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	0019196	A. BUILDING: _____ B. WING _____	C 01/07/2026

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(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 01/05/2026, with information gathered through 01/07/2026, Surveyor conducted a complaint investigation at VitaCare Living Cross Plains. Eight deficiencies were identified. One of 8 deficiencies was a repeat violation (see Statement of Deficiency (SOD) W10511). Complaint was substantiated. Census: 17	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not follow 1 of 1 resident's Individual Service Plan (ISP) as written. Resident 2 required assistance from staff to empty his/her urinal which was not provided. Findings include: On 01/05/2026, at approximately 12:30 PM, Surveyor detected a urine-like odor emanating down the resident bedroom hallway. Surveyor entered Resident 2's room and determined that his/her room had a strong urine-like scent. Surveyor observed a urinal next to Resident 2's bed approximately half full of a dark brown substance that smelled strongly of urine. Resident Care Specialist F entered the room to respond to Resident 2's call light. Resident Care Specialist F stated s/he would empty Resident 2's	N 388		

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urinal after s/he assisted him/her and made his/her bed. Surveyor exited the room.

On 01/05/2026, Surveyor reviewed Resident 2's record.

Resident 2 moved into the facility, 02/26/2025, with diagnosis including benign prostatic hyperplasia with urinary frequency.

Resident 2's ISP, dated 12/26/2025, documented: "Uses a urinal at bedtime and will need staff assistance with emptying the urinal."

Resident 2's medical "After Visit Summary," dated 01/03/2026 documented:
"We found evidence of inflammation on your CT scan and your urinalysis is consisted with urinary tract infection (UTI)."

On 01/05/2026, at approximately 1:05 PM and 2:30 PM, Surveyor observed Resident 2's room, and the urinal still had not been emptied. The urinal was still approximately 50% full.

On 01/05/2026, at approximately 2:45 PM, Surveyor interviewed Regional Director C and Assistant Executive Director D. Surveyor explained his/her observations. Regional Director C stated s/he would address the concern.

On 01/07/2026 at 11:00 AM, Surveyor interviewed Licensee A, Regional Director B, and Regional Director C. Surveyor reviewed the observation and Resident 2's ISP. Licensee A stated when a staff member enters a resident's room and observes a care that needs to be addressed, they were to complete it.

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N 426	Continued From page 2	N 426		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not provide or arrange supervision for residents of the facility who experienced behavioral needs. Staff left Resident 4 unsupervised during his/her smoke break which resulted in him/her eloping from that location. Findings include: The provider is licensed to provide cares for up to 19 residents in the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled. On 12/08/2025, the department received a concern that residents were not properly supervised which resulted in elopements. On 01/05/2026, Surveyor reviewed police records involving Resident 4 eloping from the facility which were provided by the local police	N 426		

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department. The records documented: 12/08/2025 9:20 AM - On Monday, December 8, 2025, at approximately 9:20 am, [citizen], hereinafter referred to as [citizen], contacted the police department and reported that an elderly fe/male, later identified as [Resident 4], appeared to be disorientated walking near Baer Park and asking for a ride home. [Citizen] did not believe that [Resident 4] was dressed properly for the weather conditions. It was approximately 20 degrees at the time [citizen] called us. I responded to the area and located [Resident 4] walking on Military Road headed toward Church Street. [Resident 4] appeared to be cold, s/he was shaking, and his/her face was red. [Resident 4] asked me for help getting home. [Resident 4] voluntarily got into my squad car, and I transported him/her to the Police Department. [Resident 4] appeared confused on how s/he got to Cross Plains but continually told me s/he walked. ... I contacted Vita Care and spoke to an employee, later identified as [Resident Care Specialist G], that confirmed [Resident 4] lived at Vita Care. [Resident Care Specialist G] also confirmed that s/he was not aware that [Resident 4] had walked away from Vita Care. After repeated phone call attempts, I was finally able to speak with a Vita Care supervisor, [Assistant Executive Director D]. [Assistant Executive Director D] told me s/he was enroute to the police department. I informed [Assistant Executive Director D] that I had requested the [local emergency medical services] to respond to the police department to evaluate [Resident 4], after learning from [Resident 4] that s/he had fallen on the ice after walking away from Vita Care.

