STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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	{N 000}		
{N 000}	Initial Comments On 04/22/2026, Surveyor conducted a standard survey, verification visit, and 1 complaint investigation at Long Lake House. As a result, 11 deficiencies were identified, 4 were repeat deficiencies. See Statement of Deficiency (SOD) HGN913, dated 05/07/2024. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 5	{N 000}		
N 191	83.13(3)(d) Posting activity schedule. The CBRF shall post all of the following: Activity schedule as required under s. DHS 83.38(1)(c). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an activity schedule was posted in the facility. This had the potential to affect 5 of 5 residents in the facility. Findings include: On 04/22/2026, at approximately 10:50 AM, Surveyor toured the facility. Surveyor did not observe an activity schedule posted in the facility for the duration of the survey. On 04/22/2026, at approximately 2:45 PM,	N 191		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 191	Continued From page 1 Surveyor interviewed House Manager B. House Manager B confirmed the code requirement. House Manager B reported the facility "used to post the activity schedule", but s/he was unaware why the current schedule was not posted. House Manager B reported s/he would ensure the schedule was posted for residents.	N 191		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the provider and its operation did not comply with all laws governing the Community-Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. The licensee did not comply with requirements and special orders outlined in a Notice and Order letter from the Department. As a result of the verification visit, 11 deficiencies were identified. Four of the 11 violations were repeat deficiencies. Findings include: The provider is licensed as an AA (ambulatory) facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally disabled, emotionally disturbed/mental illness, alcohol/drug dependent, physically disabled, and traumatic brain injury. On 04/22/2026, at approximately 7:00 AM,	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 196	Continued From page 2	N 196		

Surveyor reviewed Department records and identified the following:

On 03/27/2024, Surveyor completed a verification visit, complaint investigation, and standard survey. Ten deficiencies were identified, and 1 complaint was unsubstantiated.

On 05/07/2024, Statement of Deficiency (SOD) HGN913 and Notice and Order letter was sent via email. The following deficiencies were identified:

N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments
N0385 83.35(2) Temporary Service Plan.
N0387 83.35(3)(b) Service Plan Development: Parties Involved
N0389 83.35(3)(d) Service Plans Updated Annually or On Changes
N0481 83.43(1) Environment Safe, Clean, and Comfortable
N0499 83.45(3) Toxic Substances
N0502 83.46(1)(a) Comfortable and Safe Temperatures
N0511 83.46(3) Public Water Supply or Well Water Test
N0530 83.47(3) Fire Inspection
N0538 83.48(3)(a) Fire Detection Systems Inspected Annually

The Notice and Order letter included the following:

Special Orders:

"Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Long

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 196	Continued From page 3 Lake House: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to resolve each deficiency as identified in Statement of Deficiency HGN913. WITHIN 45 DAYS of receipt of this notice, the licensee's corrective measures shall include the development (or review/revision) of written procedures to address, at a minimum: Pre-Admission and Ongoing Assessments - The provider shall assess each resident's needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities, or condition, and at least annually. - The assessment, at a minimum, shall include all areas applicable to the resident in accordance with Wis. Admin. Code § DHS 83.35(1)(c). - The provider shall prepare a written report of the results of the assessment and shall retain the assessment in the resident's record in accordance with Wis. Admin. Code § DHS 83.35(1)(d). - All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Individual Service Plans (ISP) - A temporary service plan is prepared, and available for staff to implement, to meet the immediate needs of the resident until the	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 196	Continued From page 4 comprehensive Individual Service Plan is developed and implemented. - A comprehensive ISP is developed within 30 days after admission and based on the assessment required under Wis. Admin. Code § DHS 83.35(1)(a). - The provider shall involve the resident and the resident's legal representative, as appropriate, in developing the individual service plan and the resident or the resident's legal representative shall sign the plan acknowledging their involvement in, understanding of an agreement with the plan. - The ISP shall be reviewed and revised annually or when there is a change in a resident's needs, abilities or physical or mental condition. The review shall be based on the required assessment. - All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. - All staff responsible for providing services to residents will review the resident's ISP and will provide services in accordance with the plan. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the provider's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 196	Continued From page 5 signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures required in Order #1 will be made available to department representatives upon request. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide each resident's legal representative and case manager (if any) with a copy of Statement of Deficiency HGN913 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. Required evidence will be made available to the department representatives upon request..." On 04/22/2026, Surveyor conducted a verification visit for SOD HGN913 and 1 complaint investigation. The following deficiencies were identified: N0191 83.13(3)(d) Posting Activity Schedule N0196 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0247 83.22(2) Task Specific Training N0302 Resident Health Screening and Documentation N0386 83.35(3)(a) Comprehensive Individualized Service Plan N0387 83.35(3)(b) Service Plan Development: Parties Involved (repeat deficiency) N0481 83.41(1) Environment Safe, Clean, and Comfortable (repeat deficiency) N0488 83.44(1)(c) Clothes Dryers Enclosed and	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 196	Continued From page 6 Vented N0511 83.46(3) Public Water Supply or Well Water Test (repeat deficiency) N0538 83.48(3)(a) Fire Detection Systems Inspected Annually (repeat deficiency) N0617 83.55(6)(b) Bath and Toilet Areas: Water Temperature On 04/22/2026, at approximately 2:45 PM, Surveyor interviewed House Manager B. House Manager B confirmed s/he was responsible for completing and updating resident ISPs. House Manager B reported s/he did not receive any training as outlined in the special orders of SOD HGN913 related to individualized service plans. House Manager B reported s/he was unaware of special orders and requirements outlined in SOD HGN913 Cross Reference DHS 83.22(2) Task Specific Training DHS 83.35(3)(a) Comprehensive Individualized Service Plan DHS 83.35(3)(b) Service Plan Development: Parties involved	N 196		
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: 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.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 247	Continued From page 7 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: N0247 83.22(2) Task Specific Training Based on record review and interview, the provider did not ensure 1 of 2 employees (House Manager B) reviewed obtained all task specific training. House Manager B, who had responsibilities for completing resident individualized service plans (ISPs), did not have training in ISP development.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 247	Continued From page 8 Findings include: On 04/22/2026, at approximately 12:15 PM Surveyor requested House Manager B's training record. House Manager B was hired on 11/11/2004. Surveyor did not receive House Manager B's training records. House Manager B's record did not contain evidence of training or evidence of meeting an exemption for ISP development training. On 04/22/2026, at approximately 2:45 PM, Surveyor interviewed House Manager B. House Manager B confirmed s/he is responsible for completing and updating resident ISPs. House Manager B reported s/he did not receive training related to ISPs. House Manager B reported s/he completes yearly training but was unsure of all required courses completed each calendar year. House Manager B confirmed the provider did not have evidence s/he completed or met an exemption for ISP development training prior to assuming these job duties. As of 04/23/2026 at 4:30 PM, Surveyor did not receive any training transcripts from the provider for House Manager B.	