STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 03/24/2026, Surveyor conducted a standard licensure survey and complaint investigation at Pine Meadows 4. Data was collected through 04/01/2026. The complaint was substantiated. Thirteen deficiencies were identified. One of the 13 deficiencies was a repeat deficiency. See Statement of Deficiency (SOD) M3J812, dated 11/30/2023. Census: 12	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF. The licensee did not maintain all required records when the CBRF transitioned to a new management company. Findings include: The provider is licensed, since 04/04/2023, to care for up to 16 residents in the client groups of: advanced aged, irreversible dementia/Alzheimer's	N 196		

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

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N 196	Continued From page 1 disease, physically disabled, and terminally ill. On 03/24/2026, Surveyor started a standard licensure survey and a complaint investigation. Surveyor gathered documentation through 04/01/2026. On 03/24/2026 at 12:18 p.m., House Manager (HM) B told Surveyor they did not have any original records of residents, employees or safety reports since the new management company took over. HM B told Surveyor Administrator A was in contact with the licensee and the licensee was aware the previous records were no longer available. HM B told Surveyor the current management team took over 01/12/2026. On 03/25/2026 at 11:45 a.m., HM B told Surveyor the previous management company "destroyed" parts of the previous electronic records, and they have started the new electronic records on 03/13/2026. At 1:15 p.m., HM B told Surveyor they were unable to access the previous electronic record system. Surveyor was unable to review required documentation of resident records to ensure the provider was in compliance with Wis. Admin. Code ch.83. On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed HM B, Administrator A was on the phone and Staff E was present. Administrator A told Surveyor that some things got lost in transitioning between the old electronic records and the new electronic records. Surveyor allowed the provider through 04/01/2026 to submit additional documentation if it was located. On 04/01/2026 at approximately 9:30 a.m.,	N 196		

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N 196	Continued From page 2 Surveyor interviewed HM B and Administrator A on the phone. HM B told Surveyor they were able to locate the previous safety inspection reports, which were emailed to Surveyor. Surveyor reviewed recommended deficiencies with administrative codes. Administrator A told Surveyor, "It's all semantics." S/he explained to Surveyor that they were going through a change of ownership and needed time to change over into their new electronic system. Surveyor explained that they were operating under the same license that was issued in 2023. As a result of the survey, 13 deficiencies were issued, and the complaint was substantiated. Cross References: N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0223 DHS 83.18(1) Employee Records Maintained And Current N0385 DHS 83.35(2) Temporary Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Changes N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0454 DHS 83.42(1) Resident Record Maintained N0499 DHS 83.45(3) Toxic Substances N0503 DHS 83.46(1)(b) Portable Space Heaters Prohibited N0535 DHS 83.48(1)(b) Smoke And Heat Detectors Per NFPA72	N 196		

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N 220	Continued From page 3	N 220		
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 ensure 1 of 2 employees reviewed were screened for communicable disease including tuberculosis (TB) using standards set by the Centers for Disease Control and Prevention (CDC) within 90 days before the start of their employment. Findings include: The CDC states: "All U.S. health care personnel should be screened for tuberculosis (TB) upon hire (i.e., preplacement). This process includes a risk assessment, symptom evaluation, and TB blood test or TB skin test." Retrieved from: https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm on 04/01/2026.	N 220		

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N 220	Continued From page 4 On 03/24/2026, Surveyor reviewed Caregiver C's employee file. Caregiver C's date of hire was 03/10/2026. Caregiver C had a documented communicable disease screen, dated 03/10/2026. Surveyor did not locate a TB blood or skin test in Caregiver C's file. On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed House Manager (HM) B, Administrator A was on the phone and Staff E was present. Surveyor explained that Caregiver C's TB test was not located in his/her employee file. HM B told Surveyor Caregiver C was scheduled to have a TB test on Tuesday (03/31/2026). HM B told Surveyor Caregiver C began working on the floor on 03/13/2026. The provider did not ensure Caregiver C was tested for TB before the start of employment.	N 220		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the	N 223		

