STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015325	A. BUILDING: _____ B. WING _____	C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF HASMER LAKE	N168 W22022 MAIN ST JACKSON, WI 53037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 12/09/2025 with information gathered through 12/17/2025, Surveyor conducted a standard survey and 4 complaint investigations at Charter Senior Living of Hasmer Lake, a Community-Based Residential Facility (CBRF) in Jackson, WI. Seventeen deficiencies identified. Four of 17 are repeat deficiencies. Four of 4 complaints substantiated. Census: 14	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and staff interview, the CBRF did not send a written report to the Department within 3 working days after any time law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety, or welfare of residents or employees. Findings include:	N 164		

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

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N 164	Continued From page 1 On 11/10/2025, the Department received a complaint concerning medication management. On 12/09/2025 at approximately 10:00 AM, Surveyor interviewed Executive Director B. Executive Director B stated s/he was contacted by caregiver staff on 11/08/2025 that there was no medication passer for the PM shift. Executive Director B stated s/he was finally able to get someone to come in around 11:50 PM that night. Executive Director B confirmed there was no medication passer on 11/08/2025 from 5:00 PM-11:50PM and the residents did not receive their scheduled 4:00 PM and 8:00 PM medications. On 12/09/2025, Surveyor reviewed the Village of Jackson Police Department calls report dated 11/08/2025. The report stated the following: -"[Officer F] was contacted by Paramedic about a situation that was occurring at Charter of Hasmer. Paramedic was contacted around 8:45 PM, a temp caregiver advised [him/her] their med passer did not show up to work. Temp caregiver was wondering if Paramedic would pass out meds for them. Paramedic advised temp caregiver [s/he] was not able to pass meds out for them. [Officer F] made contact with temp caregiver. Temp caregiver advised [s/he] worked for a temp agency that was filling shifts at Charter of Hasmer. [S/he] advised there was another temp worker working with [him/her]. [S/he] advised the employee who is certified to pass medications did not show up to work. [S/he] advised the one staff who was not a temp worker called the director who has not fixed the issue. [Officer F] spoke with [Caregiver G], who was at the other building. [Caregiver G] advised the med passer was supposed to be at work at 5:00 PM but never showed up. Because they don't have a	N 164		

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N 164	Continued From page 2	N 164		

med passer, none of the residents who need medication in the afternoon have received their medication. They advised one resident was waiting to eat until [s/he] got [his/her] insulin but decided to eat and had [his/her spouse] come give [him/her] some insulin. [Caregiver G] advised [s/he] called [his/her] director, [Executive Director B], and advised [him/her] of the issue. [S/he] advised [Executive Director B] kept saying someone would respond, but no one ever showed up. They advised a 3rd shift med passer would be in at 11:00 PM. They advised they did not have a med passer for the entire 2nd shift. Because no one on scene was a med passer with Charter of Hasmer, they were not sure what residents get their meds. [Officer F] spoke with [Executive Director B], over the phone. [S/he] advised the med passer never showed up to work. [S/he] advised [s/he] and [his/her] manager were trying to contact other med passers to respond to the facility, but everyone was unavailable. [S/he] advised one of [his/her] employees advised they would respond after they finished with a family event. [Executive Director B] did not know when the employee who said they would respond would actually show up to the facility. [Officer F] advised [Executive Director B] to call [him/her] back when [s/he] found out when someone would be responding to the facility. The [Executive Director B] called back at 11:07 PM. [S/he] advised [s/he] had a med passer responding to the facility. [S/he] advised there would be a few people fired due to the situation that occurred. Staff was advised to call rescue if anyone was having medical issues due to not receiving medications. They advised a 3rd shift med passer would be in at 11:00 PM."