N 247		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 302	Continued From page 9 immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation of a screening for clinically apparent communicable disease, including tuberculosis (TB) by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission for 1 of 2 residents (Resident 9) reviewed. Findings include: On 04/22/2026, at 11:30AM, Surveyor reviewed Resident 9's record. Resident 9 was admitted on 02/07/2026. Resident 9's record did not contain any evidence Resident 9 had been screened for communicable diseases including TB. On 04/22/2026, at 11:40 AM, Surveyor interviewed House Manager B. House Manager B reported Resident 9 moved into the facility from his/her parents' house. House Manager B reported s/he was unsure if Resident 9 was seen by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before, or 7 days after admission. House Manager B reported Resident 9 was treated inpatient for her/his mental health prior to being admitted but was unsure if a TB test was completed/documented. House Manager B	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 302	Continued From page 10 reported s/he was working with Resident 9's case manager to obtain his/her physician information to schedule an appointment. CROSS REFERENCE DHS 83.35(3)(a) Comprehensive Individualized Service Plan DHS 83.35(3)(b) Service Plan Development: Parties involved	N 302		
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. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure 1 of 2 residents (Resident 9) had a completed individualized service plan (ISP) within 30 days of admission. Findings include:	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 11 On 04/22/2026, at 11:30AM, Surveyor reviewed Resident 9's record. Resident 9 was admitted on 02/07/2026. Resident 9's record contained a temporary ISP dated 02/09/2026. Surveyor did not locate evidence of an ISP completed within 30 days of admission for Resident 9. On 04/22/2026, at 11:40 AM, Surveyor interviewed House Manager B. House Manager B reported s/he was responsible for completing resident ISPs. House Manager B confirmed Resident 9 required an updated ISP after her/his temporary ISP was completed and it was not completed. House Manager B did not provide an explanation why Resident 9's ISP was not completed. CROSS REFERENCE DHS 83.28(4)(a) Resident Health Screening and Documentation DHS 83.35(3)(b) Service Plan Development: Parties involved	N 386		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its	{N 387}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 387}	Continued From page 12 approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have the resident or resident's legal representative sign the Individual Service Plan (ISP) acknowledging their involvement in, understanding of, and agreement with the plan for 1 of 2 residents (Resident 9) records reviewed. Residents 9's temporary ISP did not have all required signature signatures. This is a repeat deficiency. See Statement of Deficiency (SOD) HGN913. Findings include: On 04/22/2026, at 11:30AM, Surveyor reviewed Resident 9's record. Resident 9 was admitted on 02/07/2026. Resident 9's file indicated s/he had a guardian and a managed care organization (MCO). Resident 9's record contained a temporary ISP dated 02/09/2026. The ISP was not signed by Resident 9's MCO representative(s) or guardian. On 04/22/2026, at 11:40 AM, Surveyor interviewed House Manager B. House Manager B reported s/he was responsible for completing resident ISPs. House Manager B confirmed the code requirement. House Manager B reported s/he planned to have the ISP signed when the MCO visited the facility. MCO's. House Manager B reported s/he would email Resident 9's MCO	{N 387}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 387}	Continued From page 13 representative and guardian for required signatures. CROSS REFERENCE DHS 83.35(3)(a) Comprehensive Individualized Service Plan DHS 83.28(4)(a) Resident Health Screening and Documentation	{N 387}		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was maintained in a safe, clean, comfortable, and homelike environment. The facility was in need of cleaning and repairs to walls, flooring, and fixtures. This is a repeat deficiency. See Statement of Deficiency HGN913, dated 05/07/2024. Findings include: The facility is licensed as an AA (ambulatory) facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally disabled, alcohol/drug dependent, physically disabled, and traumatic brain injury.	{N 481}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 481}	Continued From page 14 On 04/22/2026, at approximately 10:50 AM, Surveyor toured the facility. First floor bathroom -The ceiling fan had an accumulation of a grey substance consistent with dust. -The sink fixture contained brown stains and black marks -Tissue was on floor next to and around the toilet. -The floor vent had a reddish-brown appearance, consistent with rust, and contained a grey substance consistent with dust. -Walls originally painted off-white, were stained and marked with black and brown marks. Kitchen -The refrigerator was missing the door handle. -The freezer door contained brown stains. -The walls behind the sink and counter contained multiple food stains. -The island drawers were dirty and had food spills. -There were brown stains on the counter. -The island drawers were dirty and had food spills. -There were brown stains on the counter. Dining Room -Paint was chipped and or missing in multiple locations on the east wall/baseboards . -Return air vents had an accumulation of grey substance consistent with dust. -Exit emergency lighting had an accumulation of a grey substance consistent with dust. Laundry Room -Wall behind and adjacent to dryer contained accumulation of a grey substance consistent dryer lint.	