On 01/05/2026, Surveyor reviewed the written reports filed by the provider with the department, which documented:

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N 426	Continued From page 4 12/08/2025 - Resident is new to community on 12/5/2025. Staff advised need supervision with smoking as is a high elopement risk. Staff was reeducated following elopement on 12/06/2025 and disciplinary action taken. Resident was found by local police department. Resident taken to police station and [Assistant Executive Director D] contacted. [Assistant Executive Director D] went to police department, resident did fall while outside and was sent by ambulance to be assessed for wrist pain (not new to resident). Returned in the evening to community with brace on right wrist for small fracture. On 01/05/2026, at approximately 11:30 AM, Surveyor arrived at the facility and observed that the facility utilized egress doors that required the Surveyor to ring a doorbell to enter the facility. On 01/05/2026, at approximately 12:30 PM, Surveyor interviewed Resident Care Specialist F. Surveyor asked for clarification on how staff knew what cares were to be provided to a new resident. Resident Care Specialist F stated in the electronic computer system there are identified tasks. Resident Care Specialist F showed Surveyor how s/he would look up a resident's task. Surveyor asked if s/he worked the day that Resident 4 had eloped from the facility on 12/08/2025. Resident Care Specialist F stated Resident 4 moved into the facility on 12/05/2025 and s/he did not work until AM shift (7:00 AM to 3:00 PM) 12/08/2025, so s/he relied on the NOC staff report and the task list. Resident Care Specialist F stated, "The NOC shift told us that [Resident 4] did not need to be supervised during smoke breaks." On 01/05/2026, Surveyor reviewed Resident 4's record.	N 426		

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N 426	Continued From page 5 Resident 4 moved into the facility 12/05/2025. Resident 4's "Admission Assessment," dated 12/09/2025, completed in person by Assistant Executive Director D, documented: "Resident is a high Elopement Risk." "Elopement History: Has not eloped but has history of wandering in apartment complex. Knocking on other residents' doors. Delusions that family lives in apartment complex." The pre-admission assessment was completed 4 days after resident had moved in. Resident 4's "Master Care Plan," dated 12/09/2025, documented: "Social and Cognitive - Pattern of Wandering: Elopements on 12/06/2025 and 12/08/2025. Needs constant supervision, and supervision with smoking. Cannot be left alone outside." "Fall Risk Summary - 24 hours of supervision with 24-hour awake care staff." The "Master Care Plan" which was utilized as Resident 4's individualized service plan (ISP) was completed 4 days after resident moved in. Resident 4 did not have a temporary ISP upon admission. Resident 4's "Service Notes" documented: 12/05/2025 4:54 PM - Written by Assistant Executive Director D - Upon resident arrival, s/he seems to be very agitated due to new environment, until residence [sic: resident] get adjustment [sic: adjusted] to the facility, [Resident 4] is to be accompany [sic: accompanied] when going out to smoke. 12/06/2025 7:00 AM - Written by Resident Care Specialist H - Resident has tried to elope a	N 426		

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couple times today, s/he's very confused and feels like s/he needs to leave the building staff has tried to redirect him/her a couple of times but s/he still refuses to listen, resident got out the building this morning and got into another person care [sic: car], and they called the facility to let us know s/he was in their care and they would bring him/her back right away. ... then resident tried to elope again staff was right behind him/her trying to get him/her to come back in the building ...
12/06/2025 10:11 AM - Written by Resident Care Specialist G - This morning the resident tried to exit out of the front door 4 different times. I told him/her if s/he gives me a moment I could take him/her out and sit with him/her for a little but that I can't allow him/her to go outside alone. I took him/her outside for a cigarette and s/he kept walking further away from the property. I told him/her that s/he could be out but had to stan on the property ... s/he finally turned around but was agitated asking why am I telling him/her what to do and that s/he can be out alone.
12/06/2025 10:35 AM - Written by Resident Care Specialist I - The resident is walking around to every door in the facility attempting to leave. I told him/her that the doors are locked and we can't leave at the moment s/he said that s/he will try every door until we let him/her out. S/he leaned on the door near [room number] until it opened and exited the facility. Once outside s/he asked the [individual] salting the driveway if s/he could give him/her a ride home.
12/06/2025 1:37 PM - Written by Assistant Executive Director D - Writer received a call around 9:59 AM reporting that [Resident 4] has exit out of the facility. Staff reported that [daughter/son] called the facility stating that [Resident 4] is in the car with a stranger and s/he's on his/her way back to the facility. ... Staff reported [Resident 4] was out of the facility for 20