On 12/16/2025 at approximately 10:30 AM, Surveyor interviewed Regional Director of

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N 164	Continued From page 3 Operations A. Regional Director of Operations A stated the previous director would have self-reported the incident. Surveyor reviewed facility e-files and the last self report sent to the Department was an unrelated event on 09/18/2025. Regional Director of Operations A stated the previous director did not self-report the incident.	N 164		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 2 of 2 employees reviewed had been screened for clinically apparent communicable disease including tuberculosis (TB). Caregiver D did not have a screening within 90 days before the start of employment and Caregiver E did not have a screening or TB test within 90 days before	N 220		

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N 220	Continued From page 4 the start of employment. This is a repeat deficiency. See Statement of Deficiency (SOD) WZSJ11, dated 02/24/2022. Findings include: On 12/09/2025, Surveyor reviewed Caregiver D and Caregiver E's record and identified the following: -Caregiver D was hired on 09/03/2024. Caregiver D's record did not contain a communicable disease screening. -Caregiver E was hired on 11/18/2025. Caregiver E's record did not contain a communicable disease screening or TB test. On 12/16/2025 at approximately 10:30 AM, Surveyor interviewed Regional Director of Operations A. Regional Director of Operations A stated if staff did not have it in their files when Surveyor requested the information, then they did not complete it.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident	N 230		

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N 230	Continued From page 5 changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 (Caregiver D and Caregiver E) caregivers reviewed had orientation training including job responsibilities, prevention and reporting of resident abuse, neglect and misappropriation of resident property, emergency and disaster plan and evacuation procedures, Community Based Residential Facility policies and procedures and recognizing and responding to resident changes of condition before performing any job duties. Findings include: On 12/08/2025, Surveyor reviewed Caregiver D and Caregiver E's record. Caregiver D was hired on 09/03/2024. Caregiver E was hired on 11/18/2025. Surveyor could not locate orientation training for Caregiver D and Caregiver E. On 12/11/2025 at 11:11 AM, Surveyor interviewed Executive Director B. Executive Director B confirmed Caregiver D and Caregiver E are active emloyees and perform job duties at the CBRF. Executive Director B stated s/he could not locate any documentation Caregiver D and Caregiver E completed orientation training upon hire.	N 230		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise	N 247		

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N 247	Continued From page 6 ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by:	N 247		

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N 247	Continued From page 7 Based on record review and interview, the provider did not ensure Caregiver E's employee record reviewed obtained all task specific training prior to assuming the duties. Caregivers E, who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties. Findings include: On 12/08/2025, Surveyor reviewed employee records to verify compliance with task specific training requirements. Surveyor requested training records from Executive Director B for Caregiver E. Surveyor identified the following: -Caregiver E was hired on 11/18/2025. -The records for Caregivers E did not contain evidence of training or evidence of meeting an exemption for personal care training. On 12/11/2025 at 11:11 AM, Surveyor interviewed Executive Director B. Executive Director B confirmed s/he could not locate any documentation Caregiver E completed or met an exemption for provision of personal care training prior to assuming these job duties.	N 247		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.	N 352		

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N 352	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, 7 of 7 residents reviewed (Resident 2, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9 and Resident 10), did not receive their prescribed 8:00 PM medications on 11/08/2025 due to no med passer available. This is a repeat deficiency. See Statement of Deficiency (SOD) 81YW11, dated 06/24/2025. Findings include: On 11/10/2025, the Department received a complaint regarding residents not receiving their medications as prescribed. On 12/09/2025 with information gathered through 12/16/2025, Surveyor reviewed Resident 2, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9 and Resident 10's record. Surveyor identified the following: Resident 2 Resident 2 was admitted on 04/25/2024. Resident 2's November 2025 Medication Administration Record identified the following: -Acetaminophen 500 MG caplet, take one tablet by mouth twice daily for pain at 8:00 AM and 8:00 PM. -Naproxen 250 MG tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Olanzapine 5 MG tab, take 1 tablet by mouth once daily at bedtime at 8:00 PM. -Resident 2's November 2025 MAR stated Resident 2 did not receive his/her 8:00 PM medications on 11/08/2025. Resident 2 missed 3 doses of his/her medication. The exception reason stated outside of parameters.	N 352		

