STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013388	A. BUILDING: _____ B. WING _____	R-C 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRUS TIVOLI COMMUNITY	2805 HUNTERS TRAIL PORTAGE, WI 53901

(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 04/30/2026, Surveyor conducted a verification visit at Aspirus Tivoli Community. Three deficiencies were identified. Two of 3 deficiencies were repeat violations. See Statement of Deficiency (SOD) BPUN11, dated 10/16/2025 and SOD JFHZ12, dated 09/29/2022. The previous deficiencies from SOD BPUN11, dated 10/16/2025 were substantially corrected. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 30	{N 000}		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess 1 of 1 resident (Resident 5) reviewed when s/he had a change in his/her	N 381		

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

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N 381	Continued From page 1 needs, abilities, and/or physical and mental condition. Resident 5 did not have an assessment completed after returning to facility from being hospitalized for a right hip fracture. Findings include: On 04/30/2026, Surveyor reviewed Resident 6's record and identified the following: Resident 5 was admitted to the facility on 09/11/2024 with diagnoses including dementia, atrial fibrillation, and chronic kidney disease. Resident 5 had an activated healthcare power of attorney. Surveyor reviewed the facility's e-file and reviewed a self-report dated 03/14/2026. The following was found: "On Saturday 3/14/2026, [Caregiver H] heard [Resident 5] yelling for help. Staff went to investigate why [Resident 5] was screaming, Resident was found on the floor on [his/her] back to [his/her] closet. Staff asked what happened. [Resident 5] stated [s/he] was trying to get a hoodie from [his/her] closet and lost [his/her] balance. Staff noticed that [Resident 5] hit [his/her] head and was bleeding. Asked if [s/he] was having any pain and [s/he] stated "no." Staff called POA that resident would be sent to the emergency room for evaluation. 911 was called and resident was transported via ambulance to the hospital. Additional note: resident is independent. Incident outcome: [Resident 5] was taken to the emergency room. Radiographs showed closed fracture of neck of right femur and olecranon fracture, right. [Resident 5] was admitted to ....hospital, Monday, 3/16/26. [Resident 5] had procedure performed to correct right hip fracture."	N 381		

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N 381	Continued From page 2 Resident 5's progress notes dated 03/16/2026 documented: "Late entry for 03/14/2026: heard loud bang from another resident's room. Resident fall was at the closet and fell backwards into counter/table. Had coworker grab a towel to put pressure on the wound, while I went to call 911. Did fall result in injury?: Yes-presumed major injury, fractured R hip, R elbow, laceration to head right hip(s) head arm. Transferred to emergency room." A review of Resident 5's March 2026 medication administration record showed Resident 5 did not receive his/her medications 03/15/2026 to 03/20/2026. Resident 5's progress notes documented: "-03/23/2026: Resident had requested to have PT/OT therapy at [provider name] outpatient for [his/her] fractured hip and elbow. -03/27/2026: Staples removed form [sic] head. Follow up post hospitalization. -04/01/2026 ....appointment for ortho moved until next week due to risk." Resident 5's record did not contain a change of condition assessment following his/her right hip fracture and return to the facility. On 04/30/2026 at 2:00 PM, Surveyor interviewed Administrator A and RN I. Surveyor requested a change of condition assessment following Resident 5's right hip fracture and hospitalization in March 2026. RN I stated s/he would review Resident 5's record. On 04/30/2026 at 2:45 PM, Surveyor interviewed Administrator A and RN I. Both staff explained they searched Resident 5's electronic health	N 381		

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N 381	Continued From page 3 record (EHR) and could not locate an assessment for Resident 5 following his/her hip fracture and hospitalization. RN I stated the provider had gone through a systems change with their EHR system so s/he was still learning where all reports were located. RN I stated s/he thought s/he completed the assessment after Resident 5 had returned from the hospital. Surveyor stated evidence of a change of condition assessment for Resident 5 would need to be submitted no later than 05/01/2026 at 10:00 AM. Both staff verbally agreed. As of 05/04/2026, no further records were sent.	N 381		
{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 observation, record review and interview, the provider did not ensure 2 of 2 resident's (Resident 2 & Resident 10) individual service plans (ISPs) were accurate to their	{N 389}		

