STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010415	A. BUILDING: _____ B. WING _____	R-C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF ELKHORN	450 E GENEVA ST ELKHORN, WI 53121

(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 10/20/2025, with information obtained through 10/28/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit, complaint investigation, and standard licensing survey at Kindredhearts of Elkhorn, a community-based residential facility (CBRF) located in Elkhorn, WI. As a result of the survey, 17 deficiencies were identified. Six deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) FTUV15, dated 07/09/2025, SOD FTUV14, dated 12/05/2024, SOD FTUV13, dated 07/12/2024, SOD FTUV12, dated 02/02/2024, SOD FTUV11, dated 08/25/2023, SOD BBRN12, dated 01/20/2023, and SOD BBRN11, dated 07/21/2022. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. The complaint was substantiated. Census: 19	{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 record review and interview, the provider did not ensure that the CBRF and its operation complied with all laws governing it.	{N 196}		

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

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{N 196}	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV15, dated 07/09/2025, and SOD FTUV14, dated 12/05/2024. Findings include: Example 1 - Repeated noncompliance On 10/20/2025, Surveyor reviewed Department records for the provider. Within the records, Surveyor observed an e-mail communication from Regional Director K to the Department, which was sent on 10/06/2025 (3:34 p.m.) and documented, "...Just wanted to check in. Are we on your radar to come visit us soon? We are ready!..." Surveyor reviewed SOD FTUV15, in which a previous deficiency for "N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws" was documented. On 10/20/2025, with information obtained through 10/28/2025, Surveyor conducted a complaint investigation, verification visit for SOD FTUV15, dated 07/09/2025, and standard licensing survey. Seventeen citations of noncompliance were identified, 6 of which were repeat citations, as identified below: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws This requirement is being cited for a third time. See SOD FTUV15, dated 07/09/2025, and SOD FTUV14, dated 12/05/2024. Of note, the previous times this was cited in SOD FTUV15 and SOD FTUV14 involved the provider not following special orders as directed by the Department in each SOD's corresponding Notice and Order letter.	{N 196}		

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{N 196}	Continued From page 2 N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses This requirement is being cited for a third time. See SOD FTUV13, dated 07/12/2024, and SOD FTUV12, dated 02/02/2024. N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication This requirement is being cited for a second time. See SOD FTUV15, dated 07/09/2025. N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes This requirement is being cited for a fourth time. See SOD FTUV15, dated 07/09/2025, SOD FTUV14, dated 12/05/2024, and SOD FTUV13, dated 07/12/2024. N0431 DHS 83.38(1)(g) Health Monitoring This requirement is being cited for a third time. See SOD FTUV15, dated 07/09/2025, and SOD FTUV11, dated 08/25/2023. N0558 DHS 83.48(8)(b) Sprinkler System Installation and Maintenance This requirement is being cited for a third time. See SOD BBRN12, dated 01/20/2023, and SOD BBRN11, dated 07/21/2022. Example 2 - Order not to admit new or additional residents (NNAO) On 10/20/2025, Surveyor conducted a complaint investigation into concerns that a resident was admitted to the provider when the provider was under an order not to admit new or additional residents. On 10/20/2025, Surveyor reviewed Department	{N 196}		

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{N 196}	Continued From page 3	{N 196}		

files for the provider, which included the most recently issued SOD, SOD FTUV15, and its corresponding "Notice and Order" letter. The "Notice and Order" letter was dated 08/08/2025 and documented the following order:

"Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Kindredhearts of Elkhorn NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency FTUV15 are corrected, compliance is verified by the Department, and this Order is rescinded in writing."

On 10/20/2025, Surveyor reviewed the resident roster, provided by Acting Director R. Resident 23 was identified as having been the only new resident since the last survey, SOD FTUV15, from 07/09/2025. On the roster, the residents' admission dates were handwritten by Acting Director R. Resident 23's admission date was written as "8-1-25."

On 10/20/2025, Surveyor reviewed Resident 23's record. Resident 23 was documented as being his/her own legal representative. Resident 23's admission date on his/her facesheet was identified as 08/01/2025, however, his/her admission agreement was signed by him/her and dated 08/15/2025 (7 days after the Department's order was in place).

At approximately 4:51 p.m., Surveyor interviewed Regional Director K, Acting Director R, and Acting Director S about Resident 23's admission. Regional Director K reported that Resident 23

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{N 196}	Continued From page 4	{N 196}		

started "renting" the room on 08/01/2025 but did not move in until 08/15/2025. Regional Director K reported that the owner thought that since Resident 23 took "financial control" of the room prior to the NNAO on 08/08/2025 s/he could move in after the NNAO was received. Regional Director K reported that that was how things were done in Illinois. Regional Director K asked Surveyor if the provider should not have admitted Resident 23.

On 10/28/2025, at approximately 2:23 p.m., Surveyor interviewed Social Worker FF, who worked in the county in which the provider was located. Social Worker FF reported being aware that Resident 23 was admitted to the provider after the provider was already under a NNAO. Social Worker FF reported that s/he initially spoke with a representative from an agency that was assisting Resident 23 find placement on 08/12/2025. Social Worker FF reported that s/he was aware of the NNAO and had informed the representative of this, who was unaware that the provider was under a NNAO. Social Worker FF reported that the representative followed up with him/her again later and reported s/he had spoken with the provider's staff, who reported they could admit Resident 23 because s/he signed an admission agreement prior to the NNAO and also reported they could backdate the agreement.

On 10/28/2025, Surveyor reviewed e-mail correspondence from Social Worker FF. In the e-mails, dated 08/20/2025 and 09/03/2025, Social Worker FF reported that facility staff had informed a coordinator that was assisting Resident 23 with moving that Resident 23 could be admitted to the provider after the date the NNAO was issued because s/he had signed paperwork for admission prior to the order being

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{N 196}	Continued From page 5 in place. Of note, Resident 23's admission agreement was signed by him/her on 08/15/2025, approximately 7 days after the NNAO took effect. Cross Reference: N0220 DHS 83.17(2)(a) Employees Screened for Communicable Disease N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0243 DHS 83.21(1)-(3) All Employee Training N0247 DHS 83.22(1)-(4) Task Specific Training N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes N0409 DHS 83.37(1)(j) Proof-of-Use Record N0431 DHS 83.38(1)(g) Health Monitoring N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed and Vented N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(f) Other Evacuation Drills N0558 DHS 83.48(8)(b) Sprinkler System Installation and Maintenance N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperature N0667 DHS 83.59(7)(b) Required Exit Signs Lighted	{N 196}		
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	N 220		

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N 220	Continued From page 6	N 220		

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 that the CBRF obtained documentation from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse indicating that 3 of 3 employees reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of their employment.

Findings include:

On 10/20/2025, Surveyor conducted a review of 3 employees to verify compliance with communicable disease screening requirements. Surveyor requested communicable disease screens from Acting Director R for Caregiver V, Caregiver W, and Caregiver X.

Example 1 - Caregiver V

The communicable disease screen for Caregiver V, hired 03/01/2025, consisted of a tuberculosis skin test administered on 03/31/2025 (approximately 1 month after his/her hire) and read on 04/02/2025. The person who identified

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N 220	Continued From page 7	N 220		

themselves as having administered and read Caregiver V's tuberculosis skin test did not have credentials identified. There were no other communicable disease screen records provided for Caregiver V.

At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee communicable disease screening. When asked what the credentials were of the person who read Caregiver V's tuberculosis skin test results, Acting Director R reported that that person was a licensed practical nurse. Acting Director R confirmed s/he had no other evidence of Caregiver V having been screened for communicable disease.

Example 2 - Caregiver W

There was no communicable disease screen provided for Caregiver W.

At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee communicable disease screening. Acting Director R and Acting Director S confirmed there was no evidence that Caregiver W had been screened for communicable disease.

Example 3 - Caregiver X

The communicable disease screen for Caregiver X, hired 06/24/2025, consisted of the 2-step tuberculosis skin test completed between 08/15/2022 - 08/26/2022 (approximately 3 years prior to his/her hire date). There were no other communicable disease screen records provided for Caregiver X.

