

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
{M 000}	INITIAL COMMENTS On 03/17/2025, Surveyor conducted a verification visit, complaint (x2) investigation and self-report investigation at Northwoods Assisted Living LLC. Data collection continued through 04/08/2025. The deficiencies identified in statement of deficiency (SOD) 9GJ311, dated 11/18/2024, were corrected. The complaints were substantiated. One deficiency was identified. The self-report was closed. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 2	{M 000}		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from physical, sexual or mental abuse, neglect, and financial exploitation or misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 and Resident 2 were free from abuse. Per DHS 88.02(1): "Abuse" means conduct which is not accidental and which causes or could reasonably be expected to cause harm to a resident, and which may be physical abuse, mental abuse or material abuse. Findings include:	M 572		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 1 The provider is licensed to care for 4 residents in the client groups of emotionally disturbed/mental illness, developmentally disabled, advanced age and irreversible dementia/Alzheimer's disease. On 01/07/2025 the Department received a complaint alleging a caregiver placed their hand over the mouth of a resident and threatened to slap the resident. On 03/07/2025, the Department received a complaint alleging Owner A physically abused a resident and took the resident's property. On 03/07/2025, the Department received a self-report indicating Price County Sheriff's Department would be pressing charges on Owner A for putting his/her hands around a resident's neck. On 03/17/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/18/2024. Resident 1 discharged on 01/09/2025. Resident 1 has a guardian. On 03/17/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 08/30/2024. Resident 2 discharged on 03/07/2025. Resident 2 was alert and oriented and was his/her own decisionmaker. Resident 2's diagnoses included: Aneurysm of heart, acute kidney failure, acquired absence of left foot, type 2 diabetes mellitus w/diabetic neuropathy, type 2 diabetes mellitus w/ hyperglycemia, long term use of insulin. On 03/17/2025 at 11:00 AM, Surveyor interviewed Owner A. Surveyor asked Owner A about an incident of alleged abuse involving Resident 1 and Caregiver C. Owner A stated that Caregiver C admitted to covering Resident 1's mouth	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 2 because Resident 1 was screaming. Owner A reported that House Manager (HM) B conducted an investigation and Caregiver C was terminated. Owner A stated, "I believe [HM B] was in contact with [Price County Department of Social Services]. Owner A confirmed that the incident involving Resident 1 and Caregiver C occurred on 12/20/2024. On 03/17/2025 at 11:30 AM, Surveyor asked Owner A about an incident of alleged abuse involving Resident 2 and Owner A. Owner A stated, "[Resident 2] was not happy with us. [S/He] was not taking medications. [Resident 2] went to [his/her] room (and) turned [his/her] radio up loud and wouldn't turn it down. We removed the radio from [his/her] room." Owner A reported that Resident 2 was eating Cheetos in his/her room. Owner A stated, "We don't allow residents to eat in their room; it makes a mess and attracts mice. I removed the Cheetos from [his/her] room; [Resident 2] claimed I (Owner A) attacked [him/her]." Owner A stated that Resident 2 claimed Owner A grabbed his/her shirt and placed a hand around his/her neck. Owner A commented, "I did not touch [him/her]." Owner A verified that the alleged incident occurred on 03/03/2025. Owner A stated further, "[Resident 2] went to the doctor on 03/06/2025 and told the doctor that I abused [him/her]." Owner A confirmed that Resident 2 moved out on 03/07/2025. On 03/17/2025 at 2:15 PM, Surveyor interviewed Price County Adult Protective Services (APS) Worker G via telephone. Surveyor asked APS Worker G about an alleged incident of abuse involving Resident 2 and Owner A. APS Worker G reported that Price County APS was informed of an incident involving Resident 2 and Owner A	M 572			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 3 and the incident occurred on 03/03/2025, at the provider. APS Worker G indicated that