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{N 389}	Continued From page 4 condition and needs. Resident 2's ISP was not updated with new interventions after 4 falls from 03/01/2026 to 04/30/2026. In addition, Resident 2's ISP did not identify use of a broda chair and oxygen concentrator. Resident 10's ISP was not updated with new interventions related to his/her behaviors of refusing cares and aggression. This is a repeat deficiency. See Statement of Deficiency (SOD) BPUN11, dated 10/16/2025. Findings include: On 04/30/2026 at 11:20 AM, Surveyor toured Resident 2's bedroom. Surveyor observed a broda chair next to a small white table and an oxygen concentrator next to Resident 2's recliner chair. On 04/30/2026, Surveyor reviewed resident records and identified the following: Example 1: Resident 2 Resident 2 was admitted to the facility on 06/01/2022 with a diagnoses of Alzheimer's disease and seizure disorder. Resident 2 had an activated healthcare power of attorney. Resident 2's ISP dated 12/02/2025 documented: "Transfers: Resident is assist of 1 on occasion for transfer off the couch/bed/toilet. Cognitive: Resident is unable to make decisions, unable to remember things that happened a short time ago, unable to remember things that happened a long time ago. (10/15/2025) Fall/safety: Resident is at risk for falls have/history of falls due to cognitive	{N 389}		

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{N 389}	Continued From page 5 impairment, decreased mobility, unsteady gait, services ALF to provider-evaluate risk. Call light within reach, provide adequate lighting in [his/her] room at night. Alarm in place at all times when in bed. Bariatric bed. Bed in lowest position at night. Fall mat in place. Frequent checks. Report any falls to RN/AL manager promptly. Outside services: Hospice. Chronic/Recurring Illness: Seizure disorder: health care monitoring, each shift, administration of medication as ordered, proper fall precautions in place (bariatric bed, fall mat, bed alarm, low bed) daily." Resident 2's progress notes dated 03/01/2026 to 04/30/2026 documented: "-03/09/2026: Late entry for 03/07/2026-resident was seen in empty room walking and starting to walk backwards when [s/he] lost balance and fell. Did fall result in injury? -Yes-presumed minor injury, bruising back of head. -03/23/2026: resident was wandering after having [his/her] shower, being toileted. Resident attempted to stand at the handrail on the wall just outside the day room and fell onto [his/her] side. Did fall result in injury? -No apparent injury. -04/02/2026: resident noted to be "droopy" today. Leaning forward. No eating as well as usual. Temp 99.6, pulse 83, O2 95% room air, BP 111/80, resp 16. Runny nose. Covid test positive. Resident assisted to [his/her] room, and droplet precautions started. Hospice contacted. -04/16/2026: resident was sliding out of chair previous and staff repositioned [him/her]. Resident traveling around area. Found on ground in front on wheelchair sitting slid from chair. Did fall result in injury? -No apparent injury. -04/28/2026: resident was sitting in recliner when [s/he] helped [him/herself] up and lost balance. Did fall result in injury? -No apparent injury. -Staff measuring oxygen saturation on the	{N 389}		

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{N 389}	Continued From page 6 following dates: 03/02, 03/09, 03/11, 03/22, 03/23, 04/02, 04/03, 04/05, 04/06, 04/07, 04/08, 04/09, 04/16, 04/28." The ISP was not updated to include new interventions after 4 falls from 03/01/2026 to 04/30/2026. The last update to Resident 2's fall interventions was 10/15/2025. Resident 2's ISP did not identify the use of a broda chair and oxygen concentrator. Example 2: Resident 10 On 04/30/2026 at 9:30 AM, Surveyor observed Resident 10 walking around the unit undressed while holding a white t-shirt as a pair of pants. At 9:37 AM, Resident 10 was observed yelling (cussing) in the hallway. Resident 10 set off a door alarm and by 9:40 AM, staff were able to get Resident 10 into his/her room. On 04/30/2026 at 11:23 AM, Surveyor interviewed Housekeeper J. Surveyor asked why an exit banner was spread across a doorway in the unit. Housekeeper J reported the banner was used to deter Resident 10 from going to that side of the unit because s/he wanders and goes into other resident rooms. Housekeeper J reported Resident 10 ripped away several name plates off the wall that displayed resident names and room numbers. At 11:30 AM, Surveyor observed 10 name plates around the Mother Mary (dementia unit) that had been tore down. Resident 10 was admitted to the facility on 03/06/2026 with a diagnosis of dementia. Resident 10 had an activated healthcare power of attorney. Resident 10's ISP dated 03/06/2026 documented: "I am at risk for wandering. Services ALF to Provider: Wandering/elopement policies	{N 389}		