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N 223	Continued From page 5 provider did not maintain and keep current an employee record for 1 of 2 employees reviewed. Caregiver C's employee file did not include documentation of all required training. Findings include: On 03/24/2026, Surveyor reviewed Caregiver C's employee file. Caregiver C's date of hire was 03/10/2026. Caregiver C's record did not include documentation of training in resident rights, client groups, and challenging behaviors. His/her employee file did not include delegation from a registered nurse (RN) to administer medications such as insulin, nebulizers, and suppositories. On 03/25/2026 at approximately 11:45 a.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor Caregiver C worked alone in the facility on the overnight shift on 03/19/2026. On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed HM B, Administrator A was on the phone and Staff E was present. Surveyor explained there must be at least one qualified resident care staff present in the facility at all times and Caregiver C would not be considered a qualified resident care staff as his/her record did not include documentation that s/he completed training in resident rights, client group, challenging behaviors, and RN delegation. Staff E reviewed Caregiver C's employee record during the interview. Surveyor asked Staff E if s/he located documentation of the missing training. Staff E told Surveyor s/he did not locate documentation of the missing training.	N 223		

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N 223	Continued From page 6 On 03/30/2026, Surveyor received an email from Administrator A and HM B that included documentation that Caregiver C completed all of the required training on 03/10/2026 and received RN delegation on 03/16/2026. On 04/01/2026 at approximately 9:30 a.m., Surveyor interviewed HM B and Administrator A on the phone. Surveyor explained concerns that Caregiver C's employee record was not maintained and kept current when Surveyor reviewed the employee file on 03/24/2026, as Caregiver C did not have all documentation of completed training in his/her record at the time his/her file was reviewed.	N 223		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a written temporary service plan (TSP) to meet the immediate needs of 1 (Resident 3) of 1 resident reviewed that was a new admission. This is a repeat deficiency. See Statement of Deficiency (SOD) M3J812, dated 11/30/2023. Findings include: On 03/24/2026 at approximately 11:25 a.m.,	N 385		

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N 385	Continued From page 7 Surveyor interviewed Resident 3. Resident 3 told Surveyor s/he lived at the facility for approximately 2 weeks. Resident 3 told Surveyor it was "going okay." S/he said staff were "fine." Surveyor asked about staff working the overnight shift. Resident 3 told Surveyor s/he did not meet any of the staff on the overnight shift. S/he said staff did not come in and help him/her during the overnight. On 03/25/2026, Surveyor reviewed Resident 3's record. It was unclear as to when his/her admission date was as his/her face sheet indicated s/he was admitted on 01/29/2026. Surveyor reviewed his/her H & P (history and physical), which was dated 03/04/2026. The H & P indicated it was completed at the skilled nursing facility Resident 3 resided at prior to his/her admission to the CBRF. Resident 3 signed his/her admission agreement on 03/11/2026. Surveyor did not locate a pre-admission assessment or TSP in Resident 3's record. On 03/25/2026 at approximately 11:45 a.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor the new management team took over running the facility on 01/12/2026. S/he said the previous management company "destroyed" parts of the electronic record system. HM B told Surveyor they started a new electronic records system on 03/13/2026. HM B said s/he was unable to locate Resident 3's individual service plan and pre-admission assessment. On 03/25/2026 at 12:37 p.m., HM B told Surveyor s/he conducted the in person pre-admission assessment for Resident 3 at the skilled nursing facility. S/he told Surveyor "It's (pre-admission assessment) in the old system." HM B said s/he started an assessment in the new electronic	N 385		

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PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

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N 385	Continued From page 8 record but has not completed it yet. On 03/25/2026, Surveyor reviewed the electronic record for Resident 3. There was an individual service plan (ISP) that started on 03/24/2026. The task administration record (TAR) also indicated cares were entered into the system on 03/24/2026. Surveyor did not locate a TSP for Resident 3. On 03/30/2026, HM B and Administrator A emailed Surveyor with Resident 3's handwritten pre-admission assessment, dated 01/28/2026. On 03/30/2026, Surveyor emailed Administrator A and HM B and asked what Resident 3's date of admission was. On 03/30/2026, HM B replied, via email, which indicated Resident was admitted on 03/09/2026. The provider did not prepare and implement a TSP to meet the immediate needs of Resident 3.	N 385		
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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