{N 481}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 481}	Continued From page 15 Living Room -Wall behind couch contained missing/chipped paint in multiple locations -Return vent above couch contained an accumulation of a grey substance consistent with dust. Stairway leading to basement -Broken handrail which contained duct tape to hold the pieces together. Basement Living Room with access to all residents -The flooring was uneven and separating in multiple areas. Basement bathroom -Green substance consistent with body wash covered an approximate 6 inch (") by 9" area on the shower floor. -Towels that appeared wet and soiled were lying on the ground. On 04/22/2026, at approximately 10:45 AM, Surveyor interviewed Resident 8. Resident 8 reported the facility needed updates and repairs. On 04/22/2026, at approximately 11:40 AM, Surveyor interviewed House Manager B. House Manager B confirmed there were concerns in the home which needed to be fixed. House Manager B reported staff are responsible for cleaning the facility. House Manager B reported s/he would notify the licensee and maintenance of needed repairs in the facility.	{N 481}		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 488	Continued From page 16 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, interview and record review, the provider did not ensure 1 of 1 clothes dryer in the laundry room had vent tubing of rigid material. The clothes dryer observed did not have rigid vent tubing connected. Findings include: On 04/22/2026, at approximately 10:50 AM, Surveyor toured the facility. Surveyor observed a dryer on the first floor of the facility. The vent tubing from the dryer was on the floor in separate pieces behind the dryer and was disconnected from the dryer. A grey substance consistent with lint was located on the wall behind and adjacent to the dryer. On 04/22/2026, at approximately 11:40 AM, Surveyor interviewed House Manager B. House Manager B confirmed the code requirement. House Manager B reported s/he would inform the Licensee to ensure dryer vent was fixed. Cross Reference N0538 83.48(3)(a) Fire Detection Systems Inspected Annually.	N 488		
{N 511}	83.46(3) Public water supply or well water test. Public water supply. The CBRF shall use a public	{N 511}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 511}	Continued From page 17 water supply when available. If a public water supply is not available, the CBRF shall have a well that is approved by the state department of natural resources. The CBRF shall have the well water tested at least annually by the state laboratory of hygiene or other laboratory approved under ch. HFS 165. The CBRF shall maintain documentation of annual testing results. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the well water was tested annually for 1 of 2 years (2025) reviewed by the state laboratory of hygiene or other laboratory approved under ch. HFS 165. This is a repeat deficiency. See Statement of Deficiency (SOD) HGN913, dated 05/07/2024. Findings include: On 04/22/2026, at approximately 11:10 AM, Surveyor reviewed the facility safety files. Surveyor reviewed an annual water test dated 10/21/2024. Surveyor did not locate evidence of an annual water test completed in 2025. On 04/22/2026, at approximately 11:40 AM, Surveyor interviewed House Manager B. House Manager B confirmed the code requirement. House Manager B reported s/he was responsible for the annual water test. House Manager B reported s/he believed the water test was completed in 2025, but s/he could not locate the documentation. Surveyor did not receive evidence of a completed annual water test in 2025.	{N 511}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 538}	Continued From page 18	{N 538}		
{N 538}	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the fire detection system was inspected for 1 of 2 calendar years (2025). This is a repeat deficiency. See Statement of Deficiency (SOD) HGN913, dated 05/07/2024. Findings include: On 04/22/2026, at approximately 11:10 AM, Surveyor reviewed the facility safety files. Surveyor reviewed an annual fire detection system inspection dated 07/02/2024. Surveyor did not locate evidence of an annual fire detection system inspection for 2025. On 04/22/2026, at approximately 11:40 AM, Surveyor interviewed House Manager B. House Manager B confirmed the code requirement. House Manager B reported s/he believed there was an inspection completed more recently but would have to contact the company for the report. Surveyor did not receive evidence of a completed annual fire detection system completed in 2025.	{N 538}		
N 617	83.55(6)(b) Bath and toilet areas: water temperature	N 617		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 617	Continued From page 19 The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs 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, record review, and interview, the provider did not ensure the temperature of water at fixtures used by residents did not exceed 115 degrees Fahrenheit (F) in 1 of 2 bathrooms. Bathroom water temperature in the first-floor bathroom exceeded 115 degrees Fahrenheit (F) and measured at 141.6 degrees F. Findings include: The facility is licensed as an AA (ambulatory) facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally disabled, emotionally disturbed/mental illness, alcohol/drug dependent, physically disabled, and traumatic brain injury. On 04/22/2026, at approximately 10:50 AM, Surveyor toured the facility and identified the following: First floor common bathroom: water temperature 141.6 degrees F. On 04/22/2026, at approximately 11:10 AM, Surveyor reviewed the facility safety files. Surveyor did not locate evidence of water temperature checks in facility safety files.	N 617		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	**8208 RACINE AVE WIND LAKE, WI 53185**

(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 617	Continued From page 20 On 04/22/2026, at approximately 11:40 AM, Surveyor interviewed House Manager B. House Manager B. House Manager B reported s/he was unaware of the code requirement. House Manger B reported s/he would ensure maintenance would adjust water temperature to the appropriate temperature.	N 617		