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{N 389}	Continued From page 7	{N 389}		

implemented, monitor hypnotic medications. Behavior: I need redirection at times. Approach me in a calm manner when trying to direct. I like to tear paper, and tinker so if I am pulling apart items redirect me to an area where I can do this safely with legos, puzzles ect. I may wander and try to exit seek or go into other resident area. Try to redirect me or distract me with a game like balloon volleyball."

Resident 10's progress notes documented: "-03/28/2026: resident continues to pull the alarms off the door and goes out the back door. Resident is safe back in the building.
-04/07/2026: the resident exhibited intimidating behavior the following number of times this (NOC) shift: resident was getting staff faces when we would tell [him/her] no that [s/he] couldn't go into other residents rooms, diversional activity was offered and was reassurance was offered and was toileting was offered and was not effective/not easily altered. The resident resisted care the following number of times this (NOC) shift: 1. Resident had soiled [his/her] pants and refusing to let anyone change [him/her] with multiple attempts. Reassurance was offered and was toileting was offered and was diversional activity was offered and was not effective/not easily altered. The resident was physically abusive the following number of times this (NOC) shift): 2. Shoved staff when we were trying to redirect from other residents rooms and also grabbed staffs gown and riped [sic] it.
-04/11/2026: the resident was physically abusive the following number of times this shift: 1. Waited to get [him/her] up until [s/he] got up on [his/her] own. Helped change [his/her] clothes. Refused to be washed up will try again later. [S/he] appeared agitated. [S/he] did swing at me. Hard to get [his/her] medication in [him/her]. Gave in a small

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{N 389}	Continued From page 8	{N 389}		

amount of coffee.
-04/12/2026: resident slept-in and when [s/he] got up [s/he] refused cares, retried 3 times. Diversional activity was offered and was fluids/snacks were offered and was toileting was offered and was not effective or easily altered, didn't get [him/her] to change clothes and [s/he] was pretty much agitated, mad and hyper. Around 11am tried to give [him/her] a shower, [s/he refused and almost hit me and coworker, tried several approach, [s/he] was not having it.
-04/16/2026: agitated, had incontinent bm and continent loose BM this am in unoccupied room. Resident resisting cares all am. The more approaches the more upset resident becomes. Refusing meds. Throwing pants, and wipes while staff trying to assist. Another staff member approached, and resident finally allowed some clean up assist.
-04/17/2026: resident was wandering most of the NOC shift. Kept busy doing puzzle, folding laundry and in room "organizing." Resident ran water in kitchen sink while in room flooding the kitchen floor and parts of the carpeting in room and outside of door. Drain was in sink. Hid drain up in resident kitchen cupboard. Resident fell asleep around 4:30am. @ 2:19 PM: resident is ripping the signs off the wall, restroom sign, salon sign. The resident resisted care the following times this (AM) shift: 4. The resident was physically abusive the following number of times this (AM) shift: 3.
-04/19/2026: @ 5:58 AM: the resident exhibited dangerous/violent behavior the following number of times this (NOC) shift. Resident action/statement: when trying to stop [him/her] from entering another residents room [s/he] grabbed my scrub top and raised [his/her] fist at me ....Woke up at 130 in the morning and has been on the go since. ...Yelling at staff when