Resident 2 was seen at Mayo Clinic in Eau Claire on 03/06/2025, and made a complaint to a clinic nurse (Nurse D). According to APS Worker G, Resident 2 had reported that Owner A choked and grabbed Resident 2 by the shirt and Owner A took Resident 2's Cheetos, mini refrigerator, prosthetic leg and wheelchair on 03/03/2025. APS Worker G stated APS went to the facility to interview Resident 2 on 03/07/2025 and Resident 2 had moved out. On 3/17/2025 at 2:46 PM, Surveyor interviewed Case Worker E via telephone. Surveyor asked Case Worker E about an alleged incident of abuse involving Resident 2 and Owner A that occurred on 03/03/2025 at the facility. Case Worker E stated that Resident 2 had made an abuse complaint to Nurse D on 03/06/2025 at the Mayo Clinic in Eau Claire. Case Worker E reported that s/he spoke to Resident 2 via telephone on 03/06/2025 and Resident 2 reported that Owner A choked him/her, took his/her prosthetic leg and wheelchair away, took his/her Cheetos and mini refrigerator, and threatened to take his/her bed. Case Worker E indicated that Resident 2 was his/her own decisionmaker. On 03/17/2025 at 4:36 PM, Surveyor interviewed Resident 2 via telephone. Surveyor asked Resident 2 about cares at the facility and about an alleged incident of abuse that occurred on 03/03/2025. Resident 2 stated, "[Owner A] tried to kill me. I have a prosthetic leg and use a wheelchair and [Owner A] took my prosthetic leg and wheelchair." Resident 2 verified that the incident occurred at the facility on 03/03/2025 and Resident 2 "could not take care of it until Thursday (03/06/2025)." Resident 2 stated that	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 4 social services had record of the incident and that there was a police report. Resident 2 stated that s/he reported the abuse to Nurse D at Mayo Clinic in Eau Claire, during a medical appointment on 03/06/2025. Resident 2 reported that the incident caused him/her to be fearful and s/he had trouble sleeping after the incident. Resident 2 reported that around 11:30 PM on Monday (03/03/2025), Resident 2 was in his/her room. Resident 2 stated, "I was eating Cheetos in my room. [Owner A] came in my room and told me to give [him/her] my Cheetos. [S/he] tried to strangle me; [s/he] put [his/her] hand on my neck and grabbed my shirt with [his/her] other hand. I believe I was in bed. [Owner A] went to get a broom after the Cheetos spilled on the floor. [Owner A] took my prosthetic leg (left leg) and wheelchair out of my room. I crawled and grabbed another wheelchair in my room and wheeled out to the bathroom in the kitchen. [Owner A] tried to take the other wheelchair from me. I used my right leg to hang on to the wheelchair so [Owner A] couldn't take it." Resident 2 reported that Owner A stated that s/he was "going to kill me." Resident 2 reported that Resident 2 and Owner A were alone when Owner A grabbed and threatened him/her. Resident 2 commented, "I am glad I moved." Resident 2 reported that Resident 2 spoke to Case Worker E via telephone on 03/06/2025 and to law enforcement about the abuse. Resident 2 verified that s/he moved out of the facility on Friday, 03/07/2025. On 03/18/2025 at 1:06 PM, Surveyor interviewed Nurse D via telephone. Nurse D. Surveyor asked Nurse D about an alleged abuse incident that occurred on 03/03/2025 involving Resident 2 and a caregiver at the provider. Nurse D stated that	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 5 Resident 2 reported s/he was choked by Owner A at the provider on Monday, 03/03/2025. Nurse D indicated that Resident 2 attended a medical appointment at Mayo Clinic in Eau Claire on 03/06/2025. Nurse D stated Resident 2 reported that on Monday (03/03/2025), Resident 2 was choked by Owner A and Owner A took away Resident 2's prosthetic leg, wheelchair, refrigerator and Cheetos. Nurse D reported that Nurse D would provide Surveyor with Resident 2's statement to Nurse D. Nurse D indicated that Nurse D reported the alleged abuse to Price County Adult Protective Services and law enforcement. On 03/18/2025, Surveyor reviewed a statement taken on 03/06/2025 by Nurse D regarding Resident 2's abuse allegation. Nurse D's statement, read, in part, "Patient (Resident 2) stated, Monday night my caregiver was choking me. [S/He] put her hands around my neck and said, 'I am going to kill