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N 389	Continued From page 9 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 the individual service plan (ISP) was reviewed and revised for 2 of 2 residents reviewed (Resident 4 and Resident 5) when they had a change in their condition. Findings include: On 03/24/2026 at approximately 11:45 a.m., Surveyor interviewed Resident 4 in his/her room. Resident 4 was in his/her bed. Surveyor observed there was an air mattress on the bed and Resident 4 had a urinary catheter. Resident 4 told Surveyor s/he had cerebral palsy and s/he stayed in his/her room most of the time. Resident 4 told Surveyor s/he had a sore on his/her butt. Surveyor asked Resident 4 how s/he transferred out of his/her bed. Resident 4 explained to Surveyor staff used a mechanical lift with 2 staff members to transfer him/her. On 03/24/2026 at 11:52 a.m., Surveyor observed Resident 5 seated in a wheelchair. On 03/24/2026 at approximately 12:30 p.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor Resident 4 required 2 staff to assist with a mechanical lift and s/he had a stage III pressure injury to his/her bottom. HM B told Surveyor Resident 5 required 2 staff at times to transfer. On 03/25/2026 at approximately 11:45 a.m.,	N 389		

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PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

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N 389	Continued From page 10	N 389		

Surveyor interviewed HM B. HM B told Surveyor the new management team took over running the facility on 01/12/2026. S/he said the previous management company "destroyed" parts of the electronic record system. HM B told Surveyor they started a new electronic records system on 03/13/2026.

On 03/25/2026, Surveyor reviewed resident records, including a paper binder and the electronic record for Resident 4 and Resident 5.

Resident 4's date of admission was 06/02/2020. S/he had multiple diagnoses including cerebral palsy. There was a signed ISP in Resident 4's binder, dated 04/10/2025. The ISP read, in part: "Provide full assistance with transferring from bed to wheelchair/device, assist with pushing wheelchair/device. 1 - 2 ASSIST FOR TRANSFERS WITH GAIT BELT." Resident 4's ISP did not indicate s/he used a mechanical lift with 2 staff for transfers. The ISP did not indicate s/he had a stage III pressure injury to his/her buttocks and did not indicate s/he had a urinary catheter.

Resident 5's date of admission was 11/0/2019. S/he had multiple diagnoses including diabetes, congestive heart failure, and chronic kidney disease. Resident 5 was enrolled in hospice and had an activated power of attorney. Resident 5's fall assessment, dated 02/25/2026, by HM B indicated Resident 5 was a total assist for ambulation, used a wheelchair, and had 3 or more falls in the past 6 months. There was a signed ISP in Resident 5's binder, dated 04/12/2025. The ISP read, in part: "Utilizes 2 WW (wheeled walker) ... Can walk and ambulate independently ... Can independently transfer from bed to walker and around the home." Resident

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PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

