STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 01/07/2025, Surveyors conducted 3 complaint investigations at Anchor Communities, a CBRF located in Fox Lake, WI. As a result of the investigation, 4 violations of Chapter DHS 83 were issued. One complaint was substantiated. Two Complaints were unsubstantiated. Census:	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure that Resident 1 was free from mistreatment. Licensee B used loud, profane and inappropriate language when interacting with Resident 1. Findings include: On 12/13/2024, the Department received a complaint that alleged that residents were subjected to loud, profane and inappropriate	N 348		

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
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 348	Continued From page 1	N 348		

language by Licensee B when interacting with residents.

On 01/07/2025 at 9:00 AM, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted 12/05/2024 with diagnoses that include but are not limited to: Traumatic brain injury with left sided hemiparesis, anxiety, depression, peripheral neuropathy and chronic polyneuropathy.

On 01/07/2025 at 9:30 AM, Surveyors interviewed Resident 1 who stated s/he had been at the facility for about 1 month. Resident 1 stated that s/he had some belongings at his/her previous placement that s/he wanted moved to facility. Licensee B did retrieve some of Resident 1's belongings from previous placement but Licensee B told Resident 1 that s/he could not move all belongings to facility. Resident 1 stated, "Licensee B told me that I can't bring any more of my [expletive] in here even though it is my stuff. Licensee B told me to quit [expletive] about it and shut up." Resident 1 stated that when s/he was speaking to Adult Protective Services C (APS) C, Licensee B barged in and yelled, "I'm sick of your [expletive] complaining. You can't bring any more of your [expletive] in this facility!" Resident 1 stated that s/he had belongings of sentimental value that Licensee B loaded on a trailer but would not allow Resident 1 to retrieve him/herself due to the temperatures and Resident 1's medical condition. Resident 1 stated that APS-C offered to retrieve some of Resident 1's belongings that had sentimental value, but Licensee B told APS-C that s/he was not allowed and if s/he left to go get them, APS-C would not be allowed back in the facility and would no longer be welcome at the facility. Resident 1 stated that APS-C was a witness to most of the interaction between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 348	Continued From page 2 him/her and Licensee B. On 01/07/2025 at 10:45 AM, Surveyor interviewed Administrator A who confirmed that there was a verbal altercation between Licensee B and Resident 1. Inappropriate language and raised voices were use by Resident 1 and Licensee B. Administrator A stated that "We don't have room for all of Resident 1's stuff, we just don't." Administrator A acknowledged that despite not having room for all of Resident 1's belongings, Licensee B was out of line and should not have yelled or used inappropriate language towards Resident 1. On 01/09/2025 at 3:00 PM, Surveyor interviewed APS-C via telephone. APS-C confirmed s/he was at the facility and spoke with Resident 1 on 12/13/2024. APS-C confirmed that Licensee B was present at the facility and spoke to Resident 1 very inappropriately. "Licensee B was yelling and swearing at Resident 1 telling him/her, "You are not moving any more of your [expletive] in here! I'm sick of all your [expletive]!" APS-C stated that s/he told Licensee B that s/he should not be talking to Resident 1 that way. APS-C told Licensee B that Resident 1 still had some items of sentimental value on the trailer and that APS-C would go look for them. APS-C stated that Licensee B yelled in front of Resident 1, "You can't get any more of his/her [expletive] and bring it in here! If you walk out of this facility, you are not allowed back in and are no longer welcome here!"	N 348		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope.	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 386	Continued From page 3 Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was provided a comprehensive individual service plan (ISP) within 30 days after admission and developed a comprehensive ISP for him/her which included: identification of their needs, desired outcomes, identification of program services, frequency and approaches to services/care, established measurable goals with specific time limits for attainment, specified methods for delivering needed care and who was responsible for delivering the care. Resident 1 was admitted to the facility on 12/06/2024. Resident 1 was diagnosed with but not limited to: seizures and generalized anxiety disorder. Since admission Resident 1 had refused a majority of his/her scheduled psychotropic medications prescribed for treatment of anxiety. Resident 1 was prescribed 3 as needed (PRN) psychotropic medications for anxiety and/or insomnia.	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 386	Continued From page 4 On 01/07/2024, Surveyors reviewed Resident 1's ISP. The ISP was not signed by Resident 1 or their case manager (Case Manager C). The ISP did not contain documentation of Resident 1's seizures, anxiety disorder, and PRN psychotropic medications. FINDINGS INCLUDE: On 12/13/2024, the Department received a complaint regarding resident treatment. On 01/07/2025, Surveyors arrived at the facility for a complaint investigation. RECORD REVIEW: On 01/07/2025, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 12/06/2024. Resident 1 was his/her own person. Resident 1's managed care organization (MCO) case manager was Case Manager C. The face sheet documented Resident 1 being a high fall risk and a history of seizures. On 01/07/2025, Surveyor reviewed Resident 1's "Move in assessment," dated 12/06/2025. The assessment did not contain documentation regarding Resident 1's history of seizures and/or anxiety disorder. On 01/07/2025, Surveyor reviewed Resident 1's December 2024 medication administration record (MAR). Resident 1 was prescribed 1,000 mg of Levetiracetam every morning, and 1,500 mg of Levetiracetam every evening for seizures. The December 2024 MAR contained the following psychotropic medication orders:	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 386	Continued From page 5 1.) Escitalopram 10 mg tablet - once daily for generalized anxiety disorder. 2.) Mirtazapine 30 mg tablet - once at bedtime for anxiety/insomnia. 3.) Trazodone 50 mg tablet - once at bedtime for insomnia. 4.) Buspirone 10 mg tablet - one tablet up to 3 times daily as needed (PRN) for anxiety. 5.) Hydroxyzine HCL 25 mg tablet - one tablet up to 3 times daily as needed for anxiety. 6.) Quetiapine 25 mg tablet - one-half tablet once at bedtime as needed for insomnia. The December 2024 MAR documented the following administrations and/or refusals of the above psychotropic medications from 12/07/2024 to 12/31/2024: 1.) Escitalopram 10 mg tablets were not administered. Resident 1 refused 25 times. 2.) Mirtazapine 30 mg tablets were administered 8 times. Resident 1 refused 17 times. 3.) Trazodone 50 mg tablets were administered 24 times. Resident 1 refused 1 time. The December 2024 MAR documented 0 administrations of the PRN psychotropic medications: Buspirone 10 mg tablet, Hydroxyzine HCL 25 mg tablet, and Quetiapine 25 mg tablet. On 01/07/2025, Surveyor reviewed Resident 1's ISP. The ISP was not signed by Resident 1 or Case Manager C. Under the subsection titled, "PSYCHOTROPIC MEDICATIONS - USING," the following is documented, "Resident is prescribed psychotropic medications ...Using psychotropic medications related to specific behaviors: See MAR for medications ...Appropriate use of medications will be maintained. Resident to show no adverse affects (sic.) related to psychotropic	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 386	Continued From page 6	N 386		