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to 25 minutes.
12/08/2025 9:29 AM - Written by Resident Care Specialist F - Staff members were told by NOC (evening) that the resident was allowed to go outside and smoke with no further instructions.

Resident 4's incident reports documented:
12/06/2025 10:00 AM - 9:55 AM the resident's [daughter/son] called to let us know that [Resident 4] was in a car heading to [store]. When the resident arrived, I spoke to the person that dropped him/her back off and s/he stated that s/he found him/her wandering right outside the facility near the streets. S/he said s/he asked for a ride in which s/he had no problem giving him/her one. S/he said there [sic: they were] heading towards [store] when s/he started to be able to tell that something wasn't right.

12/08/2025 9:00 AM - Reported missing from phone call around 9:30 AM, [Resident 4] last seen at 8:30 AM in dining room having breakfast. Cops called saying they had found resident.

On 01/05/2026, at approximately 2:00 PM, Surveyor interviewed Regional Director C and Licensed Practical Nurse E. Surveyor asked for clarification on how Resident 4 was able to elope from the facility on 12/06/2025 and 12/08/2025 and staff did not know s/he had left the building. Regional Director C stated there was a breakdown in communication between staff and a staff member had opened the door for Resident 4 to exit, so s/he could smoke, and they had not supervised him/her during the smoke break. Licensed Practical Nurse E stated the electronic computer system was updated upon admittance stating s/he was an elopement risk. Surveyor noted the pre-admission assessment, and the care plan were dated 12/09/2025, which identified

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N 426	Continued From page 8 s/he was an elopement risk, after s/he eloped from the facility. Regional Director C referenced Resident 4's service notes where Assistant Executive Director D documented on 12/05/2025 that Resident 4 was an elopement risk and was to be supervised during smoke breaks. Regional Director C was unable to explain if service notes updated the task list that staff members were to follow. On 01/07/2026 at 11:00 AM, Surveyor interviewed Licensee A, Regional Director B, and Regional Director C. Surveyor discussed the concerns that Resident 4 was able to elope from the building on 12/06/2025 and 12/08/2025. Licensee A stated that staff did not communicate effectively to ensure the safety of the residents and staff members were written up for the incidents.	N 426		
N 431	83.38(1)(g) Health monitoring. 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	N 431		

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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 observation, record review and interview, the provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) was reviewed when s/he experienced a change of condition.

Resident 2's ISP was not updated to include guidelines for staff to monitor his/her oxygen levels.

Findings include:

The provider is licensed to provide cares for up to 19 residents in the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.

On 01/05/2026, at approximately 2:30 PM, Surveyor entered Resident 2's bedroom and observed him/her utilizing oxygen. Surveyor observed an oxygen concentrator which was set at 3 liters (L).

On 01/05/2026, Surveyor reviewed Resident 2's record.

Resident 2 admitted to the facility, 02/26/2025, with diagnosis including chronic obstructive

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pulmonary disease (COPD). Resident 2 was represented by Guardian J.

Resident 2's individual service plan (ISP), dated 12/26/2025, documented:
"Respiratory Equipment: Needs assistance with oxygen. [Resident 2] is to wear 2 L of nasal cannula during the daytime continuously for oxygen saturation. [Resident 2] is on oxygen 4 L by nasal cannula at night for COPD. Staff will assist and make sure that [Resident 2] has this on at bedtime."