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N 389	Continued From page 11 5's ISP did not indicate s/he required assistance with 1 - 2 staff for transfers. The ISP did not indicate Resident 5 used a wheelchair. On 03/25/2026 at 1:15 p.m., HM B told Surveyor s/he had started a comprehensive assessment on Resident 5, in the new electronic system, but it was not completed yet. HM B told Surveyor Resident 5 did have a change in condition within the last 2 months. HM B said their new electronic system was started on 03/13/2026 and they were unable to access the previous electronic records. On 03/30/2026, Administrator A and HM B emailed Surveyor Resident 4's and Resident 5's ISPs with a report date of 03/30/2026. The provider did not ensure Resident 4's and Resident 5's ISPs were reviewed and revised when they had a change in condition.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record.	N 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 393	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 (Resident 3) of 1 resident reviewed, that was a new admission, was evaluated within 3 days of admission for evacuation capabilities. Findings include: On 03/24/2026 at approximately 11:25 a.m., Surveyor interviewed Resident 3 in his/her room. Resident 3 was seated in a wheelchair. S/he told Surveyor s/he lived at the facility for about 2 weeks. On 03/25/2026, Surveyor reviewed Resident 3's record including a paper binder and the electronic record. It was unclear as to when his/her admission date was as his/her face sheet indicated s/he was admitted on 01/29/2026. Surveyor reviewed his/her H & P (history and physical), which was dated 03/04/2026. The H & P indicated it was completed at the skilled nursing facility Resident 3 resided at prior to his/her admission to the CBRF. Resident 3 signed his/her admission agreement on 03/11/2026. There was an evacuation assessment in the electronic record, dated 02/24/2025 [sic]. Surveyor opened the assessment in the electronic record, and the assessment was not completed. On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed House Manager (HM) B, Administrator A was on the phone and Staff E was present. Surveyor explained concerns including Resident 3's evacuation assessment not being completed within 3 days of his/her admission. Administrator A said s/he could see there was an assessment in the electronic record.	N 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 393	Continued From page 13 Surveyor asked Administrator A to open the assessment to see that it was not completed. Administrator A confirmed to Surveyor it was not completed. On 03/30/2026, Surveyor emailed Administrator A and HM B and asked what Resident 3's date of admission was. On 03/30/2026, HM B replied, via email, which indicated Resident was admitted on 03/09/2026. The provider did not evaluate Resident 3 within 3 days of his/her admission to determine Resident 3's evacuation capabilities.	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate 2 of 2 residents reviewed (Resident 4 and Resident 5), that resided at the facility for longer than a year, at least annually for his/her mental or physical capability to respond to a fire alarm. Findings include: On 03/24/2026 at approximately 11:45 a.m., Surveyor interviewed Resident 4. Resident 4 told Surveyor staff used a mechanical lift with 2 staff members to transfer him/her.	N 394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 394	Continued From page 14 On 03/24/2026 at approximately 12:30 p.m., Surveyor interviewed House Manager (HM) B and asked which residents required 2 assist for transferring. HM B told Surveyor Resident 1 and Resident 4 required 2 staff to assist with a mechanical lift. HM B told Surveyor Resident 5 and Resident 6 required 2 staff at times to transfer. On 03/25/2026 at approximately 11:45 a.m., Surveyor interviewed HM B. HM B told Surveyor the new management team took over running the facility on 01/12/2026. S/he said the previous management company "destroyed" parts of the electronic record system. HM B told Surveyor they started a new electronic records system on 03/13/2026. On 03/25/2026 at 1:55 p.m., Surveyor interviewed Caregiver J and asked how Resident 4 and Resident 5 transferred. Caregiver J told Surveyor Resident 4 used a mechanical lift with 2 staff to transfer. S/he said Resident 5 was a pivot transfer with 1 or 2 staff. On 03/25/2026, Surveyor reviewed resident records, including a paper binder and the electronic record for Resident 4 and Resident 5. Resident 4's date of admission was 06/02/2020. S/he had multiple diagnoses including cerebral palsy. Surveyor did not locate a completed evacuation assessment for Resident 4. Resident 5's date of admission was 11/01/2019. S/he had multiple diagnoses including diabetes, congestive heart failure, and chronic kidney disease. Resident 5 was enrolled in hospice and had an activated power of attorney. Resident 5's electronic record had an evacuation assessment,	N 394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 394	Continued From page 15	N 394		

dated 02/25/2026. Surveyor opened the assessment, and the assessment was not completed.

On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed HM B, Administrator A was on the phone and Staff E was present. Surveyor explained concerns including Resident 4 and Resident 5's evacuation assessments were not completed. Administrator A said s/he could see there was an evacuation assessment in Resident 5's electronic record. Surveyor asked Administrator A to open the assessment to see that it was not completed. Administrator A confirmed to Surveyor it was not completed. Surveyor explained concerns related to having only 1 staff working at times when there were multiple residents that required 2 staff for assist for transfers. Administrator A told Surveyor those residents were a point of rescue in case of a fire.

