STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015057	A. BUILDING: _____ B. WING _____	R-C 08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWCARE RESIDENCE	**903 MAIN AVE CRIVITZ, WI 54114**

(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 08/06/2025, Surveyor conducted a verification visit at Newcare Residence. Additional information was collected through 08/08/2025. As a result of the visit 2 deficient practices were identified, including 1 repeat violation. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 23	{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 record review and interview the licensee did not ensure all legal responsibilities were met. The licensee was issued a Statement of Deficiency (SOD) (SOD 9EZU11 dated 12/11/2024) on 05/05/2025 and did not take steps to comply with the orders and enforcement. Findings include: The provider was issued SOD 9EZU11 on 05/05/2025 at 9:42 AM via the e-mail accounts the provider submitted for the Electronic Statement of Deficiency. The notification included a letter of enforcement that included: "ORDER TO COMPLY WITH REQUIREMENTS 1. Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch.	N 196		

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

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N 196	Continued From page 1 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request. The Department may, without notice, conduct an inspection to verify the licensee's corrective action at any time after the date of compliance. Pursuant to Wis. Stat. § 50.03(5g)(cm), the department may impose a $200 inspection fee for an on-site inspection to review compliance of violations resulting in enforcement action... SPECIAL ORDERS 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 Newcare Residence: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to protect and promote each resident's right to live in a safe environment. WITHIN 45 DAYS of receipt of this notice, the licensee's corrective measures will include, at a minimum:	N 196		

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N 196	Continued From page 2 Fire Protection Systems The licensee shall obtain an inspection of the facility's smoke and heat detection system, at the licensee's expense, from a licensed contractor. The licensee will obtain the installation of any needed upgrades to the integrated smoke and heat detection system in order to meet the requirements specified by Wis. Admin. Code ch. DHS 83. Department approval is required before installing a smoke and heat detection system. The licensee shall submit plans for review of any needed upgrades to the integrated smoke and heat detection system to the Office of Plan Review and Inspection (OPRI). The licensee will retain documentation to evidence OPRI completed the plan review and approved of the proposed changes to the existing smoke and heat detection system. Additionally, the licensee will obtain documentation from the service contractor to verify effective operation of the system after completion of the approved scope of work. Emergency and Disaster Plan The licensee shall develop (or review and revise) a written emergency and disaster plan. The plan shall include, at a minimum: (a) procedures for orderly evacuation, or other department approved response, during an emergency or disaster; (b) procedures for any resident who refuses to follow evacuation or emergency procedures; (c) the location of an emergency shelter for the residents; (d) a means of transporting residents to the emergency shelter; (e) how meals and medications will be provided to residents at the emergency shelter; and (f) the responsibilities of employees during emergency and evacuation procedures.	N 196		

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N 196	Continued From page 3 Additionally: - All managers and resident care staff will receive in-service training regarding the facility's written emergency and disaster plan and related procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request." On 08/06/2025, Surveyor conducted an on-site verification visit for the previously issued SOD 9EZU11 (dated 12/11/2025) and interviewed Chief Financial Officer (CFO) B at 10:00 AM. CFO B stated s/he had not been made aware the SOD had been sent to the provider and stated most of the physical plant concerns remained unchanged since the last survey. At 10:30 AM, CFO B called Licensee F with Surveyor present. Licensee F stated s/he reviewed his/her e-mail and phone communication and confirmed s/he received the SOD on 05/05/2025 at 9:42 AM via e-mail. Licensee F stated s/he recalled not being able to open the attachment and forwarded the e-mail to Staff G, who was also not able to open the attachment. Licensee F stated s/he did not reach out to notify the Department that the attachment could not be opened and believed neither did Staff G. Licensee F did not recall pursuing the issue or taking any further action to access or correct the SOD. As a direct result of the Licensee not uphoilding his/her legal respondsibilites, the verification visit	N 196		

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N 196	Continued From page 4 conducted on 08/06/2025 found the provider remained out of compliance: Safe Environment Based on observation, record review, and interview the provider did not ensure residents were living in a safe environment. Multiple concerns were identified regarding the safety of the facility's physical plant including emergency evacuation plans, areas in need of repair, smoke separation, and fire and heat detection systems. This is a repeat violation. See Statement of Deficiency (SOD) 9EZU11, dated 12/11/2024. Cross reference: N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment	N 196		
{N 358}	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure residents were living in a safe environment. Multiple concerns were identified regarding the safety of the facility's physical plant including emergency	{N 358}		