medication use. Resident behaviors to be controlled as allowed by progression of disease process ...". The ISP did not contain documentation related to Resident 1's history of seizures and/or current needs/interventions for seizures.

INTERVIEW:

On 01/07/2025 at 9:20 AM, Surveyors interviewed Resident 1. Resident 1 reported s/he suffered from a TBI and seizure disorder. Resident 1 reported his/her last seizure was a long time ago. Resident 1 reported s/he had grand-mal seizures when episodes occurred. Resident 1 reported his/her seizures were managed by the medication Keppra (Levetiracetam) and adequate sleep. Resident 1 reported that s/he had lived at the facility for 32 days and s/he hadn't been able to get adequate sleep, due to Resident 2 watching the community television in the facility living room. Resident 1 reported Resident 2 would turn the volume up on the television directly outside Resident 1's door between the hours of 11:00 PM and 5:00 AM, and this would keep Resident 1 awake at night. Resident 1 reported s/he had reported these incidents with Resident 2 to staff, but staff would not intervene on Resident 1's behalf. Resident 1 reported the medications the facility had been administering to him/her did not look like what he had been taking previously. Resident 1 reported not having the type of rapport with staff or Licensee B to where s/he felt safe at the facility.

On 01/07/2025 at 9:45 PM, Surveyors interviewed Resident 2. Resident 2 reported s/he had been told by staff to keep the volume on the living room television to a reasonable level during nighttime hours. Resident 2 reported s/he had a television

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 386	Continued From page 7	N 386		

in his/her room, but the temperature in his/her room was colder in comparison to the living room temperature. Resident 2 reported there had been multiple disagreements between Resident 1 and Resident 2 over the living room television. Resident 2 reported an incident where Resident 1 had pulled the cords out of the living room television, while Resident 2 was in the dining room.