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N 352	Continued From page 9 Resident 5 Resident 5 was admitted on 06/26/2025. Resident 5's November 2025 Medication Administration Record identified the following: -Acetaminophen 325 MG caplet, take two tablet by mouth every eight hours at 8:00 AM, 2:00 PM, 10:00 PM. -Diclofenac 1% Gel-50 GM apply 4 grams of gel topically to R lateral thigh twice daily at 8:00 AM and 8:00 PM. -Quetiapine 25 MG-take one tablet by mouth every 12 hours at 8:00 AM and 8:00 PM. -Resident 5's November 2025 MAR stated Resident 5 did not receive his/her 8:00 PM medications on 11/08/2025. Resident 5 missed 3 doses of his/her medication. The exception reason stated outside of parameters. Resident 6 Resident 6 was admitted on 10/28/2025. Resident 6's November 2025 Medication Administration Record identified the following: -Atorvastatin 40 MG tab, take one tablet by mouth night at 8:00 PM. -Everolimus 0.5 MG tab tab, take one tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Ipratropium 0.06% Nasal Spray, instill 2 sprays in each nostril four times daily at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. -Metoprolol Tart 100 MG tab, take one tablet by mouth twice daily at 8:00 AM and 8:00 PM. -MG Plus Protein 133 MG tab, take one tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Mycophenolic Acid DR 360 MG HD1, take 2 tablets by mouth twice daily at 8:00 AM and 8:00 PM. -Potassium CL ER 20 MEQ tab, take 2 tablets (40 MEQ) by mouth twice daily at 8:00 AM and 8:00 PM.	N 352		

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N 352	Continued From page 10 -Prednisolone Ace 1% Ophth Susp, Instill one drop in left eye four times daily for 4 days at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. -Quetiapine 25 MG tab, take one tablet by mouth nightly at 8:00 PM. -Resident 6's November 2025 MAR stated Resident 6 did not receive his/her 8:00 PM medications on 11/08/2025. Resident 6 missed 8 doses of his/her medication. The exception reason stated outside of parameters. Resident 7 Resident 7 was admitted on 07/18/2024. Resident 7's November 2025 Medication Administration Record identified the following: -Eliquis 2.5 MG tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Metoprolol Tart 25 MG tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Montelukast 10 MG tab, take 1 tablet by mouth nightly at 8:00 PM. -Symbicort 160/4.5 MCG-120 INH, inhale 2 puffs by mouth twice daily at 8:00 AM and 8:00 PM. -Resident 7's November 2025 MAR stated Resident 7 did not receive his/her 8:00 PM medications on 11/08/2025. Resident 7 missed 4 doses of his/her medication. The exception reason stated outside of parameters. Resident 8 Resident 8 was admitted on 04/01/2024. Resident 8's November 2025 Medication Administration Record identified the following: -Buspirone 5MG tab, take one tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Carvedilol 25 MG tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Lantus Solostar 100 Unit/ML Pen, Inject 20 units subcutaneously once daily at bedtime at 8:00 PM. -Resident 8's November 2025 MAR stated	N 352		

