STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019630	A. BUILDING: _____ B. WING _____	R-C 10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VIEW	10507 S CHICAGO ROAD OAK CREEK, WI 53154

(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 09/18/2025 with information gathered through 10/03/2025, Surveyor conducted a standard survey, two complaint investigations, and a verification visit for SOD 8VXY11, dated 04/21/2025, at Country View, a Community-Based Residential Facility (CBRF) in Oak Creek, WI. Nine deficiencies were identified. One of the 9 deficiencies was a repeat deficiency from Statement of Deficiency 8VWY11, dated 04/21/2025. Two of 2 complaints substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 50	{N 000}		
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 observations, record review, and interview, the licensee did not ensure that the provider and its operation were compliant with all laws governing a community based residential facility. As a result of the verification visit, 9 deficiencies were identified. One of the 9 deficiencies was a repeat deficiency. The provider did not implement all special orders identified in Statement of Deficiency (SOD) 8VWY11 received by Licensee A on 06/09/2025.	N 196		

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

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N 196	Continued From page 1 Findings include: On 09/18/2025, Surveyor reviewed Department records and identified on 06/09/2025, SOD 8VWY11 and a Notice and Order Letter containing special orders were issued to Administrator A via email with the following: "Based on the results of the Department ' s investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Country View: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., 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 45 DAYS of receipt of this notice, the licensee will develop and implement corrective measures to address the health monitoring deficiency identified in Statement of Deficiency 8VWY11. All managers and resident care staff with responsibilities for medication administration and management will receive inservice training regarding the provider's corrective measures. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training." On 09/18/2025 with information gathered through 10/03/2025, Surveyor conducted a complaint investigation, and verification visit for SOD	N 196		

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N 196	Continued From page 2 8VXY11, dated 04/21/2025, at County View. As a result of the survey, the provider was issued 9 deficiencies. One of the 9 was a repeat deficiency. The following 9 deficiencies, which includes this violation, were identified: N 196 83.14(2)(a) Licensee Ensures Facility Complies with Laws N 381 83.35(1)(a) - Pre-Admission And Ongoing Assessments - This is a repeat deficiency. N 387 83.35(3)(b) - Service Plan Development: Parties Involved N 392 83.35(4) - Resident Satisfaction Evaluation N 397 83.36(1)(b) - Qualified Staff In Charge On Duty And Awake N 481 83.43(1) - Environment Safe, Clean, And Comfortable N 499 83.45(3) - Toxic Substances N 504 83.46(1)(c) - Heating System Maintenance N 640 83.59(2)(b) - Solid Core Wood Doors Or Equivalent On 09/18/2025, at approximately 4:49 PM, Surveyor reviewed the facility's inservice training documentation regarding the provider's corrective measures. The following was identified: -On 06/13/2025 all management were re-educated on facility policy regarding timely updating of care plans and any change in condition. Resident care staff with responsibilities for medication administration and management did not receive inservice training regarding the provider's corrective measures. On 09/18/2025, at approximately 4:49 PM, Surveyor interviewed Administrator A and confirmed receipt of SOD 8VWY11 and the	N 196		

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N 196	Continued From page 3 accompanying Notice and Order Letter. Administrator A confirmed resident care staff with responsibilities for medication administration and management did not receive inservice training regarding the provider's corrective measures.	N 196		
{N 381}	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 3 and Resident 5) were assessed after falls. Resident 3 had falls on 07/28/2025, 08/28/2025, and 09/16/2025 and was not assessed. Resident 5 had falls on 02/04/2025 and 08/23/2025 and was not assessed. This is a repeat deficiency. See Statement of Deficiency 8VWY11, dated 04/21/2025. Findings include: On 09/18/2025, Surveyor reviewed resident	{N 381}		

