STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 08/25/2025, Surveyor conducted a complaint investigation, verification visit, and self-report investigation at A Colfax Senior Living LLC. The complaint was unsubstantiated. Two violations were identified. One violation was a repeat deficiency. See Statement of Deficiencies (SOD) DBX312, dated 11/26/2024 and SOD DBX311, dated 07/22/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 53	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 3's individual service plan (ISP) was implemented as written. Resident 3's elopement intervention was not followed on 08/25/2026. Findings include: On 07/24/2025, the Department received a self-report from the provider indicating Resident 3 eloped on 07/23/2025. Resident 3 fell and injured him/herself after s/he crossed the county highway next to the facility. The self-report read, "The resident sustained a skin tear and likely facial bruising from the fall... A WanderGuard device will be placed on the resident's person tonight, as	N 388		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 388	Continued From page 1	N 388		

requested by the family."

On 08/25/2025 at approximately 9:30 AM, Surveyor interviewed Resident 3. Resident 3 was in bed and his/her bare feet and ankles were visible. Surveyor did not see a WanderGuard on Resident 3.

At 9:37 AM, Surveyor interviewed Caregiver C. Caregiver C stated s/he had worked at the facility for approximately 1 month, and s/he was assigned to Resident 3's wing. Surveyor asked if there were any residents who had been assessed to be elopement risks. Caregiver C listed 3 residents, but did not identify Resident 3 as an elopement risk. Surveyor asked if any residents on Caregiver C's unit had WanderGuards. Caregiver C stated all residents identified as having an elopement risk should have a WanderGuard device on their ankle or walker. Surveyor asked if Resident 3 should have a WanderGuard; Caregiver C stated s/he was unsure but acknowledged that Resident 3 recently eloped.

Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 04/14/2025. His/her ISP, updated 07/24/2025, read: "RISK - ELOPEMENT (WANDERGUARD IN USE) ... Directions: Confirm Wanderguard [sic] is securely in place and functioning each shift. Check that door alarms, sensors, and access points are operational. Monitor for signs of exit-seeking, restlessness, or confusion-especially during high-risk times (shift changes, mealtimes). Redirect the resident using calm verbal cues, engaging activities, or relocation to a supervised area. Immediately report any alarms, missing devices, or attempted exits to the nurse or supervisor. Document checks, interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 388	Continued From page 2 used, and any changes in behavior. Schedule: Daily@ As Needed Resident's Needs: The resident is at risk for elopement due to cognitive impairment, confusion, restlessness, or exit-seeking behavior. A Wanderguard [sic] device is in place as a safety measure to alert staff of unauthorized exit attempts, which have been identified as an elopement risk. Resident left facility on 7/23 to go to the store [sic] telling staff [s/he] was leaving with family." At approximately 12:50 PM, Surveyor interviewed Administrator A and Licensed Practical Nurse (LPN) B. Both stated Resident 3 should have a WanderGuard on and staff should be checking it daily. At approximately 1:00 PM, LPN B and Surveyor checked Resident 3's ankles, wrists, and walker and did not locate a WanderGuard. LPN B stated s/he was unsure where the WanderGuard was or how long Resident 3 did not have it on. At 1:30 PM, Assistant Administrator (AA) D entered Administrator A's office with Resident 3's WanderGuard. AA D stated s/he found it in Resident 3's dresser. AA D stated s/he placed the WanderGuard on Resident 3's ankle on 07/24/2025, but it appeared that it had been cut off and placed in his/her dresser. AA D was unsure how long Resident 3's WanderGuard was on Resident 3's body after s/he applied it on 07/24/2025.	N 388		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 3 addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure health monitoring services were provided for 2 of 3 residents sampled. Resident 1's health was not monitored after s/he underwent emergency gallbladder surgery. Resident 1 experienced symptoms (vomiting) 2 days after his/her return, and his/her record did not include physician notification. Resident 2's weight was not monitored daily as ordered. Resident 2 experienced chest pain on	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 4	{N 431}		

08/22/2025 and was sent to the emergency department. The provider continued not to monitor Resident 2's weight after this event.

This is a repeat deficiency. See Statement of Deficiencies (SOD) DBX312, dated 11/26/2024 and SOD DBX311, dated 07/22/2024.

Findings include:

RESIDENT 1:
On 08/25/2025 at 9:23 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he had emergency surgery last week.

On 08/25/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/27/2024. Resident 1's observation notes, dated 08/18/2025 through 08/25/2025, read: "08/19/25 12:30 PM... This writer (Administrator A) was notified by staff that resident was not looking well ... Resident was looking clammy and uncomfortable, saying [his/her] side was hurting. Writer brought resident back to [his/her] room to sit and rest in recliner while I reached out to the POA (power of attorney) about resident. Writer suggested [s/he] take [Resident 1] to Urgent [sic] care and POA agreed. [S/he] came and picked resident up to go to hospital to be checked out."

"08/22/25 1:45 PM ... Resident returned from the Hospital."