Resident 2's oxygen orders documented:
08/21/2025 - [Resident 2] is oxygen 4 L by nasal canula at night for COPD. Staff are to assist [Resident 2] to make sure that this is on at bedtime.
10/02/2025 - [Resident 2] has order that [s/he] is to have 2-4 L on nasal cannula continuous for oxygen saturation. S/he is to have 2 L during the daytime and 4 L during the night.

On 01/05/2026, at approximately 2:00 PM, Surveyor interviewed Regional Director C and Licensed Practical Nurse E. Surveyor asked for clarification on how staff monitored Resident 2 to determine what oxygen level should be set on his/her oxygen concentrator. Licensed Practical Nurse E stated that this was an assisted living facility, not a skilled nursing facility, and staff were not required to monitor resident oxygen levels. Licensed Practical Nurse E stated that Resident 2 could independently adjust his/her oxygen levels. Surveyor commented that Resident 2's ISP documented that s/he was to utilize oxygen continuously, but Surveyor observed Resident 2 not wearing his/her oxygen during lunch. Licensed Practical Nurse E stated that Resident 2 was noncompliant with his/her oxygen use.

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N 431	Continued From page 11 Surveyor reviewed Resident 2's ISP with Regional Director C and Licensed Practical Nurse E and stated the ISP did not identify that Resident 2 was noncompliant with oxygen use and did not provide guidelines for staff on how to properly monitor oxygen levels, so they could determine what oxygen level between 2 - 4 L should be utilized. Regional Director C stated the ISP would be updated accordingly. On 01/07/2026 at 11:00 AM, Surveyor interviewed Licensee A, Regional Director B, and Regional Director C. Surveyor discussed the concerns regarding the monitoring of Resident 2's oxygen levels. Licensee A stated that all resident health monitoring would be provided by staff.	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. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident received appropriate medication administration.	N 432		

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Resident 2 was prescribed Trelegy Ellipta (inhaler) and two inhalers were being used during the same timeframe and staff were unable to determine which inhaler should be utilized and if Resident 2 had received the correct dosage.

Findings include:

On 01/05/2026, at approximately 12:30 PM, Surveyor observed Resident 2's Trelegy Ellipta inhaler, with an open date of 12/31/2025, with 27 of 30 remaining doses, lying on the floor, near his/her nightstand.

On 01/05/2026, at approximately 3:00 PM, Surveyor and Assistant Executive Director D reviewed Resident 2's medications in the med cart. Surveyor observed another Trelegy Ellipta inhaler, with an open date of 12/22/2025, with 16 of 30 remaining doses. Surveyor asked Assistant Executive Director D which inhaler was being utilized and did Resident 2 have a bedside order for the inhaler. Assistant Executive Director D asked Resident Care Specialist F to follow up on the inhaler concern. Resident Care Specialist F went to Resident 2's room and returned with the inhaler that Surveyor had seen earlier. Resident Care Specialist F stated s/he had taken the inhaler into Resident 2's room.

On 01/05/2026, at approximately 3:20 PM, Surveyor interviewed Regional Director C and Licensed Practical Nurse E. Surveyor stated that based on the two inhalers, one with 16 remaining doses and one with 27 remaining doses, that would mean 17 doses had been administered but only 15 days had passed since 12/22/2025. Regional Director C stated that Resident 2 could self-administer the medication him/herself, but staff needed to observe him/her during

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administration to ensure that s/he completed the process correctly. Regional Director C stated, since the inhaler was left in his/her room, staff did not observe Resident 2 administer the medication.

On 01/07/2026, Surveyor reviewed Resident 2's record.

Resident 2 admitted to the facility, 02/26/2025, with diagnosis including chronic obstructive pulmonary disease (COPD).

Resident 2's Medication Administration Records (MAR), dated 12/22/2025 to 01/05/2026, documented:
Trelegy Ellipta 200-62.5-25 MCG (micrograms) daily - self-administer - Inhale 1 puff by mouth once daily for COPD.
The MAR documented the medication had been administered as prescribed.