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{N 381}	Continued From page 4 records and identified the following: Resident 3 -Resident 3 was admitted to the provider's home on 06/03/2024. -Resident 3's incident report, dated 07/28/2025, stated the following: "Staff observed [Resident 3] laying on [his/her] back in [his/her] room. [Resident 3] stated that [his/her] back hurt a little, but [s/he] was ok. [Resident 3] stated [s/he] went to grab [his/her] coffee and over corrected [his/her] fall backwards onto [his/her] back. Staff was able to assist [Resident 3] up. Vitals were taken twice. Second [blood pressure] in normal range. All parties notified." -Resident 3's incident report, dated 08/28/2025, stated the following: "[Resident 3] was on [his/her] way to dinner and stopped at the chairs by the [medication cart] to receive [his/her] insulin before eating. [Resident 3] went to sit down on chair and missed the edge of the seat and landed on [his/her] bottom. Staff observed this and was able to help [him/her] up immediately. [Resident 3] did not sustain any injury. Vitals were taken. All parties notified." -Resident 3's incident report, dated 09/16/2025, stated the following: "[Resident 3] came to staff early in the morning. When [Resident 3] came downstairs staff observed that both [Resident 3's] knees were bleeding. [Resident 3] stated that [s/he] fell early that morning but got [him/herself] up and was not in pain so went back to bed. Staff took vitals and gave [Resident 3] [bandages] for [his/her] knees after they were cleansed. [Resident 3] has been monitored. No changes. All parties notified."	{N 381}		

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{N 381}	Continued From page 5 Resident 3's record did not contain any evidence of assessments completed for Resident 3 after either of the 3 falls. Resident 5 -Resident 5 was admitted to the provider's home on 10/18/2018. -Resident 5's incident report, dated 02/04/2025, stated the following: "[Resident 5] fell out of [his/her] wheelchair in the bathroom today. [S/he] had unbuckled [his/her] seatbelt and was trying to use the bathroom [himself]. However, [s/he] leaned too far onto the right arm rest and it pushed down and [s/he] fell out of [his/her] chair. Medics were called because [s/he] landed on [his/her] head. Medics helped [Resident 5] back into [his/her] chair and we gave [him/her] an ice pack for the bruising on [his/her] head. Medics did not think [s/he] needed to go out for future evaluation due to [his/her] vitals being stable." -Resident 5's incident report, dated 08/23/2025, stated the following: "[Resident 5] was observed by staff lying on the floor on the left side of [his/her] body. [Resident 5] had been reaching for [his/her] remote instead of calling for help and fell out of [his/her] broda chair. Staff was able to assist [Resident 5] back into [his/her] chair. [Resident 5] did not sustain injuries. Hospice was notified. All parties contacted." Resident 5's record did not contain any evidence of assessments completed for Resident 5 after either of the 2 falls. On 09/23/2025, at approximately 5:30 PM, Surveyor interviewed Administrator A. Administrator reported s/he was responsible for assessments. Administrator A confirmed there	{N 381}		

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{N 381}	Continued From page 6 were no assessments completed after each of the above falls for Resident 3 and Resident 5.	{N 381}		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 3 of 3 resident's record reviewed (Resident 2, Resident 3, and Resident 6). Findings include:	N 387		

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N 387	Continued From page 7 On 09/18/2025, surveyor reviewed resident records and identified the following: Resident 2 -Resident 2 was admitted to the facility on 01/30/2024. -Resident 2 was his/her own person. -Resident 2's ISP, dated 07/03/2025, was not signed or dated by Resident 2. Resident 3 -Resident 3 was admitted to the facility on 06/03/2024. -Resident 3 was his/her own person. -Resident 3's ISP, dated 08/05/2025, was not signed or dated by Resident 3. Resident 6 -Resident 6 was admitted to the facility on 12/01/2021. -Resident 6 had an activated healthcare power of attorney. -Resident 6's ISP, dated 04/20/2025, was not signed or dated by his/her activated healthcare power of attorney. On 09/23/2025, at approximately 5:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed Resident 2's and Resident 3's ISPs were not signed or dated by them. Administrator A confirmed Resident 6's ISP was not signed or dated by his/her activated healthcare power of attorney. Administrator A reported s/he did not follow-up with appropriate parties to obtain signatures.	N 387		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the	N 392		