you.' [Nurse D] asked which facility the patient resides at which [s/he] stated, 'Northwoods LCC in Hawkins, WI.' (I) asked who assaulted [him/her] and [s/he] stated, 'The caregiver and owner.' (I) asked why [s/he] did this to [him/her]. [S/He] stated, 'Well, I guess my music was too loud and [s/he] came in and took my radio. And then [s/he] came back later and took my prosthetic leg and wheelchair, and I had to crawl around until I could get my other wheelchair. Then [s/he] caught me eating in my room since I am diabetic and took my mini fridge. I guess [s/he] got so mad at me that [s/he] took [his/her] one hand and put it around my neck and then the other on my chest grabbing my shirt.' Patient was very tearful during this encounter." On 03/26/2025, Surveyor reviewed HM B's Investigation Summary Report (dated:	M 572			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 6 03/06/2025). The Investigation Summary Report noted that the investigation involved an alleged abuse incident that occurred on 03/03/2025 between Resident 2 and Owner A. The alleged incident occurred in Resident 2's room around 11:30 PM on 03/03/2025. HM B noted, "I interviewed [Owner A] around 5:00 PM on 03/06/2025. [S/he] (Owner A) stated that around 8:00 PM [Resident 2] refused to take [his/her] medications for Caregiver I. When [s/he] (Owner A) asked [him/her] (Resident 2) why [s/he] was refusing [his/her] medication [s/he] ignored [him/her] and refused to talk. [S/He] stated that [s/he] then went to [his/her] room and turned [his/her] radio on at maximum volume. [S/He] stated [s/he] entered [Resident 2's] room and reminded [him/her] of the house rule that stated 'no loud noises or TV in main living area after 9:00 PM,' [s/he] refused to turn it down. [S/He] then went back in [his/her] room a few minutes later and asked [him/her] to turn it down again as it was disturbing the other residents. [S/He] again refused. [S/He] stated that [s/he] went back in there a couple minutes after the second attempt to get the radio turned down with staff member [Caregiver I] and told [Resident 2] that the stereo was being removed from the room and would be returned the next day. [S/He] unplugged it and handed it to [Caregiver I] and instructed [him/her] to take the stereo out of [his/her] room. [Caregiver I] left around 9:00 PM. [S/He] stated [s/he] (Resident 2) then started eating a bag of Cheetos. [S/He] went in to ask [him/her] if [s/he] could come out of [his/her] room if [s/he] needed to eat as eating is generally not allowed in resident rooms. [S/He] stated that [Resident 2] proceeded to call [him/her] names and threw the bag of Cheetos at [him/her]. [S/He] (Owner A) cleaned them up and [Resident 2] then went to bed. [S/He] denies any intent to harm the resident	M 572			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 7 [sic] [S/He] also denies that [s/he] physically touched [him/her], [Resident 2]." HM B noted further, "I called the home phone at [provider] around 6:00 PM to speak with [Resident 2] on 03/06/2025. [S/He] stated that at the appointment at Mayo Clinic on 03/06/2025 [s/he] reported to the doctor that [s/he] was no longer happy living in [his/her] home and that [Owner A] put [his/her] hands around [his/her] neck. [S/He] mentioned that the Eau Claire Police Department came to the hospital and took his statement. [S/He] also mentioned that Mayo Clinic called Price County PD (police department) and APS (Adult Protective Services). When this writer asked [him/her] about the incident [s/he] stated that [Owner A] was upset that [s/he] was being too loud with the Cheetos in [his/her] room, so [s/he] came in [his/her] room and put [his/her] hand around [his/her] neck. [S/He] stated that [s/he] did not feel safe living there anymore and that [Owner A] took his wheelchair and [his/her] leg that same night. I asked [him/her] why [s/he] didn't report it to the police that night. [S/he] stated that [s/he] didn't think of it until now." HM B noted, "I have not been able to speak to [Resident 2] anymore regarding the incident as [s/he] was placed in a new home by 12:30 PM on 03/07/2025. After interviewing everybody involved in the incident [sic] I feel there is no action that can be taken now. It is currently handled by the Price County PD and I will await to see if any charges are filed against [Owner