On 01/07/2025 at 10:00 AM, Surveyors interviewed Administrator A. Administrator A stated Resident 1 was diagnosed with TBI, seizure disorder and mental illness. Administrator A stated Resident 1 had refused most medications but had maintained compliance with his/her anti-seizure medications. Administrator A reported s/he had been told by Resident 1's care team to monitor and send Resident 1 directly to an emergency room (ER) if s/he should have a seizure. Administrator A stated Resident 1 had pulled cords out of the living room television in protest of other resident's utilizing the television.

On 01/07/2024 at 12:02 PM, Surveyor interviewed Resident 1 in the living room. Resident 1 reported staff had not offered him/her PRN medication for anxiety since his/her admission to the facility. Resident 1 stated s/he had not been asked to sign an ISP since s/he moved into facility.

On 01/07/2024 at 1:00 PM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged Resident 1's move-in assessment nor current ISP had listed his/her diagnoses of seizure disorder and/or anxiety disorder. Administrator A acknowledged Resident 1's individualized needs in the event of a seizure were not identified in the current ISP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 386	Continued From page 8 Administrator A acknowledged Resident 1 had been prescribed PRN psychotropic medications for anxiety and/or insomnia. Administrator A acknowledged the current ISP nor the MAR documented specific behaviors related to the PRN psychotropic medications. Administrator A acknowledged Resident 1's current ISP had not been signed by Resident 1 and/or Case Manager C.	N 386		
N 502	83.46(1)(a) Comfortable and safe temperatures A CBRF shall maintain comfortable and safe temperatures. The CBRF shall provide tempered air at all times to eliminate cold air drafts. The heating system shall be capable of maintaining temperatures of 74º F. in areas occupied by residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that temperatures were maintained of 74 degrees Fahrenheit. Four resident bedrooms had measured temperatures of 69 degrees Fahrenheit or less. Findings include: Upon arrival, Surveyor observed 2 windows on the lower level of facility that were open and letting air into the building. One window was partially closed held together with duct tape. Another window was partially closed and held together with a bungee cord.	N 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 502	Continued From page 9 On 01/07/2025 at 10:45 AM, Surveyor toured the physical environment and measured air temperatures in resident bedrooms. OBSERVATIONS: On 01/07/2025 at 10:45 AM, Surveyor measured the air temperature in Resident 1's bedroom. Resident 1 had and admitted to using a portable space heater. Resident 1 stated, "It's too cold in here, so I used the space heater, I know it's not allowed, but I don't care!" The temperature in Resident 1's bedroom measured 74 degrees Fahrenheit with the assistance of the space heater. On 01/07/2025 at 11:00 AM, Surveyor interviewed Resident 2. Resident 2 stated that s/he usually watched television in the living room instead of his/her bedroom, "because it is too cold in my room, it is much warmer out in the living room." Surveyor measured the temperature in Resident 2's bedroom to be 69 degrees Fahrenheit. On 01/07/2025 at 11:10 AM, Surveyor measured the temperature in Resident 3's bedroom. The temperature in Resident 3's bedroom was 68 degrees Fahrenheit. On 01/07/2025 at 11:30 AM, Surveyor measured the temperature in Room 13, which was not occupied. The temperature measured 67 degrees Fahrenheit. On 01/07/2025 at 12:30, Surveyor measured the temperature in Room 5, which was not occupied. The temperature measured 67.5 degrees Fahrenheit. On 01/07/2025 at 12:45 PM, Surveyor discussed	N 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 502	Continued From page 10 the above concern with Administrator A. Administrator A acknowledged that the temperature inside the facility should be maintained at 74 degrees Fahrenheit. Administrator A stated that some residents unintentionally block the heating vents with furniture or belongings which can affect the temperature. Administrator A acknowledged that the windows in the lower level should be closed as that can also affect the temperature in the building.	N 502		
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 prevent the use of a portable space heater in Resident 1's room. Resident 1 had a portable space heater in his/her room plugged in to the electrical outlet. Findings include: On 01/07/2025 at 10:00 AM, Surveyor interviewed Resident 1 in his/her bedroom. Surveyor observed that Resident 1 had a portable space heater plugged into the electrical outlet. Resident 1 stated, "It's too cold in here, I have to sleep with 4 blankets, a coat and long pants. I	N 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015950	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR COMMUNITIES LLC	209 FOREST ST FOX LAKE, WI 53933

(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 503	Continued From page 11 know that the space heater is probably not allowed but I don't care." On 01/07/2025 at 10:30 AM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged that portable space heaters are prohibited. Administrator A stated that the space heater would be removed from Resident 1's room immediately.	N 503		