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{N 389}	Continued From page 9	{N 389}		

telling [him/her] no. The resident resisted care the following number of times this shift: 2. Would not let us change [him/her], tried to reapproach with no effect. Reassurance was offered and was animal therapy was offered not effective/not easily altered. @ 3:58 PM: the resident exhibited dangerous/violent behavior the following number of times this (PM) shift: 1. Resident action/statement: was going to hit another resident, resident was trying to close dining room door when another resident was telling [him/her] to leave it open, that's when staff stepped in between the two. Almost hit the other resident. Threatened another resident and staff before staff got [him/her] redirected out of the dining room.
-04/20/2026: @ 10:30 AM: reassurance was offered. The resident resisted care the following times this (AM) shift: 2. Agitated at different times ...Refused cares was able to change clothes tried again and [s/he] still wouldn't let me wash [him/her] ....Trying to take things off the wall redirected to do something else, reassurance was offered and was not effective or easily altered. @12:06 PM: The resident verbalized feeling of anger the following times this (AM) shift: 1, resident action/statement: "I'm going to grab a torch and get your face off, [expletive] off, [expletive] you, I'm going to kill you, you son of a [expletive], I am going to beat you."
-04/21/2026: the resident expressed intimidating behavior the following number of times this (PM) shift: 1. Resident action/statement: resident has a bm, staff was trying to change resident and wash residents bottom up. Resident became angry and swung their arm at staff like they were going to hit staff.
-04/23/2026: The resident exhibited dangerous/violent behavior the following number of times this (NOC) shift: 1. Went to help resident change [his/her] clothes for the day and I told

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{N 389}	Continued From page 10 [him/her[what I was doing and I as soon as touched [s/he] tried to swing a fist at me, I backed away and left the room. The resident exhibited dangerous/violent behavior the following number of times this (PM) shift: 2. Resident action/statement: resident was in a empty room 605 at 9pm when med passer gave resident their bedtime pills and prn. Resident was sitting on the floor and wouldn't get up. After waiting 45 mins for medication to kick in, staff went to get resident off the floor and ready for bed. Resident said they would get up. Both staff fish hooked the resident by the arm to lift resident up. Resident became very upset and started to dig [his/her] nails into both staff members arms. Staff waited 5 mins. Resident said okay we could help [him/her] up. Staff went to go lift resident up a second time and resident started to squeeze staffs arms and dig [his/her] fingernails into arms. Staff walked away and let resident be." On 04/30/2026 at 1:30 PM, Surveyor interviewed Administrator A, Director of Senior Services G, and RN I. Surveyor voiced concerns for the lack of updated interventions within Resident 10's ISP related to refusing cares and aggression. Surveyor reviewed Resident 10's current intervention of needing redirection at times and approach in a calm manner. Surveyor noted staff continued to record those approaches were not effective. Director Senior Services G reported redirection was a standard intervention and successful most of the time. Surveyor shared observations of a broda chair and oxygen concentrator in Resident 2's room and not being reflected on his/her ISP. LPN I stated Resident 2 was not currently using the broda chair but had in the past. The management team stated they were unaware Resident 2 had an oxygen concentrator in his/her room, but reported	{N 389}		

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{N 389}	Continued From page 11 hospice brings items into the building without telling us. On 04/30/2026 at 2:45 PM, Surveyor interviewed Administrator A and RN I. Surveyor shared the concern of Resident 2's ISP not being updated since October 2025 related to his/her fall intervention plan and experiencing 4 falls in the past 2 months. Both staff acknowledged an understanding Resident 2's ISP was not updated and stated they would start adding dates to the ISP when new interventions were implemented.	{N 389}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure at the time of medication administration, the person administering the medication initialed the administration record for 5 of 6 resident records reviewed.	N 415		