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N 220	Continued From page 8 At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee communicable disease screening. Acting Director R and Acting Director S confirmed there was no other evidence that Caregiver X had been screened for communicable disease. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the CBRF provided 3 of 3 employees reviewed with orientation training in all the required topics before each employee performed job duties.	N 230		

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Caregiver V, Caregiver W, and Caregiver X did not complete training in the assessed needs and individual services for each resident for whom they each were responsible or in recognizing and responding to resident changes of condition.

Training completed in preventing and reporting abuse as well as emergency evacuation procedures was completed approximately 4 months, 10 months, and 3 months late for Caregiver V, Caregiver W, and Caregiver X, respectively.

Findings include:

On 10/20/2025, Surveyor conducted a review of 3 employees to verify compliance with employee training requirements. Surveyor requested training records from Acting Director R for Caregiver V, Caregiver W, and Caregiver X.

Example 1 - Caregiver V

The record for Caregiver V, hired 03/01/2025, showed that s/he completed training in preventing and reporting abuse and emergency and evacuation procedures on 07/01/2025 (approximately 4 months after his/her hire date). There was no evidence that Caregiver V completed training in the assessed needs and individual services for each resident for whom s/he was responsible or in recognizing and responding to resident changes of condition.

Example 2 - Caregiver W

The record for Caregiver W, hired 12/19/2024, showed that s/he completed training in preventing and reporting abuse and emergency and evacuation procedures on 10/18/2025

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N 230	Continued From page 10	N 230		

(approximately 10 months after his/her hire date). There was no evidence that Caregiver W completed training in the assessed needs and individual services for each resident for whom s/he was responsible or in recognizing and responding to resident changes of condition.

Example 3 - Caregiver X

The record for Caregiver X, hired 06/24/2025, showed that s/he completed training in preventing and reporting abuse and emergency and evacuation procedures on 09/23/2025 (approximately 3 months after his/her hire date). There was no evidence that Caregiver X completed training in the assessed needs and individual services for each resident for whom s/he was responsible or in recognizing and responding to resident changes of condition.

INTERVIEW:

At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee training. Acting Director S confirmed there was no other evidence of training specific to the required orientation topics for Caregiver V, Caregiver W, and Caregiver X. All acknowledged Surveyor's concern that the 2 training topics that were completed were completed months late for each caregiver reviewed. Regional Director K reported that the provider had been so focused on getting staff hired over the past couple of months that training had been overlooked.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws

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N 239	Continued From page 11	N 239		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 3 employees reviewed obtained all department-approved training as required. Caregiver V and Caregiver X did not have training in fire safety or first aid and choking within 90 days after starting employment.	N 239		

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N 239	Continued From page 12 This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV13, dated 07/12/2024, and SOD FTUV12, dated 02/02/2024. Findings include: On 10/20/2025, Surveyor conducted a review of 3 employees to verify compliance with department-approved training requirements. Surveyor requested training records from Acting Director R for Caregiver V, Caregiver W, and Caregiver X. Example 1 - Fire Safety The record for Caregiver V, hired 03/01/2025, did not contain evidence of training or evidence of meeting an exemption for fire safety. The record for Caregiver X, hired 06/24/2025, did not contain evidence of training or evidence of meeting an exemption for fire safety. At approximately 2:10 p.m., Regional Director K asked Surveyor whose responsibility it was to ensure staff completed department-approved training requirements. At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee training. All confirmed the provider did not have evidence that Caregiver V or Caregiver X completed or met an exemption for fire safety training. Regional Director K reported that the provider had been so focused on getting staff hired over the past couple of months that training had been overlooked. On 10/20/2025, Surveyor verified that neither	N 239		

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N 239	Continued From page 13 Caregiver V nor Caregiver X were on the Community-Based Care and Treatment training registry for fire safety. Example 2 - First Aid and Choking The record for Caregiver V, hired 03/01/2025, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. The record for Caregiver X, hired 06/24/2025, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. At approximately 2:10 p.m., Regional Director K asked Surveyor whose responsibility it was to ensure staff completed department-approved training requirements. At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee training. All confirmed the provider did not have evidence that Caregiver V or Caregiver X completed or met an exemption for first aid and choking training. Regional Director K reported that the provider had been so focused on getting staff hired over the past couple of months that training had been overlooked. On 10/20/2025, Surveyor verified that neither Caregiver V nor Caregiver X were on the Community-Based Care and Treatment training registry for first aid and choking. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 239		

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N 243	Continued From page 14	N 243		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be	N 243		

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N 243	Continued From page 15 completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 employee reviewed obtained all training as required within 90 days after starting employment. Caregiver W did not have training in resident rights, required client groups, and recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment. Findings include: On 10/20/2025, Surveyor conducted a review of 1 employee, Caregiver W, to verify compliance with all employee training requirements. Surveyor requested training records from Acting Director R for Caregiver W. Resident Rights The record for Caregiver W, hired 12/19/2024, showed that Caregiver W completed training in resident rights on 10/18/2025 (approximately 10 months after his/her hire and approximately 7 months after it would have been due). Client Groups The facility is licensed to provide care and services to residents within the client groups of	N 243		

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N 243	Continued From page 16 advanced aged and irreversible dementia/Alzheimer's. The record for Caregiver W, hired 12/19/2024, did not contain evidence of training or evidence of meeting an exemption for client group training. Recognizing, Preventing, Managing, and Responding to Challenging Behaviors The record for Caregiver W, hired 12/19/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. INTERVIEW: At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee training. Acting Director S confirmed that the provider did not have evidence that Caregiver W completed or met an exemption for client group and challenging behaviors training. All confirmed Surveyor's observation that Caregiver W completed training in resident rights months after it was due. Regional Director K reported that the provider had been so focused on getting staff hired over the past couple of months that training had been overlooked. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following:	N 247		

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N 247	Continued From page 17 Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 employees	N 247		

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N 247	Continued From page 18 reviewed obtained all task-specific training as required. Caregiver W, who had responsibilities for providing assistance with activities of daily living training, did not have training in the provision of personal care prior to assuming these duties. Findings include: On 10/20/2025, Surveyor conducted a review of 1 employee, Caregiver W, to verify compliance with task-specific training requirements. Surveyor requested training records from Acting Director R for Caregiver W. The record for Caregiver W, hired 12/19/2024, showed that s/he completed personal care training on 10/18/2025 (approximately 10 months after his/her hire date). At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about employee training. All confirmed Surveyor's observation that Caregiver W completed personal care training months after it was due. Regional Director K reported that the provider had been so focused on getting staff hired over the past couple of months that training had been overlooked. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 247		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats.,	{N 352}		

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{N 352}	Continued From page 19 each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 residents reviewed - Resident 14 and Resident 23 - received their prescribed medications in the dosages and at intervals prescribed by their practitioners. Resident 14, who requested his/her hydrocodone tablets for pain at least daily, ran out of his/her hydrocodone tablets on the morning of 10/03/2025. The next delivery of tablets did not occur until approximately 4:00 p.m. on 10/07/2025. There was no evidence that staff attempted to obtain a refill before his/her tablets ran out. Resident 23, who had chronic obstructive pulmonary disease (COPD), did not receive administrations of either of his/her 2 inhalers on both 10/13/2025 and 10/14/2025. Resident 23 also received the incorrect amount of insulin on 16 occasions from 09/23/2025 - 10/19/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV15, dated 07/09/2025. Findings include: On 10/20/2025, Surveyor reviewed Department records for the provider. Within the records, Surveyor observed an e-mail communication from Regional Director K to the Department, which was sent on 10/06/2025 (3:34 p.m.) and	{N 352}		

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documented, "...Just wanted to check in. Are we on your radar to come visit us soon? We are ready!..."

Surveyor reviewed SOD FTUV15, in which a previous deficiency for "N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication" was documented.

