STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018758	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - BLOOMER II	406 PRIDDY STREET B BLOOMER, WI 54724

(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 09/16/2025, Surveyor conducted a x3 complaint investigation and verification visit at VitaCare Living Bloomer II. Data collection continued through 10/02/2025. Three of 3 complaints were substantiated. Thirteen deficiencies were identified. Seven of the 13 deficiencies were repeat violations. See Statement of Deficiencies (SOD) VQ5G11, dated 05/11/2022; TR1711, dated 09/20/2022; TR1712, dated 12/05/2022; J5JP12, dated 09/27/2024; and J5JP13, dated 03/04/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 13	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form	N 158		

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

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N 158	Continued From page 1	N 158		

provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not report an allegation of misappropriation to the department within 7 days.

On 05/15/2025, staff discovered a different medication taped into the back of Resident 5's PRN (as needed) oxycodone bubble pack. The provider did not submit a self-report to the Department for this incident until 06/10/2025.

This is a repeat deficiency. See SOD VQ5G11, dated 05/11/2022 and TR1711, dated 09/20/2022.

Findings include:

On 06/02/2025, the Department received a complaint which alleged misappropriation.

On 09/16/2025 Surveyor reviewed the Department's e-file for this provider and found the following:

A self-report reported on 06/10/2025, indicated on 05/15/2025 at 10:15 PM staff were completing narcotic counts and found a different type of pill taped into Resident 5's PRN oxycodone bubble pack. An investigation was done immediately by Former Executive Director (FED) O until his/her leave of employment on 05/22/2025. On 06/09/2025, the incident was brought to Administrator B's attention by Resident 5's managed care organization (MCO). Administrator

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B could not find FED O's documentation of the investigation and started a new investigation immediately.

On 09/16/2025 at 11:45 AM, Surveyor requested any internal investigations the provider had conducted since January 2025 and Resident 5's record.

On 09/16/2025 at approximately 1:00 PM, Surveyor reviewed internal investigations and Resident 5's record.

An internal investigation done by Administrator B undated, read in part, "On 05/20/2025 [FED O] informed [Administrator B] that [his/her] investigation was completed and that [s/he] could not find a reason why a Glipizide pill was taped in [Resident 5's] Oxycodone bubble pack. Furthermore, [s/he] concluded that [s/he] could not pinpoint when it happened or who did it."

Resident 5 was admitted on 03/05/2025 and was his/her own decision maker. Resident 5 had diagnoses that included Parkinson's disease, acquired absence of right leg above the knee, atherosclerotic heart disease, heart failure, chronic kidney disease stage 3, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes mellitus type 2, and ventral hernia.

The individual service plan (ISP) dated 03/12/2025, indicated staff assisted Resident 5 with medication administration.

The medication administration record (MAR) for May 2025 indicated Resident 5 was prescribed oxycodone HCL 5 mg to take every 8 hours PRN. The MAR indicated Resident 5 had last been

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N 158	Continued From page 3 administered his/her PRN oxycodone on 05/10/2025 for pain in his/her hip. The pill count history dated 05/15/2025 at 10:43 PM, indicated Resident 5's oxycodone narcotic count was off. It stated the count was 13 and staff counted only 12. The medication Proof-of-Use Record Policy and Procedure, read in part, "Any suspected misappropriation, diversion, or loss of controlled substances must be reported in compliance with DHS (Department of Health Services) ..." Wis. Admin. Code § DHS 13.05(3), Entity Internal Investigation Responsibilities, states the following: "All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: - Collecting and preserving any physical and documentary evidence including videos; - Interviewing alleged victims and witnesses; - Collecting other corroborating/disproving evidence; - Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen, Client Right's Specialist, etc.); and - Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the	N 158		

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N 158	Continued From page 4 alleged incident. An entity's internal investigation will assist in determining if an incident must be reported to DQA (see 6.5.0. - 6.6.0.). If the incident is reported to DQA, the entity's internal investigation becomes part of the DQA caregiver misconduct investigation (see 6.7.0.)." On 10/01/2025 at 12:17 PM, Surveyor interviewed Family Member (FM) M. FM M stated the provider had not followed up with him/her yet about the incident on 05/15/2025. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, Regional Nurse (RN) C, Assistant Director (AD) D, Regional Director (RD) E, RD F, RN G, and RD H. AD D stated they did find FED O's original investigation of the incident and it was sent for Surveyor's review. RN C indicated Administrator B was going to submit the investigation to the Office of Caregiver Quality (OCQ) but had not done so yet. RN C stated they only reported the incident to the Department a month later on 06/10/2025 when the MCO inquired about it. RN C stated there had been a breakdown in communication with the incident not getting reported to the MCO either.	N 158		
N 160	83.12(2)(c) Report to law enforcement and coroner Investigating and reporting abuse, neglect, or misappropriation of property. Other reporting. Filing a report under sub. (1) or (2) does not relieve the licensee or other person of any obligation to report an incident to any other authority, including law enforcement and the coroner.	N 160		

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N 160	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure allegations of misappropriation were reported to law enforcement. On 05/15/2025, staff discovered a different medication taped into the back of Resident 5's PRN (as needed) oxycodone bubble pack. The provider did not notify law enforcement about this incident. This is a repeat deficiency. See SOD VQ5G11, dated 05/11/2022 and TR1711, dated 09/20/2022. Findings include: On 06/02/2025, the Department received a complaint which alleged misappropriation. On 09/16/2025 Surveyor reviewed the Department's e-file for this provider and found the following: A self-report reported on 06/10/2025, indicated on 05/15/2025 at 10:15 PM staff were completing narcotic counts and found a different type of pill taped into Resident 5's PRN oxycodone bubble pack. An investigation was done immediately by Former Executive Director (FED) O until his/her leave of employment on 05/22/2025. On 06/09/2025, the incident was brought to Administrator B's attention by Resident 5's managed care organization (MCO). Administrator B could not find FED O's documentation of the investigation and started a new investigation immediately. On 09/16/2025 at 11:45 AM, Surveyor requested	N 160		

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any internal investigations the provider had conducted since January 2025 and Resident 5's record.