"Use TRELEGY exactly as your healthcare provider tells you to use it. Do not use TRELEGY more often than prescribed. Use 1 inhalation of TRELEGY 1 time each day. Use TRELEGY at the same time each day. If you miss a dose of TRELEGY, take it as soon as you remember. Do not take more than 1 inhalation per day. Take your next dose at your usual time. Do not take 2 doses at 1 time. If you take too much TRELEGY, call your healthcare provider or go to the nearest hospital emergency room right away if you have any unusual symptoms, such as worsening shortness of breath, chest pain, increased heart rate, or shakiness." "Your inhaler contains 30 doses (14 doses if you have a sample or institutional pack). Write the "Tray opened" and "Discard" dates on the inhaler label. The "Discard" date is 6 weeks from the date you open

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N 432	Continued From page 14 the tray. Before the inhaler is used for the first time, the counter should show the number 30 (14 if you have a sample or institutional pack). This is the number of doses in the inhaler." (Source: Trelegy website, Things to know about Trelegy, July 2023, https://www.trelegyhcp.com), (retrieval date - July 23, 2025).)	N 432		
N 444	83.40 Oxygen storage. Oxygen storage. Oxygen storage shall be in an area that is well ventilated and safe from environmental hazards, tampering, or the chance of accidental damage to the valve stem. If oxygen cylinders are in use, oxygen cylinders shall be secured in an upright position. If stored upright, cylinders must be secured. If stored horizontally, cylinders shall be on a level surface where they will remain stationary. This Rule is not met as evidenced by: Based on observation and interview, the provider did not store oxygen cylinders in a way that ensured they were safe from environmental hazards, tampering or the chance of accidental damage to the valve. Surveyor observed 5 cylinders of oxygen not properly stored. Findings include: On 01/05/2026, at approximately 11:40 AM, Surveyor toured the facility and observed in the hallway, near the exit door and resident bedroom 6, 5 oxygen tanks. Two of the tanks were in a secure holder. On 01/05/2026, at approximately 11:50 AM, Assistant Executive Director D noted Surveyor had observed the oxygen tanks. Assistant	N 444		

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N 444	Continued From page 15 Executive Director D stated s/he was in the process of moving the oxygen tanks. On 01/05/2026, at approximately 12:25 PM, Surveyor observed the oxygen tanks had been moved to a hallway that was across from the office doors. Surveyor observed residents ambulating consistently past the unsecured oxygen tanks. On 01/05/2026, at approximately 12:30 PM, Surveyor observed an oxygen tank that was not securely stored in Resident 2's room. There was a black material device hanging over it and Surveyor could see oxygen tubing draped away from it. On 01/05/2026, Surveyor reviewed Resident 2's record. Resident 2 admitted to the facility, 02/26/2025, with diagnosis including chronic obstructive pulmonary disease (COPD). Resident 2's oxygen management documentation, dated 08/21/2025, documented: "Ensure portable tanks are being stored properly." On 01/05/2026, at approximately 3:20 PM, Surveyor interviewed Regional Director C and Licensed Practical Nurse E. Surveyor discussed his/her observation of the oxygen tanks. Regional Director C stated the oxygen tanks should have been stored in the medication room and s/he would ensure Resident 2's oxygen tank had a proper stand.	N 444		
N 598	83.54(1)(d) Bedrooms: closet, drawer, adequate space.	N 598		

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N 598	Continued From page 16 Each resident shall have or be provided within the bedroom, a closet or wardrobe with clothes hanging rods and shelves, and drawer space adequate to reasonably meet the needs of the resident. The bedroom shall have adequate accessible space for a resident ' s wheelchair or other adaptive or prosthetic equipment. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) had adequate accessible space for his/her wheelchair to enter and exit his/her bedroom. Findings include: On 01/05/2026, at approximately 1:10 PM, Surveyor observed Resident 1 in his/her apartment and walked in to interview him/her. Resident 1 was in the process of repairing the electronic component of his/her wheelchair. Resident 1 voiced concerns to Surveyor that s/he was not able to easily access his/her bedroom when utilizing his/her electric wheelchair. Resident 1 stated, "My wheelchair is my lifeline, especially on days I feel I don't have any strength." Surveyor observed the doorway to Resident 1's bedroom. The door had numerous holes and scrapes on it and the door trim was off, leaning against a corner wall. The doorway consisted of a 32 inch clearance but only had approximately 39 ½ inches clearance before Resident 1 was required to make a 90 degree turn to enter the bedroom. Surveyor measured Resident 1's wheelchair that was approximately 29 inches wide and 63 inches long with the foot pedals. Resident 1 stated s/he usually would try to walk if s/he needed to utilize his/her room.	N 598		