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{N 358}	Continued From page 5 evacuation plans, areas in need of repair, smoke separation, and fire and heat detection systems. This is a repeat violation. See Statement of Deficiency (SOD) 9EZU11, dated 12/11/2024. The facility is licensed to serve up to 26 residents who may be physically disabled, of advance age, and /or have irreversible dementia/ Alzheimer's disease. Findings Include: On 08/06/2025, Surveyor conducted an on-site verification visit for the previously issued SOD 9EZU11 (dated 12/11/2025) and interviewed Chief Financial Officer (CFO) B at 10:00 AM. CFO B stated s/he had not been made aware the SOD had been sent to the provider and stated the previously identified physical plant deficient practices that required plan review remained unchanged since the last survey. Facility Layout Prior to becoming a Community Based Residential Facility (CBRF) the building was a Skilled Nursing Facility (SNF.) At the time of the survey on 08/06/2025, the building housed both the CBRF and a SNF with an addition to the CBRF built in 2019. The first floor of the CBRF was built slightly above ground level, requiring ramps for semi/non-ambulatory residents and/or steps for ambulatory residents to enter/exit. The first floor contained CBRF resident bedrooms and common space that was directly accessible through smoke compartment doors that were kept open to the SNF resident rooms and common space. The SNF space was open and accessible internally to the CBRF residents, visitors, and staff. The SNF space contained the	{N 358}		

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{N 358}	Continued From page 6 main CBRF kitchen, storage, staff areas, and was openly connected to the CBRF on the first floor. Additionally, the SNF space contained activity rooms, a beauty salon, and therapy rooms that the CBRF residents regularly access. The basement was located below the CBRF space. The provider referred to the basement as divided between the "CBRF side" and "SNF side" although both areas were located directly under the CBRF only. The basement contained rooms with building systems for both the CBRF and SNF sides of the first floor, including the heat and water systems, electrical, ventilation, SNF laundry, garbage, and rooms for general storage, maintenance storage, and building services storage. At the time of the survey on 08/06/2025 the basement also contained some storage for resident's personal items. Physical Plant On 08/06/2025 at approximately 10:45 AM - 2:30 PM, Surveyor toured the facility accompanied by CFO B and at times Maintenance Manager (MM) C. Surveyor interviewed CFO B, and MM C during the tour. During the tour on 08/06/2025, Surveyor observed over 17 areas of smoke compartments created by lintels that exceed 8 inches that did not contain smoke detection, 2 habitable rooms that contained smoke detectors on the bottom of a joist/ beam greater than 8 inches below the ceiling level, and over 18 habitable rooms and or/ areas that were not equipped with smoke detection and/ or heat detection as required. CFO B entered each room with Surveyor and acknowledged each smoke compartment, habitable room, corridor, exit, and closet that did	{N 358}		

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{N 358}	Continued From page 7 not have smoke and/ or heat detection present. Surveyor observed the facility had multiple rooms and corridors where the walls and ceiling had cracks, leaks, holes, open areas from previous works, and areas where piping and/or electrical cords were not securely sealed with fire stopping material. CFO B entered each room with Surveyor and acknowledged each area Surveyor observed. CFO B acknowledged as the facility is large and the damage/ deterioration is extensive, all areas in need of repair may not be identified during the survey process. Basement Surveyor observed the main steps leading down to the basement from the CBRF had a compartment where smoke would accumulate with no smoke detector. It also had an area of ceiling tile that had been damaged by water. Surveyor observed the basement had multiple rooms and corridors where the walls and ceiling had cracks, leaks, holes, open areas from previous works, and areas where piping and/or electrical cords were not securely sealed with fire stopping material. Surveyor observed some orange foam material had been added to some of the areas where the wall and ceilings were cracked but it did not cover the full extent of the areas of damage and Surveyor was unable to verify if the material used was a fire stopping product. Surveyor observed doors in the basement that were labeled with "Fire Door Keep Closed" that were propped open. The room labeled "Vending Storage" had a musty mildew odor, and a dark colored mold-like	{N 358}		