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N 352	Continued From page 11 Resident 8 did not receive his/her 8:00 PM medications on 11/08/2025. Resident 8 missed 3 doses of his/her medication. The exception reason stated outside of parameters. Resident 9 Resident 9 was admitted on 09/02/2025. Resident 9's November 2025 Medication Administration Record identified the following: -Ibuprofen 200 MG tab, take one tablet by mouth every 12 hours for pain at 8:00 AM and 8:00 PM. -Melatonin 3 MG tab, take 2 tablets by mouth once daily at bedtime at 8:00 PM. -Propranolol 80 MG tab, take one tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Quetiapine 50 MG tab, take one tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Vitamin D3 2,000U (50 MCG) tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. -Resident 9's November 2025 MAR stated Resident 9 did not receive his/her 8:00 PM medications on 11/08/2025. Resident 9 missed 5 doses of his/her medication. The exception reason stated outside of parameters. Resident 10 Resident 10 was admitted on 10/03/2025. Resident 10's November 2025 Medication Administration Record identified the following: -Gabapentin 100 MG cap, take 1 capsule by mouth three times daily at 8:00 AM, 4:00 PM and 8:00 PM. -Simvastatin 20 MG tab, take 1 tablet by mouth once daily at 8:00 PM. -Resident 10's November 2025 MAR stated Resident 10 did not receive his/her 8:00 PM medications on 11/08/2025. Resident 10 missed 2 doses of his/her medication. The exception reason stated outside of parameters.	N 352		

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N 352	Continued From page 12 On 12/16/2025, Surveyor interviewed Executive Director B. Executive Director B stated the facility did not have a medication passer from 5:00 PM until almost midnight on 11/08/2025 and confirmed the residents did not receive their 8:00 PM medications on 11/08/2025. Executive Director B stated the certified medication passer did not show up for his/her shift so s/he had to try and call other staff to come in and the earliest someone could come in to pass the medications was after the 8:00 PM medication pass so all the residents who had 8:00 PM medications did not receive their medications. CROSS REFERENCE N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN	N 352		
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 observation and interview, the provider did not assess 14 residents reviewed for each	N 381		

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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 381	Continued From page 13 resident's needs, abilities, and physical and mental condition before admitting the person to the facility. There was no evidence of a completed assessment for any resident regarding window locks and alarms. All common windows and resident bedrooms had window locks and alarms. Findings include: On 12/09/2025, at approximately 12:10 PM, Surveyors observed window alarms and locks on the 2nd floor window by the elevator. On 12/09/2025 at approximately 12:15 PM, Surveyor interviewed Health and Wellness Director C. Health and Wellness Director C stated, all the resident window and common windows are like that in the facility. Surveyor asked Health and Wellness Director C if there were assessments completed on all residents regarding window locks and alarms. Health and Wellness Director C stated s/he was not sure since s/he had only been working there for a week or so, but would check. On 12/16/2025 at 10:30 AM, Surveyor reviewed the above concerns with Regional Director of Operations A. Regional Director of Operations A stated all windows have been like that since s/he has been working at the building which has been since the change of ownership. Regional Director of Operations A stated s/he would work with maintenance to take the alarms and locks off the windows. Regional Director of Operations A stated there were not any current assessments for them.	N 381		

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	0015325	A. BUILDING: _____ B. WING _____	C 12/17/2025

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N 387	Continued From page 14	N 387		
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 1 of 2 resident records reviewed (Resident 11). Findings include: On 12/09/2025 at approximately 4:00 PM, Surveyor reviewed the record of Resident 11. Resident 11 was admitted on 02/20/2025. Resident 11 has a Health Care Power of Attorney	N 387		

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N 387	Continued From page 15 (POA). Resident 11's current ISP, dated 09/24/2025, was not signed or dated by Resident 11's POA. On 12/16/2025 at approximately 10:30 AM, Surveyor interviewed Regional Director of Operations A. Regional director of Operations A stated if it was not signed, then they did not get it signed by the POA.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents' Individual Service Plans (ISP) were reviewed and updated with changes in needs, abilities or physical or mental condition. Resident 10's ISP was not updated to reflect Resident 10's change in wound care and Resident 11's was not updated to reflect change in ambulation, non-weight bearing, fall with fracture and seizure like activity.	N 389		