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N 392	Continued From page 8 CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide 3 of 4 residents reviewed (Resident 2, Resident 3, and Resident 4) and/or their legal representatives, an opportunity to complete an evaluation of the resident's level of satisfaction within the community-based residential facility (CBRF) services. Findings include: On 09/18/2025, Surveyor reviewed resident records and identified the following: Resident 2 -Resident 2 was admitted to the facility on 01/30/2024. -Resident 2 was his/her own person. -Resident 2's record showed the last satisfaction survey was dated 02/29/2024. -Resident 2's record did not contain evidence of an annual satisfaction survey provided for calendar year 2025. Resident 3 -Resident 3 was admitted to the facility on 06/03/2024. -Resident 3 was his/her own person. -Resident 3's record showed the last satisfaction survey was dated 07/03/2024. -Resident 3's record did not contain evidence of an annual satisfaction survey provided for	N 392		

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N 392	Continued From page 9 calendar year 2025. Resident 4 -Resident 4 was admitted to the facility on 06/11/2019. -Resident 4 had an activated healthcare power of attorney. -Resident 4's record showed the last satisfaction survey was dated 07/11/2024. -Resident 4's record did not contain evidence of an annual satisfaction survey provided for calendar year 2025. On 09/23/2025, at approximately 12:18 PM, Surveyor interviewed Administrator A. Administrator A confirmed resident records did not contain evidence of an annual satisfaction survey provided for calendar year 2025.	N 392		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally	N 397		

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upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at least one qualified resident care staff was on duty and awake if at least one resident in the community-based residential facility (CBRF) is in need of supervision, intervention or services on a 24-hour basis to prevent, control, or improve the resident's constant or intermittent mental or physical condition that may occur, including residents who have unstable health conditions that required close monitoring.

Caregiver D and Caregiver E, the only caregivers on duty, were discovered to be sleeping during 3rd shift on 08/29/2025.

Findings include:

On 08/29/2025, the Department received a complaint regarding an incident that occurred on 08/29/2025 alleging caregivers had been sleeping on the job.

The facility is licensed as a Class CNA (non-ambulatory) CBRF for up to 50 residents with programs in advanced aged, emotionally disturbed/mental illness, and irreversible dementia/Alzheimer's.

On 09/25/2025, Surveyor reviewed Oak Creek Police Department (OCPD) incident report, dated 08/29/2025 at 1:23 AM, stated the following: "On

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August 29, 2025, [OCPD officer] was dispatched to [this facility] for a resident [Resident 2] calling 911 reporting [s/he] has been hitting [his/her] help button and nobody has [sic] to help [him/her]. Upon [OCPD officer] arrival, [s/he] walked through the main entrance of the facility, which was fully unlocked and noticed almost all of the lights on the first floor were turned off. [OCPD officer] had to use [his/her] flashlight to navigate through the building. It should be noted there was an elderly male sitting on a bench, in the dark with a walker. There was no way [s/he] would have been able to walk without a flashlight due to the level of light in the hallway. [OCPD officer] looked around the first floor and did not locate any staff. [OCPD officer] made [his/her] way to the second floor, there was slightly more lights on but, [OCPD officer] still needed to use [his/her] flashlight to navigate down the hallway. [OCPD officer] did not locate any staff while [s/he] made [his/her] way to [Resident 2's] room.

[OCPD officer] knocked on [Resident 2's] bedroom door and spoke with [Resident 2]. [Resident 2] stated [s/he] has been hitting [his/her] emergency help button and no one has come to help [him/her]. [OCPD officer] asked [Resident 2] when [s/he] last saw a staff member and [s/he] replied that it had been a long time, over an hour. [OCPD officer] informed [Resident 2] that Oak Creek Fire Department (OCFD) was on the way to help [him/her]. [Resident 2] stated that [s/he] did not need the fire department and all [s/he] wanted was a staff member to help [him/her] change [his/her] colostomy bag. [Resident 2] refused help from OCFD.