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{N 358}	Continued From page 8 substance on the floor and walls where there were hard water deposits in a formation of a dried puddle of water beneath the leak and at along the water flow leakage lines coming out of the walls. CFO B stated s/he was aware this room regularly has water damage and stated it was due to its position under an outside back deck where water runoff collects. CFO B stated they were aware of the water damage and had had discussions about fixing the issue but had not yet. CFO B acknowledged the odor and presence of mold/mildew like substances. Per facility floor plan map, 2 rooms were labeled "Records" under the CBRF. The first room contained a smoke detector that was installed below the level of the ceiling. The room contained a fire exit stairwell that led directly up to the outside on ground level. The stairwell did not have smoke detection. Walking through the first "Records" room Surveyor then entered the second "Records" room. Surveyor observed the ceiling which was directly below the CBRF was made of wooden planks that did not provide fire separation between the floors. The ceiling had vertical planks of wood greater than 8 inches that created 16 individual smoke compartments. Each smoke compartment did not contain smoke detection. Surveyor observed 1 smoke detector installed below the level of the ceiling on the bottom edge of one of the wooden vertical lintels. The room also had a window well that had staining down the wall from water damage. Surveyor toured a room that held a gas heating system and noted the room contained areas where there were holes and cracks in the ceiling and walls that needed repair and/ or were not	{N 358}		

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{N 358}	Continued From page 9 sealed with fire stopping material. The room contained smoke detection instead of heat detection The corridor leading from what MM B referred to as the "CBRF side" of the basement to what MM B referred to as the "SNF side" of the basement had areas where lintels exceed 8 inches creating a compartment where smoke detectors are required and were not present. The corridors contained areas of holes and cracks in the ceiling and walls that needed repair and/ or were not sealed with fire stopping material. The fire rated doors between the "SNF side" and "CBRF side" of basement area were kept propped open. The SNF Laundry room had a stairwell that led directly up to the outside ground level as an emergency fire exit. The stairwell did not contain smoke detection and was obstructed by venting materials and debris. Surveyor observed the room MM C referred to as the "Laundry Chute" room, "HK Storage," the corridor directly outside of "CFO Storage," "CFO Storage" room, "Paint Storage" room, "Maintenance Storage" room, "Maintenance Shop" room, and "Nursing Home Storage" room did not contain smoke detection. The Nursing Home Storage room was the length of the building and required smoke detection every 30 ft. Some of the rooms were equipped with battery operated smoke detectors. On 08/06/2025 at approximately 1:00PM, CFO B and MM C acknowledged the smoke detectors are required to be interconnected to the fire system. First Floor CBRF	{N 358}		

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{N 358}	Continued From page 10 On the first floor Surveyor observed 4 furnace rooms each labeled by a number above the door. The furnace rooms did not appear to be fitted with fire rated doors. Surveyor observed the "Atrium" contained smoke detectors that were installed on the side walls below the level of the ceiling. The smoke detectors were installed below 12 inches from the top of the ceiling. Surveyor observed the CBRF "Food Closet" that was a walk-in room and did not contain smoke detection. Surveyor observed the CBRF "Activity Storage" room did not contain smoke detection. Surveyor observed an exit leading out to West side of the CBRF That MM C stated was an emergency exit. The door did not contain a lighted sign indicating it was an exit. Surveyor observed a exit corridor a the East end of the CBRF back residential hallway that had lintels greater than 8 inches and did not contain interconnected smoke detection. First Floor SNF Surveyor observed the fire rated doors leading from the CBRF to the SNF were kept open as residents from the CBRF are expected to access the SNF to use the "Beauty Shop," "Therapy" rooms, and at times may join for activities in the common spaces. The Beauty Shop and Therapy rooms did not contain smoke detectors. Surveyor observed an exit that was not equipped with emergency exit lighting that was within the SNF but would be the closest exit for some CBRF residents. The room just prior to the exit did not contain smoke detection.	{N 358}		

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{N 358}	Continued From page 11 Evacuation During the tour on 08/06/2025, CFO B was unable to state what the current evacuation plan was for residents. CFO B was unsure if there had been a plan approved for horizontal evacuation or of plans in place for any resident who may require point of rescue. On 08/08/2025, CFO B sent Surveyor the evacuation plan policy and procedure. The plan included a reference to utilizing horizontal evacuation that had not been approved by the Department: "C. Tenants must be evacuated to an area where there is a fire door between them and the affected area." The plan was not specific and did not indicate where the areas of horizontal evacuation were located, or which residents were to go where in the event of a fire in a different area of the facility. On 08/06/2025 at approximately 2:00 PM, Surveyor conducted an exit interview with CFO B. CFO B reviewed the deficient practices identified in the survey and stated s/he would take immediate steps for correction to maintain resident safety.	{N 358}		