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N 389	Continued From page 16 This is a repeat deficiency. See Statement of Deficiency (SOD) RT4K11, dated 11/08/2023. Findings include: On 12/09/2025 at approximately 4:00 PM, Surveyor reviewed Resident 10 and Resident 11's record and identified the following. Resident 10 -Resident 10 was admitted on 10/03/2025 with diagnoses of hypertension and type 2 diabetes. -Resident 10's Individual Service Plan (ISP) dated 10/03/2025 stated the following: "Risk for skin issue, assist with turning and repositioning frequently throughout each shift to relieve pressure from vulnerable areas." -Resident 10's observation notes stated the following: -"10/09/2025 at 3:01 PM, Type: Skin Monitoring Note: It was brought to this writers attention that [Resident 10] acquired a skin tear to [his/her] L forearm when being transferred in hoyer from shower back to recliner. Unable to determine how skin tear occurred very little bleeding noted by staff members border dressing applied, this writer and staff will be monitoring closely for comfort and s/s of any redness or swelling. Resident unable to state how skin tear happened and unaware of the skin tear until addressed by staff." -"11/15/2025 at 1:15 PM, Resident noted with dark colored area on inner left thigh, appears to looks like rubbing from briefs, with small amount of drainage, area cleansed and covered with abd pad, home health notified and will send nurse out for eval." -"11/20/2025 at 4:08 PM, open areas to left inner thigh with soiled dressings. Writer cleansed	N 389		

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areas and applied new dressings. Call made to Preceptor to inquire on wound orders and nursing visit schedule."
-"11/20/2025 at 7:45 PM, Preceptor nurse returned writer's call. Writer updated on wound status. Reports [s/he] will ensure nurse visit for 11/21 to be completed."
-"11/21/2025 at 12:03 PM, Preceptor nurse here to see [Resident 10] today. [S/he] checked and re-addressed wounds to left inner thigh."
-"11/24/2025 at 4:07 PM, Caregivers reported that laceration/wound to left inner looked worse. Area looks larger than when writer saw it last week. Area covered with bandage. Writer called and updated Preceptor home health, waiting return call."
-"11/25/2025 at 7:33 PM, Resident inner left leg has gotten worse scar is deeper yellow pus is secreting. Elbows and arms are leaking clear fluids."

Resident 11
-Resident 11 was admitted on 02/20/2025 with diagnoses of hypertension and type 2 diabetes.
-Resident 11's observation notes stated the following:
-"08/22/2025 at 11:52 AM, an incident has been recorded. [Resident 11] was sitting in chair in living room with other resident sitting in chair next to [him/her]. Staff asked [Resident 11] to get up that [s/he] needed to have [his/her] brief changed. [Resident 11] started swinging [his/her] arm making contact with other resident's face. No apparent injuries noted at time of incident. Families have been notified along with MD's incident location."
-"09/11/2025 at 12:49 PM, It was brought to this writers attention that [Resident 11] has been having behavioral issues with punching walls and wash machine in common area. R hand swelling

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has been noted this writer did obtain an order for an x-ray which has been completed with negative results for any type of injury. [Spouse] notified and aware of behaviors."
-"09/18/2025 at 9:13 AM, This writer received a phone call from NOC staff members that [Resident 11] was having seizure-like activity and foaming at the mouth with eyes rolling back. Staff immediately phone 911 who arrived and had to sedate [Resident 11] in order to attend to [him/her]. [Resident 11] was taken to hospital."
-"09/19/2025 at 3:03 PM, [Resident 11]'s anticipated discharge is Monday at 10:00 AM, [s/he] will be returning on Hospice Services."
-"09/22/2025 at 12:40 PM, [Resident 11]'s DME delivered, awaiting hospice to come in, received phone call that their visit has been delayed due to [spouse] asking that [his/her] lawyer review consents before [s/he] signs, this writer did return [spouse]'s phone call stating [Resident 11] is in need of comfort medications and things need to be expedited to be able to get [Resident 11] comfortable."
-Resident 11's Discharge Report from hospital dated 09/22/2025 at 9:15 AM stated the following: "Reason for hospitalization: Altered Mental Status, Discharge diagnoses: dementia, new-onset seizure, comminuted, displaced fracture of left proximal humerus, lactic acidosis, T7 Thoracic vertebral body fracture. Patient with elevated lactic acid and suspected seizure. Patient loaded with keppra. Patient with comminuted displaced proximal left humeral surgical neck and head fracture. Ortho was consulted and recommended surgery however after long discussion with ortho and palliative patient's activated POA declined surgery and elected for comfort care in the hospital and would like patient to return to [his/her] memory care unit with hospice. Patient is to remain in sling for