"08/24/25 7:00 PM ... At supper tonight resident got sick while eating [his/her] requested meal of rice and lactose free milk. Resident vomited twice before going back to [his/her] room, stating that [s/he] was no longer hungry. Writer (Dining Director E) checked on resident after supper was cleaned up and resident said,'[S/he] felt better but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 5 would really like to have [his/her] laundry done this evening.' Writer passed this request on to the caregivers working on the floor tonight." Resident 1's hospital discharge paperwork, dated 08/22/2025, indicated s/he was admitted to the hospital 08/19/2025 and discharged on 08/22/2025. Resident 1's diagnosis included cholecystitis acute with cystic duct obstruction. S/he underwent general surgery on 08/20/2025. The report read, "Was found to have a gangrenous gallbladder with extensive inflammatory changes. Unable to complete cholangiogram due to obstructed cystic duct, Blake drain placed into gallbladder fossa." Discharge instructions indicated to contact Resident 1's provider if s/he experienced any nausea/vomiting or inability to eat. Surveyor reviewed the providers policy on health monitoring. The policy read, "Any staff that identifies a possible change of condition in a resident will notify the Administrator [sic] or designee immediately ... the following steps will be taken if a change in condition is suspected: A. Ensure resident safety. B. check [sic] vital signs and document. C. Document resident complaints, symptoms or change in the Resident Record ... The Administrator [sic] or designee will immediately notify the resident's practitioner, legal representative, family and case management agency ... The Administrator [sic] or designee will ensure all communication with the resident's practitioner, legal representative, family, and case management agency are documented in the resident record." Resident 1's record did not include evidence that staff notified nursing or Resident 1's physician after s/he experienced nausea/vomiting on	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 6 08/24/2025. Resident 1's individual service plan (ISP), updated 08/22/2025, read: "POST-HOSPITAL MONITORING... Directions: Monitor the resident closely following return from the hospital. Obtain and document full vital signs (temperature, blood pressure, heart rate, respiratory rate, and oxygen saturation) once daily for 3 days. Monitor for changes in condition, including alertness, pain, respiratory effort, or new symptoms. Report any concerns to nursing immediately. Schedule: Daily@ AM Vitals: Blood Pressure, Pulse, PulseOx, Temperature, Respirations Resident's Needs: The resident is at risk for complications or delayed symptoms following hospitalization and requires short-term monitoring to ensure safe recovery and early identification of any emerging issues." Surveyor reviewed Resident 1's vital log and task administration record (TAR) at 12:35 PM on 08/25/2025. Resident 1's post-hospital monitoring task (added to Resident 1's tasks on 08/22/2025) was left blank on 08/23/2024 and 08/25/2025, indicating the service was not completed. The record showed Resident 1's vitals were last checked at 1:27 PM on 08/24/2025, indicating staff did not check Resident 1's vitals after s/he experienced a change in condition (nausea/vomiting). On 08/25/2025 at approximately 1:20 PM, Surveyor interviewed Administrator A and Licensed Practical Nurse (LPN) B. Neither were aware staff had not completed post-hospital monitoring for Resident 1. LPN B stated they have not been monitoring staff charting like they	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 7 should. Administrator A stated s/he expected to be cited again for health monitoring services because the previous nurse was not monitoring staff charting to ensure health monitoring tasks were completed. Administrator A stated the provider's new registered nurse started on 08/25/2025, and s/he would ensure nursing and management would review staff charting going forward. RESIDENT 2 On 08/25/2025 at 11:10 AM, Administrator A informed Surveyor that Resident 2 was the only resident who required daily vital monitoring. Administrator A said Resident 2 had an order from his/her physician for daily weight monitoring. On 08/25/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 04/10/2025, with diagnoses that included pulmonary hypertension, chronic pulmonary embolism, and chronic obstructive pulmonary disease. Resident 2's ISP, updated 07/02/2025, read: "The resident has multiple chronic medical and psychiatric conditions that require ongoing management, monitoring, and coordination with their primary care provider and specialists. The care team must remain vigilant in observing for clinical changes, documenting symptoms or concerns, and promptly informing the physician or hospice provider to prevent complications ... WEIGHT MONITORING - DAILY WEIGHTS (Physical Health/Nursing Procedures) Schedule: Daily@ AM - Daily Weight Resident's Needs: The resident requires daily weight monitoring due to a medical condition that may result in fluid retention or rapid weight fluctuations. Resident's Desired Outcomes: Staff will obtain	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 8 and record the resident's weight daily, preferably before breakfast. Nursing staff will monitor for weight trends and report any significant changes to the physician. Staff will ensure proper functioning of the scale and consistent technique to maintain data accuracy. Measurable Goals (with specific time limit for attainment): The resident's daily weight will be obtained and recorded with 100% compliance until the following review. The resident will remain within the provider-specified weight parameters until the following review. Any significant weight change will be identified and reported promptly for review by the provider, pending the following scheduled review." On 08/25/2025, Surveyor reviewed Resident 2's vital log and TAR for August 2025. These records indicated Resident 2's weight was obtained 1 day in August, on 08/08/2025. An observation note, dated 08/22/2025, indicated Resident 2 returned from an outing with complaints of severe chest pain and numbness in his/her left arm. Resident 2 was sent to the emergency room and diagnosed with "nonspecific chest pain." Resident 2 returned with instructions to take his/her pain medications, rest, and monitor for new or worsening symptoms. The provider continued not to monitor Resident 2 after s/he returned from the emergency department.	{N 431}		