A]. Action would be taken at that time." On 03/28/2025 at 1:20 PM, Surveyor interviewed Price County Sheriff's Department (PCSD) Investigator F. Investigator F reported that Investigator F interviewed Nurse D and Resident 2 via telephone on 03/06/2025. Investigator F stated that Nurse D indicated that Resident 2	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 8 came into the clinic for vaccines on 3/06/2025 and Resident 2 informed Nurse D that Owner A had placed [his/her] hands around Resident 2's neck and threatened to 'kill' Resident 2. Nurse D informed Investigator F that Resident 2 reported that Owner A took Resident 2's wheelchair, prosthetic leg, Cheetos, mini refrigerator and a radio away. Nurse D reported to Investigator F that Resident 2 stated that Resident 2 "had to crawl on the floor" to retrieve a second wheelchair so [s/he] could use the bathroom. Investigator F informed Surveyor that Investigator F spoke to Resident 2 via telephone on 03/06/2025. Investigator F asked Resident 2 to describe what happened on 03/03/2025 at Northwoods Assisted Living LLC. Investigator F indicated that Resident 2 stated that on 03/03/2025, Resident 2 was listening to his/her radio at approximately 11:30 PM, and the radio must have been too loud. Resident 2 reported to Investigator F that Owner A took away Resident 2's radio. Resident 2 reported that Resident 2 had a mini refrigerator in his/her room with soda in it because s/he was diabetic and Resident 2 was allowed to have it. Resident 2 reported that Owner A removed Resident 2's mini refrigerator from his/her room. Resident 2 stated that Resident 2 was in his/her bed eating Cheetos. Resident 2 commented that Resident 2 must have been chewing too loud because Owner A came in and "ripped the Cheetos" out of his/her hand spilling them on the floor. Investigator F indicated that Resident 2 stated that Owner A put his/her hands around Resident 2's throat and told Resident 2 that s/he "was going to kill [him/her]." Investigator F indicated that Investigator F would be referring Owner A for the following criminal charges: Strangulation & Suffocation 940.235(1),	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 9 Intentionally Abuse Patients 940-295(3)(a)1, Disorderly Conduct 947.01(1). Investigator F commented that Resident 2's statement of the alleged abuse has been consistent with medical staff, social services and law enforcement. On 04/01/2025 at 11:20 AM, Surveyor interviewed Owner A via telephone. Surveyor asked Owner A about the house rules specific to residents eating in their rooms. Owner A stated that there is no eating in resident rooms and "[Resident 2] accepted those rules." Owner A commented, "[Resident 2] could be at risk of choking if eating unsupervised and if [his/her] blood sugars were low. We offer storage space for food." On 04/01/2025 at 11:40 PM, Surveyor conducted a follow up interview with Resident 2 via telephone. Surveyor asked Resident 2 questions about his/her interaction with Owner A on 03/03/2025. Resident 2 stated, "[S/He] took my wheelchair and prosthetic leg from me; [s/he] grabbed the Cheetos out of my hand; [s/he] put one hand on my throat and [s/he] grabbed my shirt with [his/her] other hand. [S/He] tried to kill me. I am not going to take that. [S/He] said [s/he] was going to kill me. It's in the police report. I couldn't sleep for 4 days straight. That's why [Resident 1] left - [s/he] was treated poorly by staff. I was allowed to keep a small refrigerator in my room with food and soda because I am diabetic. My sugar was low that night." Resident 2 reported that Owner A removed his/her refrigerator, radio and took his/her Cheetos away and caused him/her harm by threatening, choking and grabbing him/her on 03/03/2025. On 04/02/2025 at 3:22 PM, Surveyor interviewed Case Worker H via telephone. Surveyor asked Case Worker H about Resident 1 and Resident	M 572			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 10 2's cares at the facility. Case Worker H reported that Resident 1 verified that Caregiver C had placed his/her hand over Resident 1's mouth on 12/20/2024. Case Worker H reported that apart from the 12/20/2024 incident, Resident 1 did not express prior concerns about cares. Case Worker H reported that apart from Resident 2 reporting the abuse involving Owner A on 03/03/2025, Resident 