On 03/30/2026, Administrator A and HM B emailed Surveyor updated evacuation assessments for Resident 4 and Resident 5. Resident 4's evacuation assessment was dated 03/25/2026. It did not indicate that Resident 4 required assistance from 2 staff to transfer from bed into his/her wheelchair. There were no comments to indicate Resident 4 was a point of rescue. Resident 5's evacuation assessment was dated 03/30/2026. Resident 5's assessment indicated the following: "NEEDS ONLY ONE STAFF means there is no specific evidence that the resident needs help from two or more persons in a fire emergency." There were no comments to indicate Resident 5 would be a point of rescue.

The provider did not ensure Resident 4 and Resident 5 were evaluated at least annually for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

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N 394	Continued From page 16 their physical and mental abilities to evacuate.	N 394		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide a sufficient number of employees on a 24-hour basis to meet the needs of the residents. The provider did not always have 2 staff members working when residents required the assistance of 2 staff members to assist for transfers. Resident 1 required the assistance of 2 staff with a mechanical lift for transfers. Resident 4 required the assistance of 2 staff with a mechanical lift for transfers. Resident 5 and Resident 6 required assistance of 2 staff at times for transfers. Findings include: On 01/15/2026, the Department received a complaint with multiple allegations including concerns related to staffing and the employee schedule. On 03/24/2026 at approximately 11:45 a.m., Surveyor interviewed Resident 4 in his/her room. Resident 4 was in bed. Resident 4 told Surveyor s/he had a sore on his/her butt. S/he said s/he stayed in bed most of the time. Surveyor asked how staff transfer him/her when s/he gets up. Resident 4 told Surveyor, staff used the	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 396	Continued From page 17	N 396		

mechanical lift and 2 staff to transfer him/her. Resident 4 told Surveyor at times there was only 1 staff working.

On 03/24/2026 at 12:18 p.m., House Manager (HM) B told Surveyor they did not have any of the original resident records since the new management company took over.

On 03/24/2026 at approximately 12:30 p.m., Surveyor interviewed HM B. Surveyor asked HM B which residents required 2 staff to assist with transfers. HM B told Surveyor staff roll residents to change on the overnight shift and residents do not get up after 10:00 p.m. HM B told Surveyor Resident 1 and Resident 4 required 2 staff with a mechanical lift to transfer. HM B said Resident 5 and Resident 6 at times required 2 staff to assist with transfers. Surveyor asked HM B if any of the residents had wounds. HM B told Surveyor Resident 4 had a stage III pressure injury.

On 03/24/2026, Surveyor reviewed the employee schedule from 02/01/2026 to 03/24/2026. The schedule indicated the following:
02/05/2025 - Caregiver I worked alone from 6:00 a.m. until 10:00 a.m.
03/23/2026 - Caregiver C worked alone from 11:00 p.m. until 7:00 a.m.