[OCPD officer] left [Resident 2's] bedroom and continued to search the building for a staff member. [OCPD officer] eventually located a staff

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member on the first floor in the activity room who was laying on a couch with a blanket and pillow who appeared to be sleeping. [OCPD officer] shined [his/her] light on [him/her] to where [s/he] sat up and asked what was going on. This individual was identified as [Caregiver D]. [Caregiver D] stated that [s/he] was just laying down and was not aware of any emergencies going on. [OCPD officer] informed [Caregiver D] that [Resident 2] had called 911 due to [him/her] hitting [his/her] help button and no one had come to help [him/her]. [Caregiver D] got upset by this and stated that [Resident 2] is just trying to get [him/her] in trouble. [Caregiver D] stated [s/he] just checked on all residents and everyone was fine, but [s/he] did not have a pager on [him/her] person and stated [his/her] co-worker had the pager.

[Caregiver D] pointed out where [his/her] co-worker was, who was down the hall. [OCPD officer] approached this individual who was later identified as [Caregiver E], who was on another couch with a blanket who also appeared to be sleeping. [OCPD officer] asked both [Caregiver D] and [Caregiver E] why they were sleeping and they stated they were on their break. While speaking with [Caregiver E], [OCPD officer] noticed [s/he] had a pager on [his/her] person which was actively beeping and vibrating, which [s/he] kept muting and placing back into [his/her] pocket. Both [Caregiver D] and [Caregiver E] appeared to be agitated with [Resident 2] calling stating [s/he] is just trying to cause problems. [Caregiver E] stated neither [him/her] or [Caregiver D] can help [Resident 2] with [his/her] colostomy bag because they are not certified to do that.

[Caregiver D] and [Caregiver E] stated they would

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COUNTRY VIEW	10507 S CHICAGO ROAD OAK CREEK, WI 53154

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N 397	Continued From page 13	N 397		

go to [Resident 2's] room and assist [him/her] in any way that they can help. [OCPD officer] advised both [Caregiver D] and [Caregiver E] about the complaint. It would appear from [OCPD officer] observations that [Caregiver D] and [Caregiver E] were not actively caring for any of the residents at the time [OCPD officer] was present.

During [OCPD officer] interaction with [Caregiver D], [s/he] stated that [s/he] is done with this place and said [s/he] is going to quit tomorrow.

[OCPD officer] exited the facility and began to put in [his/her] update in the parking lot of the facility. Right before clearing the call, dispatch informed [OCPD officer] that [Resident 2] was calling 911 again, informing that staff still did not come in to help [him/her]. [OCPD officer] made [his/her] way back inside the facility and noticed that all of the lights on the first floor were now on. [OCPD officer] struggled to find either [Caregiver D] and [Caregiver E] until [s/he] finally located them coming out of a back room on the first floor. Again [Caregiver D] and [Caregiver E] appeared irritated and agitated that [Resident 2] had called again. [Caregiver D] and [Caregiver E] informed [OCDP officer] that they were going up to [his/her] room right now to help [him/her].

On 08/29/2025, at approximately 11:30 PM, [OCPD officer] spoke with [Administrator A] via phone, who wanted to know more about the incident. [OCPD officer] informed [Administrator A] of everything that occurred, in which [s/he] is opening an investigation for the incident that occurred. [Administrator A] was given [OCPD officer] information, along with the report number and informed [s/he] could file an open records request to get this report that documents what