Example 1 - Resident 14

On 10/22/2025, Surveyor reviewed Resident 14's record. Resident 14 was admitted to the provider on 06/01/2025 with diagnoses including chronic pain syndrome and polyosteoarthritis. Resident 14 was documented as being his/her own legal representative. Resident 14's prescriptions included hydrocodone-APAP 5/325 mg tablets with instructions to, "Take 1/2 - 1 tablet...by mouth every 6 hours as needed for pain." Resident 14's observation notes included an entry on 10/04/2025 at 1:00 p.m. which documented, "...writer thinks [Resident 14]'s upset because [s/he]'s out of pain pills." Surveyor reviewed Resident 14's medication administration record (MAR) for October 2025 and noted that staff administered Resident 14 hydrocodone at least once daily at his/her request due to pain except for 10/04/2025 through 10/07/2025. Resident 14's proof-of-use record showed his/her hydrocodone decreased to a quantity of 0 on 10/03/2025 after his/her last tablet was administered that day at 7:06 a.m. The next entry, made at 10/07/2025 at 4:00 p.m. by Acting Director R, showed 60 tablets were added to the medication cart with the annotation, "Pharmacy delivered." Surveyor noted that the proof-of-use record, reviewed from 09/23/2025 - 10/21/2025, showed at least daily administrations of Resident 14's hydrocodone.

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{N 352}	Continued From page 21 On 10/23/2025, at approximately 9:45 a.m., Surveyor interviewed Acting Director R and Acting Director S. When asked about Resident 14's hydrocodone tablets, Acting Director R confirmed that Resident 14 had run out of his/her tablets on 10/03/2025 and had no refills left. Acting Director R reported s/he reached out to Resident 14's doctor about the tablets but his/her doctor wasn't always known to respond. When asked how s/he reached out to Resident 14's doctor, Acting Director R replied that s/he had faxed him/her and then followed up with a phone call the next day. Acting Director R reported that on this occasion, s/he recalled Caregiver I called the pharmacy on a Friday to follow up regarding Resident 14's hydrocodone tablets. Surveyor reviewed the staff schedule with Acting Director R for 10/03/2025 (Friday) and noted that Caregiver I was not on the schedule as having worked that day. Acting Director R then said it was him/her that called the pharmacy to follow up. When asked about the fax to Resident 14's medical provider that was sent, Acting Director R reported s/he believed s/he contacted Medical Provider CC, who was the prescriber of Resident 14's hydrocodone. Surveyor requested evidence of any follow up Acting Director R had with Medical Provider CC's office due that day at 1:00 p.m. At approximately 11:40 a.m., Surveyor reviewed an e-mail sent by Acting Director R at approximately 11:39 a.m. In the e-mail, Acting Director R reported, "Here is the fax document I had sent over to [Medical Provider CC's] office." Surveyor reviewed the attachment which was a picture of a "Communication Sheet" document in which Acting Director R handwrote a note requesting a refill of Resident 14's hydrocodone tablets. Acting Director R wrote that the note was addressed to Medical Provider CC and dated it	{N 352}		

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10/02/2025. There was no confirmation that the document was sent by Acting Director R. At approximately 11:42 a.m., Surveyor requested confirmation that the above fax was sent. At approximately 11:44 a.m., Acting Director R replied, "Then I do not have that to provide."

At approximately 2:39 p.m., Surveyor interviewed Nurse DD, who was the nurse for Medical Provider CC's office. Nurse DD confirmed there was no communication on or around 10/02/2025 regarding Resident 14's hydrocodone tablets.

Example 2 - Resident 23's insulin and inhalers

On 10/20/2025, at approximately 10:19 a.m., Surveyor interviewed Resident 23. Resident 23 reported that s/he had concerns with staff's ability to manage his/her medications. Resident 23 reported that s/he was diabetic and staff administered his/her insulin. Resident 23 showed Surveyor his/her insulin sliding scale chart which was posted on his/her wall. Resident 23 reported s/he had experienced health concerns related to his/her blood sugar levels and that once his/her blood sugar levels "crashed" which caused him/her to fall on the floor. Resident 23 also reported s/he had concerns of his/her medications being available. When asked to clarify what medications were not available, Resident 23 reported that in the past s/he had gone days without receiving his/her inhalers.

At approximately 10:59 a.m., Surveyor observed the medication room with Caregiver BB, who was the medication passer for that day's first shift. Caregiver BB showed Surveyor a copy of Resident 23's insulin sliding scale chart which was posted on the wall of the medication room. Surveyor verified through comparison that this

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was the same sliding scale chart posted in Resident 23's room. Caregiver BB reported that Resident 23 was known to refuse his/her insulin administration or otherwise request a certain number of units be administered to him/her that were not in accordance with his/her sliding scale. Caregiver BB reported that on those occasions, staff were to document in the MAR what Resident 23's blood sugar level was, how many units of insulin were supposed to be administered to him/her, and how many units were administered to him/her based on his/her request. Surveyor reviewed the medication cart with Caregiver BB and observed the following 2 inhalers prescribed to Resident 23:

- Anoro Ellipta 62.5-25 mcg inhaler with instructions to, "Inhale 1 puff by mouth every morning (COPD)." The pharmacy label on the bag indicated it was dispensed on 10/03/2025.

- Arnuity Ellipta 200 mcg inhaler with instructions to, "Use 1 inhalation into the lungs once daily..." The pharmacy label on the bag indicated it was dispensed on 09/23/2025.

On 10/20/2025, Surveyor reviewed Resident 23's record. Resident 23 was admitted to the provider on 08/15/2025 with diagnoses including type II diabetes mellitus, COPD, and mild cognitive impairment. Resident 23 was documented as being his/her own legal representative. Staff documented administering Resident 23's medications. Resident 23's record included a "Risk Agreement" that identified him/her demonstrating non-compliance with his/her insulin administration. The agreement documented: "Resident receives sliding scale insulin 4x daily before meals and bedtime. Staff will draw residents [sic] blood glucose levels and

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show resident the sliding scale orders set by [his/her] [primary care provider]. Resident will review the chart, disagree with sliding scale amount, and decide [his/her] own sliding scale amount...Resident states [s/he] knows [his/her] body and how [s/he] has crashed in low blood sugars too many times with a high does [sic] of insulin. Resident would like staff to ask [him/her] for [his/her] blood sugar and read the sliding scale chart of how many units...Staff will let resident know what [his/her] sliding scale insulin calls for. Staff will then chart what the sliding scale unit of insulin called for and staff will chart what the resident requested to take. Until Resident is seen by [general practitioner]."

Resident 23's prescriptions included Fiasp 100 units/mL flextouch insulin pen, with instructions to, "...Inject [subcutaneously] 4 times daily per [sliding scale]..." Though the sliding scale was not documented as part of his/her orders, Surveyor noted Resident 23's sliding scale as posted in his/her room as well as the medication room:

- 71-90: 5 units (breakfast), 0 units (lunch), 2 units (supper), 0 units (bedtime)
- 91-130: 20 units (breakfast and supper), 7 units (lunch), 0 units (bedtime)**
- 131-150: 21 units (breakfast and supper), 8 units (lunch), 2 units (bedtime)
- 151-200: 22 units (breakfast and supper), 9 units (lunch), 3 units (bedtime)
- 201-250: 24 units (breakfast and supper), 10 units (lunch), 4 units (bedtime)
- 251-300: 26 units (breakfast and supper), 11 units (lunch), 5 units (bedtime)
- 301-350: 28 units (breakfast and supper), 12 units (lunch), 6 units (bedtime)
- 351 - 400: 30 units (breakfast and supper), 13 units (lunch), 7 units (bedtime)

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{N 352}	Continued From page 25 (** = The chart identified this as Resident 23's "base dose" of insulin.) Resident 23's prescriptions also included a Tresiba 100 units/mL flextouch insulin pen, with instructions to, "...Inject 32 units [subcutaneously] at bedtime." Surveyor reviewed Resident 23's MARs from 09/23/2025 - 10/19/2025. Surveyor observed multiple occasions where the annotations by staff were consistent with Caregiver BB's report - where staff documented how much insulin Resident 23 should have received based on his/her sliding scale compared to what was administered to him/her based on his/her request. However, Surveyor observed the following 16 occasions which staff documented administering Resident 23 the incorrect amount of insulin with no other annotations: - 09/23/2025 (breakfast): Blood sugar recorded as 241 (within parameters for 24 total units, or 4 units of sliding scale), 9 sliding scale units documented as administered - 09/28/2025 (breakfast): Blood sugar recorded as 186 (within parameters for 22 total units, or 2 units of sliding scale), 4 sliding scale units documented as administered - 09/28/2025: 12 units of his/her Tresiba insulin documented as administered (compared to his/her order of 32 units) - 09/29/2025 (breakfast): Blood sugar recorded as 219 (within parameters for 24 total units, or 4 units of sliding scale), 2 sliding scale units documented as administered	{N 352}		