On 03/25/2026, Surveyor reviewed resident records including their paper charts and electronic record for 3 residents including Resident 4 and Resident 5. The evacuation assessments and individual service plans (ISP) were not updated in the electronic record. The paper charts included ISPs for Resident 4 and Resident 5 that were not updated to reflect the residents' current status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 396	Continued From page 18 On 03/25/2026 at 10:11 a.m., Surveyor interviewed HM B about the schedule. Surveyor asked if Caregiver C worked the overnight shift last night (03/24/2026). HM B told Surveyor Caregiver C did not work last night as s/he worked across the street at a different facility last night. HM B said Caregiver F worked alone in the facility on the overnight shift of 03/24/2026. The schedule indicated Caregiver C and Caregiver G worked the overnight shift on 03/24/2026. HM B told Surveyor the schedule was not correct. S/he said s/he terminated Caregiver G. At 11:45 a.m., HM B told Surveyor Caregiver C did work alone on an overnight shift on 03/19/2026. On 03/25/2026 at 1:55 p.m., Surveyor interviewed Caregiver J and asked how Resident 4 and Resident 5 transferred. Caregiver J told Surveyor Resident 4 used a mechanical lift with 2 staff to transfer. S/he said Resident 5 was a pivot transfer with 1 or 2 staff. On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed HM B, Administrator A was on the phone and Staff E was present. Surveyor explained that if a resident required 2 staff to assist with transfers they were required to have 2 staff present at all times. Administrator A told Surveyor the residents did not get out of bed at night and the residents that required 2 staff members would be a point of rescue in a fire. The provider did not provide a sufficient number of employees on a 24-hour basis to meet the needs of the residents. Cross References: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0394 DHS 83.35(5)(b) Annual Evaluation Of	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 396	Continued From page 19 Evacuation Limits N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0454 DHS 83.42(1) Resident Record Maintained	N 396		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain an accurate and current written employee schedule including full names of the employees. Findings include: On 01/15/2026, the Department received a complaint with multiple allegations including concerns related to staffing and the employee schedule. On 03/24/2026 at approximately 10:50 a.m., Surveyor interviewed House Manager (HM) B. Surveyor requested the employee roster with dates of hire and the employee schedule. HM B told Surveyor they were having "staffing issues." S/he told Surveyor s/he has terminated many of the previous employees since the new management company has taken over. Surveyor asked HM B when the new management company started. HM B said the new management company started 01/12/2026.	N 399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 399	Continued From page 20 On 03/24/2026, Surveyor reviewed the employee schedule. The employee schedule from 01/30/2026 - 03/24/2026 did not include full employee names, only their first name. On 03/25/2026 at 10:11 a.m., Surveyor interviewed HM B. Surveyor asked if Caregiver C worked in the facility last night (03/24/2026). HM B said, "No. [S/he] worked across the street." HM B said Caregiver F worked in the facility the night of 03/24/2026 alone. HM B said Caregiver G was terminated. Caregiver G was listed on the schedule. HM B said Caregiver C will work in the facility tonight (03/25/2026) through the weekend. The employee schedule indicated Caregiver C and Caregiver G worked the overnight shift the night of 03/24/2026. On 03/25/2026 at approximately 11:45 a.m., HM B told Surveyor Caregiver C worked alone in the facility on the overnight shift on 03/19/2026. The schedule indicated Caregiver G and Caregiver H worked the overnight shift in the facility on 03/19/2026. On 03/25/2026 at approximately 2:30 p.m., HM B told Surveyor Caregiver C received on the floor training on 03/13/2026, 03/14/2026, and 03/15/2026. The schedule did not indicate Caregiver C worked on those dates. The provider did not maintain an accurate and current written employee schedule with the full names of each employee.	N 399		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 454	Continued From page 21	N 454		

resident at the CBRF. Each record shall include all of the following:
(a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 454	Continued From page 22 PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident records were maintained at the community based residential facility (CBRF) for 3 of 3 residents reviewed (Resident 3, Resident 4, and Resident 5). Findings include: The provider is licensed to care for 16 residents in the client groups of: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, and terminally ill. On 03/24/2026 at 12:18 p.m., House Manager (HM) B told Surveyor they did not have any	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 454	Continued From page 23	N 454		

original records of residents, employees or safety reports since the new management company took over. HM B told Surveyor Administrator A was in contact with the licensee and the licensee was aware. HM B told Surveyor the current management team took over 01/12/2026.

On 03/25/2026 at 11:45 a.m., HM B told Surveyor the previous management company "destroyed" parts of the previous electronic records, and they started the new electronic records on 03/13/2026.

On 03/25/2026, Surveyor reviewed resident records for Resident 3, Resident 4, and Resident 5. Surveyor reviewed a paper binder and the electronic resident record.

RESIDENT 3

Resident 3's face sheet indicated s/he was admitted 01/29/2026. His/her H & P (history & physical) was dated 03/04/2026. The H & P indicated s/he was at a skilled nursing facility and was being seen for discharge from the skilled nursing facility. Resident 3 signed his/her admission agreement on 03/11/2026. Resident 3's record did not indicate a clear date as to when s/he was admitted to the CBRF. On 03/30/2026, Surveyor emailed House Manager (HM) B and asked what Resident 3's date of admission was. On 03/30/2026, HM B replied to Surveyor, via email, which indicated Resident 3's date of admission was 03/09/2026.