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N 389	Continued From page 19 comfort and NON-WEIGHT BEARING." -Resident 11's Individual Service Plan (ISP) dated 09/24/2025 stated the following: -"Ambulation: Ambulatory, walks a lot." -No information regarding Resident 11's fractures, non-weight bearing and seizures. On 12/16/2025 at approximately 10:30 AM, Surveyor interviewed Regional Director of Operations A with the above concerns. Regional Director of Operations A acknowledged the concerns and stated s/he had concerns with previous management and is currently working on fixing the issues.	N 389		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers (Caregiver D and Caregiver E), who administered injectable medication, were delegated by a registered nurse (RN) within the scope of their license to do so. Caregiver D and Caregiver E administered insulin injections without delegation. Findings include: On 12/09/2025, Surveyor requested to review	N 416		

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N 416	Continued From page 20 Caregiver D's and Caregiver E's employee records. Surveyor identified the following: -Caregiver D was hired on 09/03/2024. Caregiver D's record did not contain evidence of nurse delegation for administering injectable medication. -Caregiver E was hired on 11/18/2025. Caregiver E's record did not contain evidence of nurse delegation for administering injectable medication. On 12/09/2025 at approximately 2:30 PM, Clinical Specialist J indicated at least two residents received insulin injections. On 12/16/2025 at approximately 10:30 AM, Surveyor reviewed the above concerns with Regional Director of Operations A. Regional Director of Operations A confirmed with Regional Director of Clinical Services K that Caregiver D and Caregiver E did not have nurse delegation for administering injectable medication. Regional Director of Operations A stated s/he would make sure moving forward all staff that are passing medications have nurse delegation.	N 416		
N 487	83.44(1)(b) Separate laundry storage areas or containers Storage and transport. The CBRF shall have separate clean and dirty laundry storage areas or containers. Storage containers shall be clean, leak-proof and have a tight fitting lid. The CBRF may not transport, wash or rinse soiled laundry in areas used for food preparation, serving or storage.	N 487		

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N 487	Continued From page 21 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure soiled laundry was not transported in areas used for serving food. This is a repeat deficiency. See Statement of Deficiency (SOD) #RT4K11, dated 11/08/2023. Findings include: On 12/09/2025 at approximately 12:07 PM, Surveyor toured the facility. Surveyor observed a stacked washer and dryer in the 2nd floor dining room, a few feet from where residents were eating lunch. Surveyor observed laundry being done in the same area as the dining room. On 12/09/2025 at approximately 02:30 PM, Surveyor interviewed Executive Director B. Surveyor shared observation that resident laundry was handled in the same location residents ate. Executive Director B stated since s/he has started which was a few months ago, the laundry has always been done like that. Executive Director B acknowledged the infection control concern and stated s/he would work with maintenance to fix it.	N 487		
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 secure cleaning compounds and toxic substances were stored in a secure area.	N 499		