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{N 352}	Continued From page 26 - 09/29/2025 (lunch): Blood sugar recorded as 290 (within parameters for 11 total units, or 4 units of sliding scale), 14 sliding scale units documented as administered - 10/03/2025 (lunch): Blood sugar recorded as 394 (within parameters for 13 total units, or 6 units of sliding scale), 16 sliding scale units documented as administered - 10/04/2025 (bedtime): Blood sugar recorded as 306 (within parameters for 6 sliding scale units), 4 sliding scale units documented as administered - 10/06/2025 (breakfast): Blood sugar recorded as 203 (within parameters for 24 total units, or 4 units of sliding scale), 2 sliding scale units documented as administered - 10/12/2025 (breakfast): Blood sugar recorded as 211 (within parameters for 24 total units, or 4 units of sliding scale), 3 sliding scale units documented as administered - 10/12/2025 (supper): Blood sugar recorded as 178 (within parameters for 22 total units, or 2 units of sliding scale), 0 sliding scale units documented as administered - 10/13/2025 (breakfast): Blood sugar recorded as 179 (within parameters for 22 total units, or 2 units of sliding scale), 0 sliding scale units documented as administered - 10/13/2025 (supper): Blood sugar recorded as 151 (within parameters for 22 total units, or 2 units of sliding scale), 0 sliding scale units documented as administered	{N 352}		

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{N 352}	Continued From page 27 - 10/14/2025 (lunch): Blood sugar recorded as 167 (within parameters for 22 total units, or 2 units of sliding scale), 0 sliding scale units documented as administered - 10/15/2025 (supper): Blood sugar recorded as 221 (within parameters for 24 total units, or 4 units of sliding scale), 3 sliding scale units documented as administered - 10/15/2025 (bedtime): Blood sugar recorded as 155 (within parameters for 3 units of sliding scale), 0 sliding scale units documented as administered - 10/17/2025 (lunch): Blood sugar recorded as 210 (within parameters for 10 total units, or 3 units of sliding scale), 2 sliding scale units documented as administered Surveyor also reviewed orders for 2 different inhalers prescribed to Resident 23 - an Anoro Ellipta inhaler and a Arnuity Ellipta inhaler - with the same prescription instructions that Surveyor observed on his/her inhalers' pharmacy labels in the medication cart. In reviewing Resident 23's MARs, Surveyor observed that staff marked not administering either of Resident 23's inhalers on both 10/13/2024 and 10/14/2024 due to "other problems." The entries for both inhalers on 10/13/2025 contained annotations which documented, "Talked to [Assistant Director R] about med." There was no other information for either the 10/13/2025 or 10/14/2025 administrations documented. Surveyor then reviewed Resident 23's observation notes, which did not contain any information about his/her inhalers on or around 10/13/2025 - 10/14/2025.	{N 352}		

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{N 352}	Continued From page 28 On 10/21/2025, at approximately 4:08 p.m., Surveyor e-mailed Acting Director R and asked why Resident 23's inhalers weren't administered on 10/13/2025 and 10/14/2025. On 10/22/2025, at approximately 9:51 a.m., Acting Director R e-mailed Surveyor back and reported, "[Resident 23]'s inhalers were misplaced in a different drawer for two days. Were located and returned to the correct drawer." On 10/23/2025, at approximately 9:45 a.m., Surveyor interviewed Acting Director R and Acting Director S. Both acknowledged Surveyor's medication administration concern but said nothing further. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 352}		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. 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.	N 386		

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N 386	Continued From page 29	N 386		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that within 30 days after admission a comprehensive individual service plan (ISP) was developed for Resident 23 that identified his/her needs, program services and approaches, methods for delivering his/her needed care, and who was responsible for delivering the care.

Findings include:

On 10/20/2025, at approximately 10:19 a.m., Surveyor interviewed Resident 23. Resident 23 reported that s/he had been living with the provider for the past couple of months. Resident 23 reported s/he was frustrated because staff were supposed to clean his/her room daily for him/her but it was not being done. Resident 23 reported s/he was independent with self-care tasks, such as toileting and bathing, and ambulated with a cane. Surveyor observed a single point cane in Resident 23's room. Resident 23 reported that staff were responsible for administering his/her medications but s/he had concerns that they were managing them incorrectly because s/he had gone several days during his/her admission without them. Resident 23 reported s/he utilized a continuous glucose monitoring system to monitor his/her glucose levels for his/her diabetic management but s/he had been without his/her sensors for approximately the last month. Resident 23 reported s/he wasn't sure if it was his/her responsibility or staff's to manage his/her glucose monitoring sensor supply. While interviewing Resident 23, Surveyor observed that s/he wore glasses.

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N 386	Continued From page 30 On 10/20/2025, Surveyor reviewed Resident 23's record. Resident 23 was admitted to the provider on 08/15/2025 with diagnoses including type II diabetes mellitus with diabetic polyneuropathy. Resident 23 was documented as being his/her own legal representative. Surveyor reviewed Resident 23's ISP, which was signed as reviewed on 09/17/2025 and observed the following: - Under the sections for oral care, dressing, grooming, toileting, ambulation, transfers, and orientation, there appeared to be a populated template that documented all levels of assistance ranging from independent to total staff assistance. There was no information in those sections specific to Resident 23's needs. - Under the eating and diet sections, information conflicted as to whether Resident 23 was confirmed to pose or did not pose a choking risk. - Under the "Wandering" section, information conflicted as to whether Resident 23 posed a wandering risk. - Under the "Falls" section, information conflicted as to whether Resident 23 had no history of falling or frequently fell. - Under the sections for "Hearing" and "Eye Sight", the ISP documented that Resident 23 had "good, fair, poor" abilities for each. Both sections documented conflicting information as to whether Resident 23 required glasses and by extension, required staff assistance for managing vision-related needs. - The "Nursing Procedures-Therapy" section documented that nursing procedures were	N 386		

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provided "weekly, daily." Within that section, the following was documented on separate lines: "Physical therapy from:", "Wound care from:", "Nursing provided by Hospice." Of note, Resident 23's record did not identify him/her as receiving hospice services.

- The "Nursing Procedures-Skin Care" section documented conflicting information as to whether Resident 23's skin was "in good condition" or s/he had "open area(s) that require treatment as follows..."

- The "General Health" section, where information regarding Resident 23's diabetes management was located, documented the following: "Resident will have blood sugars between: _____ and _____..." The goal within that section was identified as, "Resident will have blood sugars maintained ordered parameters." There was no information identifying the use of Resident 23's continuous glucose monitoring system or whose responsibility it was to manage its sensors.

There was no information in the ISP identifying Resident 23's needs related to medication management and administration.

At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about Resident 23's ISP. Acting Director R acknowledged Surveyor's concern regarding the conflicting information within Resident 23's ISP and reported that s/he had utilized the provider's generalized ISP template but forgot to eliminate the sections that did not apply to Resident 23.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures

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N 386	Continued From page 32 Facility Complies with Laws	N 386		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plan (ISP) for Resident 15 was updated and revised to reflect his/her needs related to fall risk mitigation, vitals monitoring, diabetes management, and specific catheter care needs. This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV15, dated 07/09/2025, SOD FTUV14, dated 12/05/2024, and SOD FTUV13, dated 07/12/2024. Findings include: On 10/20/2025, Surveyor reviewed Department records for the provider. Within the records, Surveyor observed an e-mail communication	{N 389}		

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from Regional Director K to the Department, which was sent on 10/06/2025 (3:34 p.m.) and documented, "...Just wanted to check in. Are we on your radar to come visit us soon? We are ready!..."