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N 397	Continued From page 14 occurred." On 09/18/2025, Surveyor reviewed facility internal investigation report, dated 09/02/2025, stated the following: Summary of Incident "On August 29, 2025, at approximately 2:00 AM, [Administrator A] received a call from [Resident 2] stating that [s/he] had been paging for staff assistance for over an hour with no response and had consequently called the Oak Creek Police Department. [Resident 2] reported that [s/he] had a medical issue involving [his/her] colostomy bag and required assistance retrieving supplies stored under her bed. [Administrator A] then seen a text received at 1:58 AM from [Caregiver D], stating that police had been called. [Administrator A]contacted [Caregiver D], who confirmed that police had arrived and cleared the call after speaking with both employees and [Resident 2]. Upon arriving at the facility later that morning, [Administrator A], along with [House Manager C], initiated an internal investigation." "Surveillance Footage Review 10:12 PM: [Caregiver D] and [Caregiver E] arrived to work. 1:16 AM: [Caregiver D] seen clearing the front door sensor; appears disoriented, possibly freshly awakened. 1:28 AM: Police arrive. 1:30 AM: Paramedics arrive. 1:36 AM: Paramedics depart. 1:48 AM: Police exit. 1:58 AM: Officer re-enters following [Resident 2's] second 911 call. 2:00 AM: Officer exits after verifying [Resident 2] received care."	N 397		

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N 397	Continued From page 15 "Findings -After reviewing the Pal Care Call System, [Resident 2's] pendant page went unanswered for at least 26 minutes before police were called. [Resident 2] first pressed call pendant at 1:03 am and it was not answered until 2:02 am with 35 presses. It took the police to come back into the community for the staff to retrieve residents' supplies. -Both [Caregiver D] and [Caregiver E] were found asleep during their shift by responding law enforcement. -Neither employee responded to the first 911 call in a timely or appropriate manner. -Pager was audibly going off, contradicting claims it was not functioning or overridden by door sensor. -Failure to monitor resident pendant calls placed the resident at risk of harm, requiring external emergency response. -False or misleading statements were made by staff during the initial internal interview. -Behavior and inaction demonstrated negligence, failure to perform job duties, and a violation of facility policy and state regulations." "Policy Violations -Failure to respond to pendant call. -Sleeping during shift. -Inaccurate documentation and misrepresentation of events. -Failure to provide timely and reasonable assistance to a resident in need. -Not following facility protocol for overnight staffing and floor monitoring" "Corrective Actions / Recommendations Immediate termination of employees [Caregiver D] and [Caregiver E] due to: -Negligence in responding to a resident call,	N 397		

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N 397	Continued From page 16 -Being found asleep on duty, -Providing false and inconsistent statements during the internal investigation, -Failure to follow established care protocols." On 09/18/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 01/30/2024, with diagnoses including chronic indwelling foley catheter and ileostomy in place. -Resident 2's Individual Service Plan, dated 07/03/2025, stated the following: "Supervision: 24-hour supervision. Toileting: Current Status: [Resident 2] has an indwelling foley catheter as well as a [sic] ileostomy. [Resident 2] is for the most part, independent with managing emptying the ostomy bag and urine drainage bag. Staff assists as needed. Staff are available for assistance with toileting needs ongoing throughout the day and night. Staff to monitor for any changes and report to management. All changes are documented and reported to [Doctor of Medicine]." On 09/18/2025, at approximately 9:00 AM, Surveyor interviewed Administrator A. Administrator A confirmed Resident 2 requires 24-hour supervision and assistance from staff with managing emptying the ostomy bag and urine drainage bag. Administrator A reported Caregiver D and Caregiver E were found asleep during their shift, failed to respond to Resident 2 pendant pages and neglected to provide necessary assistance even after police intervention.	N 397		

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N 481	Continued From page 17	N 481		
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 the facility was maintained in a safe clean, comfortable, and homelike environment. The facility needed cleaning and some repairs. This had potential to affect 50 of 50 residents. Findings include: The facility is licensed as a Class CNA (non-ambulatory) facility for up to 50 residents with programs in advanced aged, emotionally disturbed/mental illness, and irreversible dementia/Alzheimer's. On 09/18/2025, at approximately 2:11 PM, Surveyor conducted a tour of the facility with House Manager C and observed the following: -Walls throughout facility showed significant signs of scraping. -Walls throughout facility had white chalklike substance. -Elevator door and door frame showed significant scratches.	N 481		