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N 499	Continued From page 22 Findings include: The provider is licensed a class CNA (non-ambulatory) community based residential facility able to serve up to 24 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. On 12/09/2025 at approximately 12:07 PM, Surveyor toured the facility and observed a stackable washer and dryer in the dining room area with a bottle of laundry detergent on top of it. The washer and dryer was not in a separate room with a door and lock so the laundry detergent was not secured. Surveyor observed residents independently go into and out of the kitchen/dining room area. At approximately 2:30 PM, Surveyor reviewed the above concerns with Executive Director B. Executive Director B acknowledged the concern of cleaning compounds not being secured and stated s/he will remind all staff that cleaning supplies should be stored in the locked cleaning closet.	N 499		
N 521	83.47(1)(c) Safety requirements: no safe evacuation If a resident cannot be safely evacuated from their bedroom as determined by the CBRF ' s assessment, the CBRF shall instruct the resident to remain in the resident ' s bedroom and the CBRF shall meet all of the following requirements: 1. Be sprinklered as required under s. HFS 83.48(8). 2. Notify the local fire department and identify the specific residents	N 521		

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N 521	Continued From page 23 using point of rescue, and provide an up-to-date floor plan identifying where those resident rooms are located. 3. Have vertical smoke separation between all floors. 4. Have 24 hour awake qualified resident care staff. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide the fire department a floor plan which informed the department of 4 of 4 residents that were a point of rescue. Findings include: On 12/09/2025 at approximately 10:15 AM, Surveyor observed the elevator not working. On 12/09/2025 at approximately 11:00 AM, Surveyor interviewed Health and Wellness Director C. Health and Wellness Director C stated the elevator has not been working for 2 weeks. At approximately 11:10 AM, Surveyor reviewed the above concerns with Executive Director B. Executive Director B stated there were four residents who rely on the elevator for safe evacuation. Executive Director B stated the elevator was out of service for about 2 weeks and was still not repaired. Surveyor asked Executive Director B if the fire department had been updated with specific residents within the facility that require assistance evacuating or have become a point of rescue due to the elevator not working. Executive Director B stated s/he was unaware if anyone had updated the fire department and would check with maintenance to see if they contacted them.	N 521		

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N 521	Continued From page 24 On 12/09/2025 at approximately 11:20 AM, Surveyor interviewed Fire Chief I. Fire Chief I stated s/he has never had any communication on any point of rescue plans nor have they been given an up-to-date floor plan from the facility at Charter Senior Living of Hasmer Lake. Fire Chief I stated the facility never let them know that the elevator was down but knows in the past they have had elevator issues. On 12/11/2025 at approximately 12:00 PM, Executive Director B identified Resident 1, Resident 2, Resident 3 and Resident 4 as residents that lived on the second floor of the facility as residents who would need assistance to evacuate and are not able to use stairs without assistance. On 12/16/2025 at approximately 10:45 AM, Surveyor interviewed Regional Director of Operations A with above concerns. Regional Director of Operations A stated s/he was not aware the Fire Department was not made aware of the elevator and floor plan with the point of rescues. Regional Director of Operations A stated there has been a lot of turnover in management and s/he plans to contact the Fire Department personally and rebuild the relationship. The provider did not provide the fire department with the required information regarding residents identified as point of rescue or the location of these residents in the facility. Residents were at risk for harm in the case evacuation was required in the event of a fire as the fire department was not made aware of the location of the residents requiring point of rescue.	N 521		

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N 521	Continued From page 25 CROSS REFERENCE N0525 DHS 83.47(2)(d) Fire Drills N0530 DHS 83.47(3) Fire Inspection N0538 DHS 83.48(3)(a) Fire Detection Systems Inspected Annually	N 521		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not identify and document residents having an evacuation time greater than 4 minutes for fire drills in calendar year 2024. The provider did not conduct fire drills in quarter 1, 2, or 3 of calendar year 2024. Findings include:	N 525		