Surveyor could not locate a pre-admission assessment in Resident 3's record. On 03/25/2026 at 12:37 p.m., HM B told Surveyor the pre-admission assessment was "in the old system." HM B told Surveyor s/he completed Resident 3's pre-admission assessment when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 454	Continued From page 24	N 454		

Resident 3 was at the skilled nursing facility. HM B told Surveyor s/he started the assessment over in their new electronic system but has not completed it yet. At approximately 2:45 p.m., HM B told Surveyor s/he had the paper copy of Resident 3's pre-admission assessment at home. HM B said the electronic copy of the pre-admission assessment did not stay or did not transfer to the new electronic records. On 03/30/2026, Administrator A and HM B emailed Surveyor the handwritten pre-admission assessment for Resident 3, dated 01/28/2026. This was not maintained in Resident 3's record at the CBRF.

Resident 3's evacuation assessment was dated 02/24/2025 [sic] in the electronic record but the assessment was not completed.

Resident 3's individual service plan (ISP) was started on 03/24/2026 but was not completed. Surveyor did not locate a temporary service plan in Resident 3's record.

There were no observation notes in Resident 3's record. The task administration record was started on 03/24/2026.

Resident 3's medication administration record (MAR) was started on 03/14/2026. There were no other MARs available to review to ensure Resident 3's medications and supplements were administered as prescribed.

RESIDENT 4

On 03/24/2026 at approximately 11:45 a.m., Resident 4 told Surveyor s/he had a sore on his/her butt. At approximately 12:30 p.m., HM B told Surveyor Resident 4 had a stage III pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 454	Continued From page 25 injury on his/her buttocks. Resident 4's record indicated s/he was admitted to the facility on 06/02/2020. Surveyor did not locate a comprehensive assessment for Resident 4. Resident 4's ISP was dated 04/10/2025 and did not indicate Resident 4 had a pressure injury. Surveyor did not locate staff documentation to accurately describe Resident 4's skin condition, significant changes in his/her skin condition, or any changes in treatment and response to treatment Resident 4 received for his/her stage III pressure injury. Resident 4's quarterly assessment for his/her scheduled psychotropic medication, buspirone, was dated 03/24/2026, by Registered Nurse (RN) K. This was the same date as the start of survey. The previous quarterly psychotropic assessment in his/her record was dated 09/29/2025. Surveyor did not locate an evacuation assessment in Resident 4's record. Resident 4's MAR started on 03/14/2026. There were no other MARS located in Resident 4's record to review for compliance. RESIDENT 5 On 03/24/2026 at 11:52 a.m., Surveyor observed Resident 5 seated in a wheelchair. Resident 5's record indicated s/he was admitted to the facility on 11/01/2019. His/her ISP, dated 04/12/2025, indicated Resident 5 ambulated independently with a 2 wheeled walker and that s/he was on hospice. A fall risk assessment, dated 02/25/2026, indicated Resident 5 was a	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 454	Continued From page 26	N 454		

total assist for ambulation and used a wheelchair. The fall assessment indicated Resident 5 had 3 or more falls in the last 6 months. A hospice note, dated 02/24/2026, indicated skilled nursing visited for a follow up from a fall. The hospice note indicated Resident 5 had a "large contusion (bruise) to the posterior bicep (back of arm)." Surveyor did not locate documentation of the fall, including date, time, and circumstances related to the fall.

Surveyor did not locate a current comprehensive assessment for Resident 5.

Resident 5's quarterly psychotropic reviews in his/her paper record were from 2024. A quarterly review for scheduled psychotropic medications in Resident 5's electronic record was dated 03/24/2026 by RN K, for scheduled quetiapine. A monthly PRN (as needed) psychotropic review was dated 03/24/2026, by RN K, for PRN lorazepam.

An evacuation assessment, dated 02/25/2026, in the electronic record was not completed.

A comprehensive assessment, dated 03/01/2026, was started, but not completed.

Resident 5's MARS were started on 03/14/2026. There were no previous MARs for Surveyor to review for compliance.

The provider did not ensure each resident record was maintained at CBRF.