Surveyor reviewed SOD FTUV15, in which a previous deficiency for "N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes" was documented.

On 10/20/2025, at approximately 12:19 a.m., Surveyor observed Resident 15's room and bathroom. Within the bathroom, Surveyor observed 2 empty catheter leg bags and 1 larger catheter bag draped over the grab bar above his/her toilet. For one of the catheters, the port where the tubing would connect to was touching the top of the toilet tank.

On 10/20/2025, Surveyor reviewed Resident 15's record. Resident 15 was admitted to the provider on 06/20/2025 with diagnoses including unspecified dementia, type II diabetes mellitus, congestive heart failure, and urine retention. Resident 15 was documented as having an activated power of attorney (POA) for healthcare. Surveyor reviewed 2 fall reports in Resident 15's records that documented the following 2 falls:

- 08/24/2025 (10:00 a.m.): Resident 15 fell when transferring off the toilet in his/her bathroom. The report documented, "resident stated 'it all happened so fast I'm not sure what happened but I think I missed the grab bar when getting off the toilet.'" The report documented that Resident 15 sustained bruising to his/her left upper arm.

- 08/29/2025 (10:56 p.m.): Resident 15 fell when transferring from his/her toilet back to his/her

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chair. The report documented, "Resident said [s/he] took [him/herself] to the bathroom and lost [his/her] balance on [his/her] way back to [his/her] chair. Resident stated [s/he] did not hit [his/her] head but was in a ton of pain. Aide asked resident why [s/he] didn't push [his/her] button and [s/he] said [s/he] did." The report documented that Resident 15 sustained a scrape to his/her left forearm. The report documented that Resident 15 was not transported to the emergency department for further evaluation, however, a hospital discharge summary, dated 09/03/2025, located in his/her record identified that s/he was admitted to the emergency department on 08/29/2025 due in part to his/her fall. The summary also identified that Resident 15 sustained skin tears to his/her right forearm as a result of the fall, was subsequently admitted to the hospital due in part to a urinary tract infection, and was recommended to follow up with recovery at a rehabilitation facility for ongoing physical therapy before returning to the provider.

Surveyor reviewed Resident 15's ISP, last signed as reviewed on 07/22/2025, which identified the following:

- Under the "Toileting" heading: "Staff assistance needed to perform foley catheter care 2x/day and as needed." There was no other information clarifying what the foley catheter care consisted of.

- Under the "General Health" heading: "Take vitals daily. Resident will have blood sugars maintained between ___ and ____. Staff are to follow Diabetic Addendum when blood sugars are outside the parameters..." Surveyor did not observe specific blood sugars documented in the blank sections above. The diabetic addendum

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within the ISP gave specific directives for how staff were to manage low blood sugar levels for Resident 15. Within the plan, steps were documented that called for the administration of 15 grams (1 tube) of glucose gel. In reviewing Resident 15's medication list, Surveyor did not see a prescription for glucose gel. Underneath the information directing for staff to take daily vitals, the following was documented: "Vitals taken and recorded weekly." The associated frequency with that directive was set to once monthly. There was no directive clarifying the inconsistency as to whether Resident 15's vitals were to be taken daily, weekly, or monthly, nor was there information to specifically identify what vitals were to be taken as part of his/her vitals monitoring.

- Under the "Physical Disabilities - Falls" section: "Impaired physical mobility. Resident has no past history of falling and requires no alternative safety measures." There was no other information regarding Resident 15's fall risk and interventions utilized to mitigate his/her fall risk. Surveyor noted that Resident 15's last reviewed ISP was prior to him/her having experienced the 2 falls as documented above.

Surveyor reviewed Resident 15's observation notes. A note on 08/24/2025 (10:00 a.m.) documented information about the same fall from the fall report of the same date as documented above. Within the entry, the following was documented: "Prevention Info: Resident was encouraged to call for assistance when needed to use the restroom and not to self-transfer. [Physical therapist] also educated resident on the importance of calling for assistance."

On 10/23/2025, at approximately 9:45 a.m.,

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{N 389}	Continued From page 36 Surveyor interviewed Acting Director R and Acting Director S about Resident 15's ISP. Regarding Resident 15's vitals monitoring, Acting Director R reported that Resident 15 required daily weight monitoring as ordered by his/her medical provider. Acting Director R reported there was no need for any other vitals monitoring. Regarding Resident 15's diabetes management, Acting Director R confirmed that Resident 15 was not prescribed glucose gel and that Resident 15's blood checks (in reference to the blank parameter norm template in his/her ISP) were not ordered to be conducted with any sort of routine frequency. Regarding Resident 15's catheter care, Acting Director R confirmed that staff conducted catheter flushes twice daily and rotated between his/her larger bags, at Resident 15's own preference to not use his/her leg bag, when they changed his/her catheter bag twice daily. Regarding Resident 15's fall risk, Acting Director R reported that an intervention was implemented for staff to stay in the room with Resident 15 while toileting him/her so that s/he would not transfer by him/herself. Acting Director R reported this intervention was implemented after Resident 15's last fall and acknowledged Surveyor's concern that this need was not documented in Resident 15's ISP. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 389}		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that	N 409		

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contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that a proof-of-use record was maintained for schedule II drugs prescribed to Resident 5, Resident 10, and Resident 14 that showed the administrator or designee auditing, signing, and dating the record on a daily basis.

Findings include:

On 10/20/2025, at approximately 4:18 p.m., Surveyor interviewed Caregiver I, who was the medication passer for that shift, about the provider's schedule II medication count system. Caregiver I reported that staff conducted counts in the provider's electronic record system and that counts on paper were only done if the electronic record system was down.

Example 1 - Resident 5

On 10/21/2025, Surveyor reviewed the proof-of-use record for Resident 5, who was prescribed morphine sulfate 100 mg/5mL syringes. The record showed 40 syringes added on 05/09/2025 with the annotation, "40 syringes delivered today." One entry each on 05/24/2025, 07/19/2025, 07/25/2025, and 07/26/2025 (4 entries total) showed deductions of 1 syringe on each of those days due to administration. No other entries or notes were made showing that

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the morphine syringes were audited on any other day between 05/09/2025 - 10/20/2025.

Example 2 - Resident 10

On 10/21/2025, Surveyor reviewed the proof-of-use record for Resident 10, who was prescribed morphine 15 mg tablets. The record showed 30 tablets added on 09/24/2025 with the annotation, "pharmacy delivered." One entry each on 10/16/2025 and 10/18/2025 showed deductions of 1 tablet due to administration. An entry on 10/17/2025 by Acting Director S clarified that Resident 10's morphine tablets were to be counted as whole tablets instead of half-tablets. No other entries or notes were made showing that the morphine tablets were audited on any other day between 09/24/2025 - 10/20/2025.

Example 3 - Resident 14

On 10/21/2025, Surveyor reviewed the proof-of-use record for Resident 14, who was prescribed hydrocodone-APAP 5/325 mg tablets. The record showed 30 tablets added on 09/05/2025 with the annotation, "pharmacy delivered." Deductions of tablets with the resulting amount were made at least daily from 09/22/2025 through 10/03/2025 (when they were marked as then being out), and 10/07/2025 (refill) through 10/20/2025. No other entries or notes were made showing that the hydrocodone tablets were audited from 09/06/2025 through 09/21/2025.

