explanation of Rights, Grievance Procedure	{N 302}		
{N 343}	83.32(2)(a) Explanation of rights, grievance procedure. Explanation of resident rights, grievance procedure, and house rules. Before the admission agreement is signed by the resident or the resident ' s legal representative or at the time of admission, the CBRF shall provide a copy of and explain resident rights, the grievance procedure under s. HFS 83.33 and the house rules to the person being admitted, the person ' s legal representative, and family members of the person. The resident or the resident ' s legal representative shall be asked to sign a statement to acknowledge the receipt of an explanation of resident rights. The CBRF shall document the date and to whom the information was provided. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a signed statement acknowledging the provider explained resident rights, the grievance procedure and house rules	{N 343}		

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{N 343}	Continued From page 4 to 2 of 2 residents reviewed (Resident 1 and Resident 2). Resident 1 did not have a signed statement by themselves indicating they had received an explanation of resident rights, the grievance procedure and house rules. Resident 2 did not have a signed statement by their legal representative indicating they received an explanation of the grievance procedure. This is a repeat deficiency. See Statement of Deficiency (SOD) 6XGU11, dated 08/19/2025. Findings include: On 12/15/2025, Surveyor conducted a verification visit at the facility. The provider is licensed to provide care for 8 residents with developmental and physical disabilities. On 12/15/2025 at 1:00 PM, Surveyor requested documentation from Licensee A indicating Resident 1 and Resident 2's legal representative had received an explanation of resident rights, grievance procedures and/or house rules. The following was identified: -Resident 1 admitted to the facility on 03/20/2024 and was his/her own decision maker. Surveyor was unable to locate documentation indicating resident rights, grievance procedures and house rules were explained to or signed by Resident 1. -Resident 2 admitted to the facility on 11/28/2016 and had a legal representative. Surveyor was unable to locate documentation indicating	{N 343}		

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{N 343}	Continued From page 5 grievance procedures were explained to or signed by Resident 2's legal representative. On 12/15/2025 at approximately 1:30 PM, Surveyor interviewed Licensee A who verified s/he did not have documentation showing resident rights, grievance procedures and/or house rules were explained to or signed by Resident 1 and Resident 2's legal representative. Cross Reference: N0302 DHS 83.28(4)(a) Resident Health Screening and Documentation	{N 343}		
{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 living environment that was safe, clean, comfortable and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) 6XGU11, dated 08/19/2025. Findings include: On 12/15/2025, Surveyor conducted a verification visit at the facility. On 12/15/2025 at approximately 1:45 PM,	{N 481}		

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{N 481}	Continued From page 6 Surveyor conducted a tour of the facility accompanied by Licensee A. Surveyor observed the following concerns: -The main living and 1 of 2 hallways had carpeting that was gray/blue in color. There were several areas where the carpeting was dirty and had fraying. There was a line of brown tape on the carpeted floor in front of Resident 3's room. -The dryer door handle was secured with duct tape. -Resident 1's white window blinds were broken. The window screens were dusty and had cobwebs. -Resident 4's white window blinds in his/her bedroom were broken. There were cobwebs in the windows. -The brown flooring in the kitchen near the base of the exit door was missing causing a 2-3 inch gap. -The white vent near 1 of 2 exit doors in the kitchen had brown-red spots resembling rust and was dirty. On 12/15/2025 at 2:00 PM, Surveyor interviewed Resident 1 who confirmed his/her window blinds were still broken and had not been replaced. On 12/15/2025 at approximately 2:05 PM, Surveyor interviewed Licensee A who acknowledged Surveyor's concerns. When Surveyor inquired about the brown floor missing at the base of the exit door, Licensee A stated, "That is never getting fixed. The flooring will need to be torn out and I don't have money for that."	{N 481}		

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{N 481}	Continued From page 7 Licensee A reported s/he has new blinds in his/her office and just needs to get them put up. S/he also stated s/he did not have money to repair the carpeting in the hallway. The provider did not ensure a living environment that was safe, clean, comfortable and homelike for all 6 residents.	{N 481}		
{N 639}	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 exit doors had latching hardware to permit opening from the inside with a one-hand, one-motion operation. This is a repeat deficiency. See Statement of Deficiency (SOD) 6XGU11, dated 08/19/2025. Findings include: On 12/15/2025, Surveyor conducted a verification visit at the facility. On 12/15/2025 at 1:45 PM, Surveyor conducted a tour of the facility accompanied by Licensee A. Surveyor observed 2 of 2 identified exits verified by Licensee A. Both exits had levered handles, but 1 of 2 exits located off the kitchen area did not open with a one-hand, one-motion operation. On 12/15/2025 at approximately 2:45 PM, Surveyor interviewed Licensee A who	{N 639}		

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{N 639}	Continued From page 8 acknowledged 1 of 2 exits did not open with a one-hand, one-motion operation. Licensee A reported s/he will have it replaced. The provider did not ensure 1 of 2 exit doors had latching hardware to permit opening from the inside with a one-hand, one-motion operation.	{N 639}		