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N 525	Continued From page 26 The provider is a Class CNA (non-ambulatory) CBRF licensed to serve up to 24 residents with diagnoses of advanced age and irreversible dementia/Alzheimer's. On 12/09/2025, Surveyor requested the provider's fire evacuation drills from calendar year 2024. Surveyor received the following reports of fire evacuation drills: - 12/24/2024: Start time 11:00 AM, end time 11:30 AM. - 11/05/2024: Start time 03:00 PM, end time 03:15 PM. - 10/23/2024: Start time 09:40 PM, end time 09:50 PM. The records did not document resident names for those who took over 4 minutes to evacuate and there was no fire drill recorded in quarter 1, 2 or 3 of calendar year 2024. On 12/16/2025 at approximately 10:30 AM, Surveyor interviewed Regional Director of Operations A. Regional Director of Operations A stated everything that they had from maintenance was given to Surveyor so if there was not documentation of it happening, then they did not have it.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015325	A. BUILDING: _____ B. WING _____	C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF HASMER LAKE	N168 W22022 MAIN ST JACKSON, WI 53037

(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 526	Continued From page 27 provider did not conduct 1 of 2 other evacuation drills at least semi-annually for calendar year 2024. Findings include: On 12/09/2025, Surveyor requested to review other evacuation drills for calendar year 2024 from Executive Director B and Health and Wellness Director C. There was no documented drills for calendar year 2024. On 12/16/2025 at approximately 10:30 AM, during exit conference, Regional Director of Operations A stated s/he was unaware the documentation was missing. Regional Director of Operations A reached out to the Regional Maintenance Manager H during the exit conference. Regional Maintenance Manager H stated s/he sent Regional Director of Operations A all that s/he could see on the TELS system. Regional Director of Operations A sent other evacuation drill to Surveyor at 10:54 AM. There was only 1 of 2 other evacuation drills sent that was dated 02/28/2024. Regional Director of Operations A acknowledged they only conducted 1 of 2 other evacuation drills for calendar year 2024.	N 526		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the	N 530		

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N 530	Continued From page 28 provider did not ensure that the annual fire inspection by the local fire authority was completed. Findings include: On 12/09/2025 at 09:30 AM, Surveyor requested calendar year 2024 of fire inspection reports from Executive Director B and Health and Wellness Director C. Health and Wellness Director C stated s/he could not locate any inspection in TELS (integrated system to help monitor maintenance tasks). On 12/16/2025 at approximately 10:30 AM, during exit conference, Regional Director of Operations A stated s/he was unaware the documentation was missing. Regional Director of Operations A reached out to the Regional Maintenance Manager H during the exit conference. Regional Maintenance Manager H did not have documentation of local fire inspection for calendar year 2024. Cross Reference: N0525 DHS 83.47(2)(d) Fire Drills	N 530		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and staff interview, the	N 538		

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	0015325	A. BUILDING: _____ B. WING _____	C 12/17/2025

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N 538	Continued From page 29 provider did not ensure the fire detection system was inspected for 1 of 1 calendar year (2024). Findings include: On 12/09/2025 at approximately 10:30 AM, Surveyor requested from Executive Director B and Health and Wellness Director C the annual fire detection system inspection for calendar year 2024. Executive Director B and Health and Wellness Director C did not have any documentation. On 12/16/2025 at approximately 10:30 AM, during exit conference, Surveyor interviewed Regional Director of Operations A. Regional Director of Operations A stated s/he could not locate an annual fire detection system inspection for calendar year 2024.	N 538		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. 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. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2	N 637		

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N 637	Continued From page 30 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 3 emergency exits was free of snow and ice. Findings include: On 12/09/2025 at approximately 10:45 AM, Surveyor toured the provider's facility with Health and Wellness Director C. Surveyor observed approximately 1 inch of snow and ice on the walkway outside the door. According to www.certifiedsnowfalltotals.com, Jackson, WI had a light period of snow December 6-7th which would indicate the snow had been there for approximately 2 days. On 12/09/2025 at approximately 2:30 PM, Surveyor shared concern with Executive Director B that the facility's side door, which was identified as an emergency exit, had approximately 1 inch of snow and ice covering the walkway that was slippery to navigate, obstructing the exit and making it hazardous. Executive Director B stated s/he would follow up with the individuals that complete the facility's snow removal to ensure the walkway was cleared.	N 637		