INTERVIEW:

On 10/23/2025, at approximately 9:45 a.m., Surveyor interviewed Acting Director R and Acting Director S about the provider's proof-of-use records. Acting Director R reported that counts

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were done at the changing of each shift every day within the provider's electronic record system. Acting Director R reported that the provider's nurse monitored the counts. When asked for additional evidence of proof-of-use records, Acting Director R e-mailed Surveyor a document titled, "Controlled Substance Count History." The document was dated 08/01/2025 - 10/22/2025. While interviewing Acting Director R and Acting Director S, Surveyor reviewed the document. The document appeared to document aggregate counts of the provider's controlled substances, with the first column labeled as "Correct Counts" and the second column labeled as "Incorrect Counts." Individual rows were broken down into daily shifts in which counts took place (for example: a row identified as the first shift count on 10/21/2025 identified "10" correct counts and "0 incorrect counts.) Surveyor did not observe any evidence of the specific medications having been audited or signatures indicating who conducted the audits. Surveyor noted a second shift count that occurred on 10/18/2025 which identified 8 correct counts and 2 incorrect counts. The specific medications that were counted and documented as having been "incorrect" were not identified in the document. Surveyor asked Acting Director R which medications were identified as being off during that count. Acting Director R reported s/he believed there was an issue with a medication that was counted in half-tablets instead of singular tablets which had to be corrected. Acting Director R confirmed that that medication was not identified in the document Surveyor reviewed. Acting Director R reported there was also a previous issue with Resident 14's lacosamide so s/he wasn't sure if that was when a count was off. Acting Director R reported s/he would reach out to the provider's nurse, Nurse EE, for additional information. Acting

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N 409	Continued From page 40 Director R reported that Nurse EE reviewed all counts daily. Surveyor gave a deadline of 1:00 p.m. that day to receive additional evidence of proof-of-use daily auditing. Nothing further was received. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 409		
{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 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.	{N 431}		

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{N 431}	Continued From page 41 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the health of 2 of 3 residents reviewed was monitored with changes in their health recorded in their records. Resident 10 was prescribed a daily diltiazem capsule for management of his/her hypertension, which had parameters for holding based on blood pressure readings below certain values. On 3 occasions from 09/23/2025 - 10/20/2025, there was no evidence of staff having taken Resident 10's blood pressure prior to administering the capsule. On 7 occasions between 10/02/2025 - 10/14/2025, Resident 10 experienced elevated blood pressure with no evidence of follow up monitoring or assessment completed by staff. On the morning of 10/16/2025, at approximately 8:00 a.m. in accordance with Resident 10's diltiazem administration, staff recorded a blood pressure of 199/93. No further follow up monitoring or assessment was completed, however, an observation note that day noted concern for Resident 10 experiencing a change of condition with complaints of chest pain as early as around lunch time. Caregiver Z documented at 8:30 p.m. that Resident 10's "vitals were taken and they seemed normal," however, Resident 10's blood pressure was not recorded to verify Caregiver Z's assessment. Resident 23's ISP directed for specific courses of monitoring and action staff were to take in response to him/her experiencing episodes of high and low blood sugars. There was no evidence that staff conducted any further monitoring or assessment of Resident 23 on 6 occasions when his/her blood sugar levels were	{N 431}		

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{N 431}	Continued From page 42 below 70 or above 400. This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV15, dated 07/09/2025, and SOD FTUV11, dated 08/25/2023. Findings include: On 10/20/2025, Surveyor reviewed Department records for the provider. Within the records, Surveyor observed an e-mail communication from Regional Director K to the Department, which was sent on 10/06/2025 (3:34 p.m.) and documented, "...Just wanted to check in. Are we on your radar to come visit us soon? We are ready!..." Surveyor reviewed SOD FTUV15, in which a previous deficiency for "N0431 DHS 83.38(1)(g) Health Monitoring" was documented. Example 1 - Resident 10 On 10/20/2025, Surveyor reviewed Resident 10's record. Resident 10 was admitted to the provider on 07/20/2023 with diagnoses including unspecified atrial fibrillation and essential hypertension. Resident 10 was documented as having an activated power of attorney (POA) for healthcare. Resident 10's prescriptions included diltiazem extended release 120 mg capsules, active as of 07/21/2025, with instructions to, "Take 1 capsule by mouth once daily for hypertension. Hold for [systolic blood pressure] </= 95 or [diastolic blood pressure] </=50..." Resident 10's individual service plan (ISP), last signed as reviewed 07/30/2025, documented the following under the "Wellness" heading: "resident is on [hospice agency] hospice and will be getting	{N 431}		

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[his/her] care through them. resident will have monthly vitals done and as needed for a change of condition. staff to report any concerns to hospice first then poa, and [medical doctor]...1.31.25 resident is now enrolled with [different hospice agency]."

Resident 10 also had a prescription from his/her hospice medical provider for morphine 15 mg tablets with instructions to, "Take 1/2 tablet (7.5 mg) by mouth every 4 hours as needed... ([shortness of breath], pain)."

Surveyor reviewed Resident 10's medication administration records (MARs) from 09/23/2025 - 10/20/2025, where staff appeared to document his/her blood pressure values in relation to his/her diltiazem administration parameters, which were taken around 8:00 a.m. prior to his/her diltiazem administration. From the MARs, Surveyor observed 3 dates that Resident 10's blood pressures were not recorded: 09/23/2025, 09/28/2025, and 09/29/2025. Staff initialed off on administering Resident 10's diltiazem on each of the days. Surveyor also observed the following 8 days in which Resident 10's blood pressure was recorded as at or around 190/90:

- 10/02/2025: 190/100
- 10/03/2025: 187/107
- 10/04/2025: 207/103
- 10/05/2025: 207/103
- 10/08/2025: 198/96
- 10/10/2025: 197/107
- 10/14/2025: 200/107
- 10/16/2025: 199/93

Surveyor reviewed Resident 10's observation notes. For 7 of the 8 entries above (10/02/2025 - 10/14/2025), there was no information regarding

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any additional follow up monitoring or assessment completed by staff in relation to Resident 10's high blood pressures. An entry on 10/16/2025 at 8:30 p.m. by Caregiver Z, approximately 12 hours from when his/her blood pressure of 199/93 was taken that morning, documented, "[Resident 10] is not [his/her] best. [S/he] didn't come out for lunch, [complains of] chest pains, it was passed down from first shift. [Resident 10] told second shift that [s/he] wanted them to bring [him/her] down lunch, but they never did bring [him/her] anything. [Resident 10] also did not come down for dinner, but [s/he] requested jello and the aide took [him/her] jello for dinner. [Resident 10] ate the jello with no issues to report. Vitals were taken and they seemed normal. [S/he] was also acting normal when [s/he] was gotten up to toilet. [Resident 10] has a bit of cold in [his/her] left eye. [S/he] says that [s/he] is now feeling better than [s/he] was feeling in the morning./afternoon [sic]." Surveyor did not observe any evidence of the blood pressure recorded that led to the assessment of his/her blood pressure seeming "normal." Resident 10's MAR showed that Caregiver Z administered Resident 10 a morphine tablet at 5:33 p.m. that evening due to him/her complaining of chest pain and shortness of breath.

By contrast to the above examples, Surveyor noted an observation note on 10/18/2025 at 9:45 p.m., by Caregiver AA, which documented, "Resident wasn't feeling well tonight, [s/he] didn't eat supper or lunch. We kept an eye on [him/her]. Did [his/her] vitals blood pressure top number was high. We called Hospice and they came in right away. We also messaged [Acting Director R]. They put oxygen on [him/her] and gave [him/her] morphine. The nurse stayed awhile and

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checked on [him/her] again. We also kept an eye on [him/her]. [S/he] is doing better. Hospice nurse will be back tomorrow to check on Resident." While there was no evidence of the blood pressure recorded that led to the assessment of Resident 10's systolic blood pressure being "high," Surveyor noted that in this occurrence further follow up contact with Resident 10's hospice agency and by extension, immediate follow up evaluation and monitoring of Resident 10 by his/her hospice nurse and the provider's staff, was documented to have occurred.

On 10/20/2025, at approximately 4:51 p.m., Surveyor requested from Acting Director R, Acting Director S, and Regional Director K all of Resident 10's vitals taken between 10/16/2025 - 10/18/2025.

On 10/21/2025, Surveyor reviewed the documentation send by Acting Director R. There were no other blood pressure values documented from 10/16/2025 - 10/18/2025 other than the ones associated with his/her daily morning blood pressure taken in accordance with his/her blood pressure medication parameters.