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Resident 1 stated, "I normally sleep in my recliner chair that is in the main area, and I have my dresser out in the main area."

On 01/05/2026, Surveyor reviewed Resident 1's record.

Resident 1 admitted into the facility 05/22/2025 with diagnoses including amputation of foot through metatarsal bone and chronic pain.

Resident 1's individualized service plan, dated 12/26/2025, documented:
"Mobility - Ambulation - Independent - no assistance needed with ambulation - Note: Able to ambulate safely without assistance by staff. Needs an assistive device to ambulate - Walker."
"Mobility - Wheelchair - Uses scooter for longer distances and appointments."

On 01/05/2026, at approximately 2:00 PM, Surveyor interviewed Assistant Executive Director D. Surveyor explained why s/he had taken pictures of Resident 1's bedroom doorway. Assistant Executive Director D stated Resident 1 did not utilize his/her bedroom often and could walk into his/her bedroom if needed.

On 01/05/2026, at approximately 2:15 PM, Surveyor observed Resident 1 in his/her electric wheelchair, utilizing the foot pedals, leaving his/her bedroom and entering the common area. Resident 1 informed Surveyor s/he had fixed the control device on the wheelchair.

On 01/07/2026 at 11:00 AM, Surveyor interviewed Licensee A, Regional Director B, and Regional Director C. Surveyor explained his/her observation. Regional Director C stated that apartment should be utilized by resident's who

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N 598	Continued From page 18 are ambulatory or only utilize a walker, versus a wheelchair. Regional Director C explained that although Resident 1 could walk short distances, the bedroom needed to be accessible if s/he had utilized his/her wheelchair.	N 598		
N 636	83.59(1)(f) Exit passageways, stairways: width maintained All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit passageways and stairways to outside exits shall be at least 36 inches in width and maintained clear and unobstructed at all times. Exit passageways and stairways to outside exits shall be at least 32 inches in width in facilities licensed on or before the effective date of this section. In existing large facilities, the minimum corridor width shall be at least 4 feet. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 of 5 exits to/from the facility were unobstructed which would hinder the ability for residents to exit the facility in an emergency situation. Findings include: On 01/05/2026, at approximately 11:45 AM, Surveyor toured the facility. Surveyor observed a bedframe sitting in front of a designated exit near Room 6, blocking the exit from use. On 01/05/2026, at approximately 12:15 PM, Assistant Executive Director D approached	N 636		

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N 636	Continued From page 19 Surveyor and stated that s/he understood the bedframe needed to be moved, but a resident had moved in on Friday and his/her items were still being moved around. On 01/05/2026, at approximately 1:45 PM, Surveyor interviewed Regional Director C. Surveyor discussed his/her observation. Regional Director C stated that Assistant Executive Director D had approached her/him and informed him/her of the concern and that the concern would be addressed. Surveyor exited the facility at approximately 3:30 PM, and the bedframe was still blocking the exit. Cross Reference: N0444 83.40 Oxygen Storage	N 636		
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.	Y3234		

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality.

This is a repeat deficiency. See Statement of Deficiency (SOD) W10511, dated 07/15/2025.

Resident 2 was not dressed in appropriate clothing.
Resident 3 did not have proper foot attire when ambulating throughout the common area.

Findings include:

The provider is licensed to provide cares for up to 19 residents in the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.

Example 1: Resident 1

On 01/05/2026, at approximately 11:30AM, Surveyor entered the facility and observed Resident 2 in his/her electric wheelchair approaching the entrance. His/Her shirt was above his/her belly, causing him/her exposure. Surveyor spoke with Resident 2 who stated s/he was getting ready for lunch. Resident 2 stated s/he would like to speak with Surveyor after lunch.