Cross References:
N0385 DHS 83.35(2) Temporary Service Plan
N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Changes

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	0019329	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE MEADOWS 4	385 ORBITING DRIVE MOSINEE, WI 54455

(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 454	Continued From page 27 N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits	N 454		
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 ensure all cleaning compounds were stored in a secure area. Findings include: The provider is licensed to care for 16 residents in the client groups of: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, and terminally ill. On 03/24/2026 at 10:37 a.m., Surveyor observed the laundry room door open (Photo 3). Surveyor entered the laundry room and observed cleaning compounds stored on the shelves (Photo 1). Surveyor observed a cleaning cart with cleaning compounds in the laundry room (Photo 2). At 10:56 a.m., Surveyor observed the laundry door remaining open. On 03/24/2026 at 11:04 a.m., Surveyor observed the shower room/bathroom. Surveyor entered the unlocked shower room and observed a bottle of cleaner with bleach setting on top of the paper towel dispenser. (Photo 4).	N 499		

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N 499	Continued From page 28 On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed House Manager (HM) B, Administrator A was on the phone and Staff E was present. Surveyor explained concerns with observations of cleaning compounds not stored securely.	N 499		
N 503	83.46(1)(b) Portable space heaters prohibited. The use of portable space heaters is prohibited except for Underwriters Laboratories listed electric heating equipment that is listed for permanent attachment to the wall. Portable space heaters shall have an automatic thermostatic control and shall be physically attached to a wall. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure portable space heaters were not used in the facility. Findings include: On 03/24/2026 at approximately 12:00 p.m., Surveyor interviewed Resident 2 in his/her room. Surveyor observed a portable heater on the floor in Resident 2's room. The portable heater was plugged in, running, and set at 78 ° Fahrenheit. On 03/25/2026 at approximately 2:30 p.m., Surveyor interviewed House Manager B, Administrator A was on the phone and Staff E was present. Surveyor explained that the portable heater observed in Resident 2's room was prohibited per administrative code. Administrator A asked Surveyor if Surveyor informed Resident 2 that it was prohibited.	N 503		

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N 503	Continued From page 29 The provider did not ensure portable space heaters were not used in the facility.	N 503		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure the smoke detectors were maintained and were tested by facility personnel at least once every other month and documentation of the testing was maintained. Findings include: The provider is licensed to care for 16 residents in the client groups of: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, and terminally ill. On 03/24/2026 at approximately 10:50 a.m., Surveyor requested the provider's safety reports from House Manager (HM) B, including documentation of smoke detector testing. On 03/24/2026, Surveyor toured the facility and	N 535		

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N 535	Continued From page 30	N 535		

heard a smoke alarm beeping stating it had a low battery. At approximately 11:00 a.m., Surveyor asked Caregiver D where the buzzing noise was coming from. Caregiver D told Surveyor the loud buzzer was a call light, and the beeping was a fire alarm. S/he said they notified maintenance.

On 03/24/2026 at approximately 11:20 a.m., Surveyor interviewed Resident 1 in his/her room. Surveyor heard that the smoke alarm beeping was coming from the ceiling in Resident 1's room. Resident 1 told Surveyor the smoke alarm had been beeping since yesterday (03/23/2026).

On 03/24/2026 at 12:18 p.m., HM B told Surveyor they did not have any original records of residents, employees or safety reports since the new management company took over. Surveyor advised HM B to contact the licensee. HM B told Surveyor Administrator A was in contact with the licensee at that time. HM B told Surveyor the licensee was aware. HM B said Administrator A contacted "previous owner" for records. Surveyor reviewed the entrance handout with HM B again and explained that Surveyor needed to review the safety reports on the handout.

On 03/30/2026, HM B and Administrator A emailed Surveyor safety reports. A report, dated 05/15/2025, indicated the smoke and heat detectors were inspected. Results of the inspection indicated 11 smoke detectors failed sensitivity testing. Surveyor did not receive a report indicating the smoke detectors were checked at least every other month.

On 03/31/2026, Surveyor emailed HM B and Administrator A. The email read, in part: "Do you know if the deficiencies listed in the [company] report, dated 05/15/2025, have been corrected? If

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N 535	Continued From page 31 so, please send documentation to indicate they were corrected." Surveyor did not receive additional documentation to indicate the deficiencies from the 05/15/2025 inspection report were corrected. Surveyor did not receive documentation to indicate the smoke detectors were checked at least every other month.	N 535		