On 10/23/2025, at approximately 9:45 a.m., Surveyor interviewed Acting Director R and Acting Director S. Acting Director R reported that typically staff called Resident 10's hospice agency when Resident 10 reported not feeling well. Acting Director R confirmed Resident 10's blood pressure was not recorded on 10/16/2025 or 10/18/2025 when s/he experienced a change of condition and reported s/he wasn't sure why. Acting Director R reported that maybe Resident 10's hospice agency had recorded Resident 10's blood pressure. When asked about the multiple dates Resident 10 experienced elevated blood

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pressure between 10/02/2025 - 10/16/2025, Acting Director R reported s/he didn't believe staff had noticed these as examples of elevated blood pressure and confirmed nothing had been reported to him/her regarding these occasions.

According to the American Heart Association (AHA), severe hypertension is characterized by systolic blood pressure higher than 180 and/or diastolic blood pressure higher than 120. It is recommended that if a person experiencing a blood pressure within those parameters does not have symptoms of a hypertensive emergency (chest pain, shortness of breath, back pain, numbness, weakness, change in vision, or difficulty speaking), a health care professional should be called. If a person is experiencing those symptoms, it is recommended to call emergency medical services (Source: American Heart Association, Understanding Blood Pressure Readings, August 14, 2025, https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings (retrieval date - October 23, 2025).).

Example 2 - Resident 23

On 10/20/2025, at approximately 10:19 a.m., Surveyor interviewed Resident 23. Resident 23 reported that s/he had concerns with staff's ability to manage his/her medications. Resident 23 reported that s/he was diabetic and staff administered his/her insulin. Resident 23 reported s/he had experienced health concerns related to his/her blood sugar levels and that once his/her blood sugar levels "crashed" which caused him/her to fall on the floor.

On 10/21/2025, Surveyor reviewed Resident 23's record. Resident 23 was admitted to the provider

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{N 431}	Continued From page 47 on 08/15/2025 with diagnoses including type II diabetes mellitus with polyneuropathy and mild cognitive impairment. Resident 23 was documented as being his/her own legal representative. Resident 23's ISP, signed as reviewed on 09/17/2025, contained the following: - The "General Health" section, where information regarding Resident 23's diabetes management was located, documented the following: "Resident will have blood sugars between: _____ and _____. Staff are to follow Diabetic Addendum when blood sugars are outside the parameters..." The goal within that section was identified as, "Resident will have blood sugars maintained ordered parameters." - The "Diabetic Addendum" section gave specific directives for how staff were to manage high and low blood sugar levels for Resident 23. Within the plan, 2 courses of interventions were directed depending on if Resident 23's blood sugar level was <50 or between 50-70. Within the course for blood sugar level between 50-70, the following steps were identified: "1. Hold insulin. 2. Administer 15 grams (1 tube) of glucose gel. Give the entire tube of gel. If resident refuses the gel, document why it [wasn't] given and provide them with 6 oz. of juice. If unable to swallow, do not administer. 3. Recheck blood glucose in 20 minutes. 4. If still below 70, repeat steps 1-3. 5. If you have repeated steps 1-2 twice, call the RD/RDOC and inform them that the gel/interventions have not brought the blood glucose level up. 6. When blood glucose level is within parameters, administer the insulin as ordered...8. Document your interventions in DAD format in the observation notes..." A specific course of steps was also documented for staff to follow in the event that Resident 23's blood	{N 431}		

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glucose was above his/her parameters. (Of note, however, the parameters, as documented above, were not identified for Resident 23.) This course of action identified the following: "1. Administer the [resident's] insulin as ordered. 2. DO NOT provide resident with meal or snack. 3. Encourage resident to drink water and walk. If unable to walk, instruct the resident to exercise by moving their arms and legs. 4. Recheck blood glucose in 20 minutes. If within parameters, then provide their meal or snack. 5. If still above parameters, contact the RD/RDOC...8. Document your interventions in DAD format in the observation notes."

Surveyor reviewed Resident 23's prescriptions and MARs from 09/23/2025 - 10/20/2025. There was no prescription for the glucose gel as identified from his/her ISP, however, there was a prescription for a glucagon emergency kit, active as of 08/19/2025, with instructions to, "Inject 1 mg subq[utaneously]/[intramuscularly] x 1 dose as needed for hypoglycemia." Resident 23 was prescribed a Fiasp insulin pen that contained instructions for sliding scale insulin administration 4 times daily based on his/her blood sugar levels. As a result, documentation identified that staff recorded Resident 23's blood sugars four times daily. From Resident 23's MARs, Surveyor reviewed the following blood sugar levels recorded on the following dates:

- 10/01/2025 (1:22 p.m.): 410

- 10/01/2025 (4:33 p.m.): 62

- 10/01/2025 (7:36 p.m.): 473

- 10/02/2025 (9:10 a.m.): 431

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{N 431}	Continued From page 49 - 10/02/2025 (8:20 p.m.): 420 - 10/16/2025 (12:19 p.m.): 69 Surveyor observed that the 2 occasions of low blood sugars (62 and 69) above fit in the parameters identified in Resident 23's diabetic addendum for follow up action and monitoring. From the observation notes, where Resident 23's ISP specifically directed for staff to document follow up monitoring, Surveyor did not observe evidence of any follow up monitoring or action taken by staff in response to Resident 23's low blood sugar levels. Regarding the 4 occasions where Resident 23's blood sugars were above 400, Surveyor did not observe evidence of any follow up monitoring or action taken by staff in response. Surveyor did not observe any annotations in Resident 23's MARs regarding the occasions of low and high blood sugar levels. On 10/23/2025, at approximately 9:45 a.m., Surveyor interviewed Acting Director R and Acting Director S. Acting Director R acknowledged Surveyor's concern regarding the lack of evidence of follow up monitoring by staff when Resident 23 experienced high blood sugar levels, but said nothing further. Regarding the 2 occasions of low blood sugar levels, Acting Director R reported that on both of those days (10/01/2025 and 10/16/2025), Resident 23 had been scheduled to undergo colonoscopies. Acting Director R reported that as a result Resident 23 could not have consume anything other than clear liquids. Acting Director R reported that for the first date, 10/01/2025, Resident 23 "did not get cleaned out enough" and so the colonoscopy was rescheduled to 10/16/2025. Acting Director R reported that on both occasions staff gave Resident 23 orange juice with sugar as well as	{N 431}		

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{N 431}	Continued From page 50 broth. Acting Director R reported s/he knew staff double checked Resident 23's blood sugar levels but confirmed s/he could find no evidence of this. Of note, Surveyor reviewed Resident 23's observation notes again. An entry on 09/01/2025 (1:45 p.m.) made by Acting Director R documented, "Resident had colonoscopy appointment today. They stated resident wasn't cleaned out enough to do procedure. Will reschedule with resident." Another entry on 09/16/2025 (9:30 a.m.) documented, "Resident returned from colonoscopy - colonoscopy was successful." Surveyor noted that these entries were made approximately 1 month prior to Resident 23's occurrences of low blood sugar, inconsistent with Acting Director R's report. Observation notes on 10/01/2025 and 10/16/2025 did not identify evidence of any additional colonoscopies that Resident 23 underwent on those days. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 431}		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 488		

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N 488	Continued From page 51 did not ensure that the dryer vent tubing for the provider's sole clothing dryer was made of rigid material. Findings include: On 10/20/2025, at approximately 12:03 p.m., Surveyor observed the provider's laundry area with Acting Director R. The sole clothing dryer was observed with an approximate 1.5' area of flexible vent tubing that then transitioned into a rigid tube. While observing the tubing, Surveyor interviewed Acting Director R. Acting Director R acknowledged Surveyor's concern and reported s/he would get his/her maintenance staff to fix the tubing. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 488		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the	N 525		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF ELKHORN	450 E GENEVA ST ELKHORN, WI 53121