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N 415	Continued From page 12 This is a repeat deficiency. See Statement of Deficiency (SOD) JFHZ12, dated 09/29/2022. Findings include: On 04/30/2026, Surveyor conducted a verification visit and reviewed resident records. The following was found: On 04/30/2026 at 11:55 AM, Surveyor observed the 12 PM medication pass with Caregiver K. While Caregiver K was preparing medications for Resident 4, Resident 8, and Resident 9, Surveyor observed the laptop attached to the provider's medication cart, the laptop screen showed the above residents did not have initials recorded for the 12 PM medication pass on 04/25/2026 and 04/26/2026. Surveyor questioned Caregiver K. Caregiver K stated s/he did not work those days but presented the Surveyor medication cards from the cart, which showed the medications had been administered. During the medication pass, Administrator A had walked onto the unit, and the Surveyor asked for clarification regarding the missing initials. At 12:10 PM, Administrator A brought Caregiver C to the medication cart. Caregiver C stated s/he was the medication passer for 4/25 and 4/26, s/he administered the medications but forgot to sign on the medication administration record (MAR). Administrator A provided retraining to Caregiver C. Example 1: Resident 4 Surveyor reviewed Resident 4's April 2026 MAR. Surveyor noted the following dates were not initialed on the MAR at the time of medication administration: -Quetiapine Fumarate 25mg - 1 tab daily (1300): 04/25, 04/26	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013388	A. BUILDING: _____ B. WING _____	R-C 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 415	Continued From page 13 Example 2: Resident 5 Surveyor reviewed Resident 5's March and April 2026 MARs. Surveyor noted the following dates were not initialed on the MAR at the time of medication administration: -Amlodipine 5mg - 2 tabs daily (Breakfast & Supper): 03/11 (supper), 04/20 (supper) -Sodium Bicarbonate 650mg - 2 tabs daily (Breakfast & Supper): 03/11 (supper), 03/15 (supper), 04/20 (supper) -Metformin 500mg - 2 tabs daily (Breakfast & Supper): 03/11 (supper), 03/15 (supper), 04/20 (supper) -Docusate Sodium 100mg - 2 tabs daily (Breakfast & Supper): 04/20 (supper) -Donepezil 10mg - 1 tab daily (supper): 04/20 -Warfarin Sodium 5mg - 5x/week (Monday, Tuesday, Wednesday, Friday, Saturday) (supper): 04/20 -Latanus SoloStar Insulin 100unit/ML solution sub-Q at bedtime: 04/20 Example 3: Resident 8 Surveyor reviewed Resident 8's April 2026 MAR. Surveyor noted the following dates were not initialed on the MAR at the time of medication administration: - Quetiapine Fumarate 25mg - 1 tab daily (1300): 04/25, 04/26 Example 4: Resident 9 Surveyor reviewed Resident 9's April 2026 MAR. Surveyor noted the following dates were not initialed on the MAR at the time of medication administration: -Brimonidine Tartrate-Timolol 0.2%-0.5% solution (1) drop to eyes both twice per day AM: 04/24 -Acetaminophen 500mg -1 tab daily (Afternoon): 4/25, 4/26	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013388	A. BUILDING: _____ B. WING _____	R-C 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRUS TIVOLI COMMUNITY	2805 HUNTERS TRAIL PORTAGE, WI 53901

(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 415	Continued From page 14 Example 5: Resident 10 Surveyor reviewed Resident 10's April 2026 MAR. Surveyor noted the following dates were not initialed on the MAR at the time of medication administration: -Levothyroxine Sodium 50mcg - 1 tab daily (AM): 04/18, 04/23 -Trospium Chloride 20mg - 2 tabs daily (AM & HS): 04/16 (HS), 04/18 (PM) -Aspiring 81 mg - 1 tab daily (Breakfast): 04/18 -Losartan Potassium 100mg - 1 tab daily (Breakfast): 04/18 -Memantine 10mg - 2 tabs daily (Breakfast & HS): 04/16 (HS), 04/18 (Breakfast) -Metformin 500mg - 2 tabs daily (Breakfast & Supper): 04/18 (both administrations) -Metoprolol 25mg - 2 tabs daily (Breakfast & Supper): 04/18 (both administrations) -Duloxetine 30mg - 1 tab daily (Breakfast): 04/18 -Trazadone 50mg - 2 tabs daily (Breakfast & Supper): 04/24 (breakfast) -Atorvastatin 80mg - 1 tab daily (HS): 04/16 On 04/30/2026 at 1:30 PM, Surveyor interviewed Administrator A, Director of Senior Services G, and RN I regarding documentation of medication administration. The management team acknowledged the findings. Director of Senior Services G reported s/he would work with RN I to complete daily audits until staff are retrained.	N 415		