2 did not express prior concerns about cares at the facility. On 04/03/2025 at 4:56 PM, Surveyor interviewed HM B. Surveyor asked HM B about an incident involving Resident 1 and Caregiver C on 12/20/2025. HM B reported that Caregiver C admitted to covering Resident 1's mouth on 12/20/2024. HM B stated that Caregiver C did not have contact with Resident 1 after the incident and Caregiver C was terminated in January 2025. Surveyor asked HM B about Resident 2's blood sugar monitoring and an incident involving Resident 2 and Owner A on 03/03/2025. HM B reported that HM B conducted an abuse investigation involving Resident 2 and Owner A. HM B stated, "The Price County Sheriff's Department came to the facility and told [Owner A] that [s/he] would be receiving criminal charges." HM B stated that Resident 2 reported being choked by Owner A and that Owner A took Resident 2's wheelchair, refrigerator, prosthetic leg and Cheetos away from Resident 2 on 03/03/2025. HM B stated further, "We provided [Resident 2] with insulin and monitored [his/her] blood sugars. [Resident 2] was diabetic and [s/he] had a refrigerator in his/her room. I let [him/her] eat in [his/her] room. I've spoken to [Owner A] about the house rules (not allowing residents to eat in their rooms); this is their home - they should be allowed to eat in their room." HM B informed Surveyor that HM B was waiting for a	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 11 police report. HM B stated, "If Owner A gets charged, Owner A won't be allowed to work at the facility." On 04/07/2025, Surveyor received and reviewed Investigator F's police report. According to the police report, Investigator F spoke to Nurse D and Resident 2 via telephone on 03/06/2025. The police report, read, in part, "[Nurse D] reported [s/he] recently saw patient from [provider], located at [address], in the Township of Kennan. The patient was identified as [Resident 2]. [Nurse D] reported that [Resident 2] came into the clinic for vaccinations and told [him/her] about [his/her] caregiver at [provider] placing [his/her] hand around [his/her] neck and telling [him/her] [s/he] would kill [him/her]. [Nurse D] told me [Resident 2] said [his/her] caregiver was [Owner A]. [Nurse D] reported the incident occurred on Monday, March 3, 2025. [Nurse D] informed me during the same time, [Owner A] had also taken property away from [Resident 2] to include a radio, a wheelchair, and [Resident 2's] prosthetic leg. [Nurse D] informed me [Resident 2] had to crawl on the floor to retrieve a second wheelchair so [s/he] could use the bathroom." The police report noted further, "I asked [Resident 2] to describe what occurred in [his/her] words. [Resident 2] informed me on Monday, March 3, 2025, at approximately 11:30 PM, [s/he] was listening to [his/her] radio. [Resident 2] informed me the radio must have been too loud, and when [Owner A] came into the room [s/he] took the radio. [Resident 2] informed me [s/he] was diabetic and had a refrigerator in the room with soda in it that [s/he] was allowed to have. [Resident 2] said [Owner A] also took [his/her] mini fridge (refrigerator). [Resident 2] said [s/he] was in [his/her] bed eating Cheetos. [Resident 2]	M 572			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 12 indicated [s/he] must have been chewing too loud because [Owner A] came in and ripped the Cheetos out of [his/her] hand spilling them on the floor. [Resident 2] said [Owner A] had to clean the spilled Cheetos up. [Resident 2] indicated [Owner A] must have been mad at [him/her] for eating in the room. [Owner A] then came in the room again and put her hands around [Resident 2's] throat and told [him/her] [s/he] was going to kill [him/her]. I asked [Resident 2] if [Owner A] restricted [his/her] breathing by having [his/her] hand on [his/her] neck. [Resident 2] said it did. [Resident 2] said while [Owner A's] hand was on [his/her] neck, [s/he] told [him/her] [s/he] would kill him. I asked [Resident 2] if there was anyone else who had seen or heard the event. [Resident 2] told me no. I asked [Resident 2] where the event happened. [Resident 2] informed me the event occurred in [his/her] bedroom at [provider]. I asked [Resident 2] if [Owner A] caused him fear. [Resident 2] said yes. [Resident 2] went on to explain that [s/he] had not slept well since Monday, March 