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N 525	Continued From page 52 residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 6 of 7 quarterly fire evacuation drills that would have been due from 01/01/2024 - 10/20/2025 were conducted. Findings include: On 10/20/2025, at approximately 9:42 a.m., Surveyor conducted a survey entrance conference with Acting Director R. During this, Surveyor requested evidence of all fire evacuation drills completed by the provider for the last 2 years. On 10/20/2025, Surveyor reviewed fire drill records provided by Acting Director R and Acting Director S. The drill records identified 4 drills that were completed in 2023 and 1 drill that was completed in 2024, on 11/31/2024. There were no records for fire evacuation drills completed in 2025. At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about fire drills. Acting Director R and Acting Director S confirmed there was no other evidence of other fire evacuation drills having been completed in 2024 or 2025. Acting Director R reported that due to the changing of management staff over the last couple of years s/he believed any records showing past drills were lost. Cross Reference:	N 525		

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N 525	Continued From page 53 N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 3 semi-annual emergency evacuation drills that would have been due from 01/01/2024 - 10/20/2025 were conducted. Findings include: On 10/20/2025, at approximately 9:42 a.m., Surveyor conducted a survey entrance conference with Acting Director R. During this, Surveyor requested evidence of all emergency evacuation drills completed by the provider for the last 2 years. On 10/20/2025, Surveyor reviewed fire drill records provided by Acting Director R and Acting Director S. The drill records identified 1 drill completed in 2024, on 04/12/2024. At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about fire drills. Acting Director R and Acting Director S confirmed there was no other evidence of other emergency evacuation drills having been completed in 2024 or 2025. Acting Director R reported that due to the changing of management staff over the last couple of years	N 526		

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N 526	Continued From page 54 s/he believed any records showing past drills were lost. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 526		
N 558	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure that sprinkler systems were maintained in accordance with the requirements in National Fire Protection Association (NFPA) 25. This is a repeat deficiency. See Statement of Deficiency (SOD) BBRN12, dated 01/20/2023, and SOD BBRN11, dated 07/21/2022. Findings include: The provider is licensed to serve up to 20 nonambulatory adults in the client groups of advanced aged and irreversible dementia/Alzheimer's.	N 558		

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N 558	Continued From page 55 On 10/20/2025, at approximately 9:42 a.m., Surveyor conducted a survey entrance conference with Acting Director R. During this, Surveyor requested evidence of the provider's sprinkler inspections completed for the last 2 years. On 10/20/2025, at approximately 9:55 a.m., Surveyor toured the building. While touring, Surveyor observed that part of the provider's sprinkler system consisted of concealed sprinklers with caps over the sprinkler heads. Some of the sprinkler heads - particularly in the hallway where the medication room was located - appeared to be partially dropped down from the ceiling. At approximately 11:57 a.m., Surveyor again requested the provider's sprinkler inspections from Acting Director R. At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about the provider's sprinkler system inspection. Acting Director R reported s/he believed that the system had been recently inspected and that the report had been sent to a former administrator who was no longer associated with the provider. Acting Director R confirmed s/he was unable to find any sprinkler system inspection records at the facility. On 10/21/2025, Surveyor reviewed an e-mail sent by Acting Director R that day to Surveyor at 12:54 p.m. Acting Director S and Regional Director K were copied on the e-mail. The e-mail stated, "I did some calling around as [vendor] didn't have the correct email address on file. But I was able to get the sprinkler system report! I've attached it	N 558		

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N 558	Continued From page 56	N 558		

below!" Surveyor reviewed the attached report which documented a sprinkler system inspection conducted for the provider on 09/03/2025. The inspection identified different deficiencies, one of which identified that some of the provider's sprinkler heads were either too low or high in hallways and that one sprinkler head was too close to an interior soffit. Another deficiency identified that the provider's backflow devices did not have provisions for forward flow testing. A third deficiency identified that the provider's sprinkler system was "not monitored."

At approximately 2:16 p.m., Surveyor replied to Acting Director R's e-mail to request evidence of reinspection or maintenance work done to address the deficiencies identified from the sprinkler inspection. Surveyor gave a deadline of the end of the day to receive additional evidence.

At approximately 3:41 p.m., Regional Director K e-mailed Surveyor back and stated, "I believe we do not have anything further to send at this time."

On 10/22/2025, at approximately 3:16 p.m., Surveyor interviewed Fire Protection Service Manager (Manager) Y, from the company that conducted the provider's most recent sprinkler inspection. Manager Y reviewed the sprinkler inspection report with Surveyor. Manager Y reported that sprinkler heads being too low or too high relative to the ceiling created gaps between the ceiling and sprinkler head, which then could allow heat - in the event of a fire - to collect in the attic and the sprinkler system to not activate as quickly as it should. Manager Y reported that sprinkler heads should be sealed to avoid any gaps between the heads and the ceiling. Regarding the sprinkler head identified as being too close to an interior soffit, Manager Y reported

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N 558	Continued From page 57 that the soffit was an obstruction and blocked the spray pattern of that sprinkler head's water. Manager Y reported that the sprinkler head should be 3-4" away from the wall. Regarding the deficiency that identified the limited forward flow testing ability, Manager Y clarified that a forward flow test was typically done annually as part of a sprinkler system inspection. Manager Y reported that in this case, there was an inability to get forward flow through the drain. Manager Y reported that the provider's sprinkler system would still work, but without the forward flow test there was an inability to ensure a sufficient amount of water pressure throughout the system. Manager Y reported that as a result of this, it was unclear whether sufficient water to meet demand would go through the sprinkler systems if it were to activate. Regarding the deficiency related to having a monitored system, Manager Y reported that NFPA 25 required the local fire department to be notified when the provider's sprinkler system was activated. Manager Y reported that a deficiency in this area was found because the activation of the provider's sprinkler system was not set to notify the local fire department. Manager Y confirmed that no one from the provider had reached out since the last sprinkler inspection to schedule additional maintenance work or correct the outstanding deficiencies. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 558		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs	N 617		

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N 617	Continued From page 58	N 617		

used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that the temperature of 2 of 4 tested water fixtures used by residents did not exceed 115° F.

Findings include:

The provider is licensed to serve up to 20 nonambulatory adults in the client groups of advanced aged and irreversible dementia/Alzheimer's.

On 10/20/2025, at approximately 12:16 p.m., Surveyor tested the water temperature of the sink in Resident 18's bathroom, located within his/her room, which reached 121.3° F.

On 10/20/2025, at approximately 12:22 p.m., Surveyor tested the water temperature of the sink in Resident 15's bathroom, located within his/her room, which reached 127.2° F.

According to the Wisconsin Department of Health Services, "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at

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N 617	Continued From page 59 particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." Sustained contact with water at or above 120° F and 127° F can result in second or third-degree burns in approximately 10 minutes and 1 minute, respectively (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K about the water temperatures. All acknowledged Surveyor's concern, and Acting Director R reported s/he would have the temperatures addressed. Regional Director K reported that they would implement a routine check of water temperatures. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 617		
N 667	83.59(7)(b) Required exit signs lighted All required exit signs shall be lighted at all times. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that all required exit signs were lighted at all times. Findings include: The provider is licensed to serve up to 20 nonambulatory adults in the client groups of	N 667		

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N 667	Continued From page 60 advanced aged and irreversible dementia/Alzheimer's. On 10/20/2025, at approximately 9:55 a.m., Surveyor toured the environment. In observing the wing of the facility where the medication room and 10 resident rooms were located, Surveyor observed 2 exit signs. Neither were lit (Photos 1-4). Throughout the remainder of the time Surveyor was on site until s/he conducted an interview with Acting Director R, Acting Director S, and Regional Director K at approximately 4:51 p.m., the signs remained unlit. At approximately 4:51 p.m., Surveyor interviewed Acting Director R, Acting Director S, and Regional Director K. Acting Director R and Acting Director S observed the lights with Surveyor. Acting Director R reported that the fire department had been there last Friday (10/17/2025, 3 days prior to the survey) to conduct an inspection and had tested the provider's emergency egress lighting system. Acting Director R reported that something occurred during the testing that resulted in the one of the emergency egress light fixtures near the entrance constantly buzzing. Acting Director R reported that as a result, the staff member who was present during the inspection turned off the breaker that controlled the power to that wing's emergency egress light systems. Acting Director R reported that up to that point s/he didn't realize the breaker being off resulted in the emergency exit signs being unlit. While observing the lights with Surveyor, Acting Director R turned the breaker back on, which then lit the exit signs. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 667		

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