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N 481	Continued From page 18 -Doors and door frames throughout facility showed significant scratches. -Wall vents throughout facility were rusted and bent. -Shower chairs throughout facility were dirty and rusted. -Activity room flooring was dirty and cracked. On 09/18/2025, at approximately 3:30 PM, Surveyor interviewed House Manager C. House Manager C confirmed there were homelike environment issues throughout the facility. House Manager C reported the facility has a maintenance team that was responsible for the maintenance of the facility.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secure area. Cleaning supplies and toxic compounds were observed in the unlocked laundry room and unlocked salon. This had potential to affect 50 of 50 residents. Findings include: The facility is licensed as a Class CNA	N 499		

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N 499	Continued From page 19 (non-ambulatory) facility for up to 50 residents with programs in advanced aged, emotionally disturbed/mental illness, and irreversible dementia/Alzheimer's. On 09/18/2025, at approximately 2:11 PM, Surveyor conducted a tour of the facility with House Manager C and observed the following: Laundry room -(2) cans of paint. -1 Gallon of CUI Solutions Lavender Magnifi-Scent All Purpose Cleaner. -(2) Neutra-Cide 256 Neutral Disinfectant Cleaner Deodorizer. -14.2 oz Pledge lemon enhancing polish. -32 oz Glass Cleaner with Ammonia -8 oz AmeriDerm Perineal Cleanser. -(2) boxes of commercial Arm/Hammer essentials Fabric Softener sheets. -154 oz Gain Liquid Detergent. There were no staff present in the laundry room and residents were able to move around freely to access toxic substances. The View Salon -64 oz Mr. Clean Meadows-Rain Multi-Surface All-Purpose Cleaner. -Bottle of Pine-Sol Multi-Surface Cleaner. -Suave Almond Shea Butter moisturizing conditioner. -Bottle of moisturizing hand sanitizer. -Speed Stick regular deodorant. -Ion smoothing foam. There were no staff present in the view salon and residents were able to move around freely to access toxic substances.	N 499		

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N 499	Continued From page 20 On 09/18/2025, at approximately 3:30 PM, Surveyor interviewed House Manager C. House Manager C confirmed the above cleaning supplies and toxic compounds were unlocked in the above-mentioned locations. House Manager C stated cleaning compounds and toxic substances should be always locked.	N 499		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider could not provide documentation to show that the heating system has been maintained in a safe and properly functioning condition for 5 of 5 furnaces. The provider did not get the gas furnaces inspected at least once every 3 years. Findings include: On 09/18/2025, Surveyor requested most recent documentation of the furnaces being inspected from Administrator A.	N 504		

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N 504	Continued From page 21 On 09/18/2025, at approximately 4:03 PM, Surveyor interviewed Administrator A. Administrator A reported the furnaces had not been inspected since April 2021. Administrator A reported s/he forgot to get furnaces inspected in April 2024. On 09/25/2025, at approximately 12:53 PM, Surveyor received an email from Regional Manager B. Regional Manager B reported all five furnaces were inspected on 09/19/2025, the day after Surveyor asked for the furnace inspections.	N 504		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the door to the laundry room, which is located on the same floor as resident bedrooms, was self-closing. Findings include: The facility is licensed as a Class CNA	N 640		

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N 640	Continued From page 22 (non-ambulatory) facility for up to 50 residents with programs in advanced aged, emotionally disturbed/mental illness, and irreversible dementia/Alzheimer's. On 09/18/2025, at approximately 3:06 PM while touring the facility with House Manager C, Surveyor observed the laundry room door located on the same floor as resident bedrooms did not have a self-closing mechanism and did not self-close when tested by Surveyor. On 09/18/2025, at approximately 3:06 PM, Surveyor interviewed House Manager C. House Manager C confirmed the laundry room door did not self-close. On 09/18/2025, at approximately 7:35 PM, Surveyor received an email from Regional Manager B. Regional Manager B reporting the following: "We put a self-closing locking door up tonight to ensure safety and compliance."	N 640		