On 01/05/2026, at approximately 12:30 PM, Surveyor interviewed Resident 2 in his/her bedroom. Resident Care Specialist F entered the room shortly after Surveyor walked in and asked Resident 2 how s/he could assist him/her and

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turned off his/her call light. Resident Care Specialist F stated, "[Resident 2], your shirt won't stay down, this shirt is too small, who picked this shirt out for you, would you like to put on a different shirt." Resident 2 stated, "Yes, I would, if that is possible. I don't know why I was dressed in this shirt." Surveyor exited the room.

On 01/05/2026, Surveyor reviewed Resident 2's record.

Resident 2 admitted to the facility 02/26/2025.

Resident 2's individualized service plan (ISP), dated 12/26/2025, documented:
"Dressing Needs: Needs moderate assistance to dress and/or undress. Staff help to choose appropriate clothes. Staff provide physical assist with dressing and undressing."

On 01/05/2026, at approximately 2:40 PM, Surveyor interviewed Regional Director C. Surveyor discussed his/her observations of Resident 2. Regional Director C stated the concern would be discussed with staff.

Example 2: Resident 3

On 01/05/2026, at approximately 11:45AM, Surveyor toured the facility and observed Resident 3 ambulating throughout the common area with one shoe on and one shoe off, leaving one foot bare. Surveyor observed Resident 3 move about the common area and heard Resident Care Specialist F calling Resident 3 to the dining room for the noon meal. Resident 3 continued to walk around the common area, appearing to be in a confused state. Resident 3 approached Surveyor and asked where s/he was and what was s/he to do. Surveyor stated, "It

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sounds like it is lunch time." Resident 3 slowly made his/her way to the dining area. Surveyor looked around the common area to determine if Resident 3 had taken his/her shoe off while in the area. The shoe was not located.

On 01/05/2026, at approximately 12:00 PM, Resident Care Specialist F assisted Resident 3 to a table for the noon meal. Resident Care Specialist F did not address Resident 3's current state.

On 01/05/2026, at approximately 12:30 PM, Resident 3 approached Surveyor as s/he was leaving the dining area, still missing a shoe. Assistant Executive Director D walked up to Surveyor and noticed that Resident 3 did not have his/her shoe on. Executive Director D asked Resident 3 if s/he would like to put his/her other shoe on. Resident 3 replied, "Yes, I would. How can we do that?"

On 01/05/2026, at approximatley 1:15 PM, Surveyor interviewed Resident Care Specialist F. Surveyor asked if s/he had noticed that Resident 3 only had one shoe on when s/he seated him/her for lunch. Resident Care Specialist F stated, "Honestly, I don't remember. I am just one person trying to prepare lunch, service lunch and get all the resident's seated. I should have noticed and I take responsiblity for that."

On 01/05/2026, Surveyor reviewed Resident 3's record.

Resident 3 admitted to the facility, 07/01/2025, with diagnoses including neurocognitive disorder with Lewy bodies and fall risk.

Resident 3's ISP, dated 12/26/2025, documented:

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Y3234	Continued From page 23 "ADL (activities of daily living) Needs - Dressing Needs: Needs minimal assistance to dress and/or undress. Staff assist to choose appropriate clothes for the weather. Staff to assist with lower half dressing." "ADL Needs - Mobility - Ambulation: Able to ambulate safely without assistance by staff. Needs an assistive device to ambulate - Cane." On 01/05/2026, at approximately 2:40 PM, Surveyor interviewed Regional Director C. Surveyor discussed his/her observations of Resident 3. Regional Director C stated the concern would be discussed with staff. On 01/07/2026 at 11:00 AM, Surveyor interviewed Licensee A, Regional Director B, and Regional Director C. Surveyor reviewed the observations of Resident 2 and Resident 3. Licensee A stated the concerns were unacceptable and staff need to provide better cares for the residents and this would be addressed.	Y3234		