3, 2025, as [s/he] was afraid [Owner A] would do it again." Investigator F's police report indicated that Investigator F interviewed Owner A in person on 03/06/2025. Investigator F reported, "I began the interview by informing [Owner A] that I had a few questions for [him/her] regarding an incident that took place on Monday, March 3, 2025. [Owner A] asked where. I informed [Owner A] the incident took place at the [provider]. I asked [Owner A] if [s/he] took a refrigerator away from [Resident 2]. [Owner A] indicated that [Resident 2's] refrigerator was removed from [his/her] room because it was filthy inside and needed to be cleaned. I asked [Owner A] if [s/he] took [Resident 2's] refrigerator away because of the condition it was in. [Owner A] indicated yes. I asked [Owner A] if [s/he]	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 13 allowed her clients to eat. [Owner A] indicated [s/he] didn't allow [his/her] clients to eat in their rooms. I asked [Owner A] why. [Owner A] indicated because of mice and other animals. [Owner A] indicated [his/her] clients were able to eat whatever they wanted in the kitchen area. [Owner A] said if [s/he] allowed [his/her] clients to eat in their bedrooms, they would have candy stuck to their bedding and to the floor. I asked [Owner A] if [s/he] remembered taking a bag of Cheetos away from [Resident 2] on Monday. [Owner A] indicated no. [Owner A] indicated [Resident 2] had Cheetos in [his/her] bedroom, but [s/he] (Resident 2) threw them at [him/her] (Owner A), and [s/he] (Owner A) swept them up. I asked [Owner A] if [Resident 2] threw the Cheetos at [him/her] on Monday. [Owner A] indicated yes. I asked [Owner A] if [s/he] remembered when that happened. [Owner A] indicated that [s/he] had no idea. I asked [Owner A] why [Resident 2] threw [his/her] Cheetos at [him/her]. [Owner A] indicated [Resident 2] was mad because [s/he] (Owner A) said [s/he] (Resident 2) couldn't eat in [his/her] room. I asked [Owner A] if [s/he] took [his/her] wheelchair out of [Resident 2's] room. [Owner A] indicated no, and said [Resident 2] had two wheelchairs. I asked [Owner A] if [s/he] took [Resident 2's] prosthetic leg and wheelchair. [Owner A] indicated no. [Owner A] made an utterance saying that [s/he] said [s/he] did. I found it odd as I had not brought up the fact of the allegation being made by [Resident 2]. [Owner A] said residents could not eat in their bedrooms, and it was a house rule. I asked [Owner A] if [s/he] tried to take the Cheetos away from [Resident 2]. [Owner A] indicated that [s/he] told [him/her] [s/he] couldn't have the Cheetos. I asked [Owner A] if at any time [s/he] became physical with [Resident 2]. [Owner A] indicated no. I asked [Owner A] if at any point	M 572		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2025
NAME OF PROVIDER OR SUPPLIER NORTHWOODS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE W11474 US HWY 8 HAWKINS, WI 54530		
(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
M 572	Continued From page 14 [s/he] put [his/her] hand around [Resident 2's] neck. [Owner A] asked why would [s/he] do that. I explained to [Owner A] I believed [s/he] was being cooperative with me to a point, but I believed there was more to the story that [s/he] wasn't telling me. [Owner A] indicated I could believe whatever I wanted, but [s/he] was telling the truth." Investigator F's report noted that Investigator F would be referring Owner A for criminal charges for the incident Resident 2 reported and the criminal charges were Strangulation & Suffocation, Intentionally Abuse Patients and Disorderly Conduct. On 04/08/2025 at 9:00 AM, Surveyor interviewed HM B via telephone. Surveyor asked HM B about his/her thoughts on the incident involving Resident 2 and Owner A. HM B reported that Resident 2 was allowed to have a refrigerator in his/her room. HM B commented, "[Resident 2] was [his/her] own person and [s/he] should be allowed to eat in [his/her] room." HM B confirmed that Owner A had removed Resident 2's mini refrigerator and radio and Owner A had instructed Resident 2 that Resident 2 was not allowed to eat in his room on 03/03/2025. HM B commented that Resident 2's account of the incident involving Owner A on 03/03/2025 has been consistent. The provider did not ensure Resident 1 and Resident 2 were free from abuse.	M 572		