On 09/16/2025 at approximately 1:00 PM, Surveyor reviewed internal investigations and Resident 5's record.

An internal investigation done by Administrator B undated, read in part, "On 05/20/2025 [FED O] informed [Administrator B] that [his/her] investigation was completed and that [s/he] could not find a reason why a Glipizide pill was taped in [Resident 5's] Oxycodone bubble pack. Furthermore, [s/he] concluded that [s/he] could not pinpoint when it happened or who did it."

Resident 5 was admitted on 03/05/2025 and was his/her own decision maker. Resident 5 had diagnoses that included Parkinson's disease, acquired absence of right leg above the knee, atherosclerotic heart disease, heart failure, chronic kidney disease stage 3, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes mellitus type 2, and ventral hernia.

The individual service plan (ISP) dated 03/12/2025, indicated staff assisted Resident 5 with medication administration.

The medication administration record (MAR) for May 2025 indicated Resident 5 was prescribed oxycodone HCL 5 mg to take every 8 hours PRN. The MAR indicated Resident 5 had last been administered his/her PRN oxycodone on 05/10/2025 for pain in his/her hip.

The pill count history dated 05/15/2025 at 10:43 PM, indicated Resident 5's oxycodone narcotic

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N 160	Continued From page 7 count was off. It stated the count was 13 and staff counted only 12. The self-report, internal investigation, and Resident 5's record did not contain any documentation indicating law enforcement were notified about the incident. An email on 09/26/2025 at 5:10 PM from Administrator B, indicated the incident had not been reported to law enforcement by FED O or him/her after the second investigation was completed. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, Regional Nurse (RN) C, Assistant Director (AD) D, Regional Director (RD) E, RD F, RN G, and RD H. RN C stated there had been a breakdown in communication with the incident not getting reported to law enforcement, which was the expectation with this type of incident. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse Neglect	N 160		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider and its operation did not comply with all laws governing the Community	{N 196}		

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{N 196}	Continued From page 8	{N 196}		

Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. The licensee did not ensure all deficiencies in Statement of Deficiency (SOD) J5JP13 were corrected.

As a result of this verification visit and 3 complaint surveys, a total of 13 violations were issued and 3 of 3 complaints were substantiated. Seven of the 13 violations were repeat deficiencies.

This is a repeat deficiency. See Statement of Deficiency (SOD) J5JP13, dated 03/04/2025.

Findings include:

The provider is licensed to care for up to 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 09/16/2025, the facility census was 13.

On 03/26/2025, the Department issued a Notice and Order letter with SOD J5JP13, dated 03/04/2025. The Notice and Order letter included orders to comply with requirements and an order to not admit new or additional residents. The Notice and Order letter read in part, "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 VitaCare Living Bloomer II NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency (SOD) J5JP13 are corrected, compliance is verified by the Department, and this Order is rescinded in writing."

On 09/16/2025, Surveyor conducted a

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{N 196}	Continued From page 9	{N 196}		

three-complaint investigation and verification visit at VitaCare Living Bloomer II.

On 10/02/2025, Surveyor reviewed Department records for VitaCare Living Bloomer II, licensed on 02/07/2022.
Since initial licensure the facility has had 9 substantiated complaints, a total of 46 deficiencies, and 17 recites issued. The following information was reviewed:

VQ5G11, dated 05/11/2022

Four deficiencies were identified. One of 1 complaint was substantiated.

1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect
2. 83.12(2)(c) Report To Law Enforcement And Coroner
3. 83.17(1) Licensee Conduct Caregiver Background Check
4. 83.19 Orientation

TR1711, dated 09/20/2022

Two deficiencies were identified. One of 1 complaint was substantiated.

1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect
2. 83.12(2)(c) Report To Law Enforcement And Coroner

TR1712, dated 12/05/2022

Ten deficiencies were identified.

1. 83.17(2)(a) Employees Screened For Communicable Disease

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{N 196}	Continued From page 10 2. 83.21(1)-(3) All Employee Training 3. 83.22(1)-(4) Task Specific Training 4. 83.28(4)(a) Resident Health Screening And Documentation 5. 83.35(5)(a) Initial Evaluation Of Evacuation Limitations 6. 83.41(3)(b) Food Safety 7. 83.43(1) Environment Safe, Clean, And Comfortable 8. 83.45(3) Toxic Substances 9. 83.46(1)(c) Heating System Maintenance 10. 83.47(2)(e) Other Evacuation Drills J5JP11, dated 04/16/2024 One deficiency was identified. One of 1 complaint was substantiated. 1. 83.32(3)(a) Rights Of Residents: Communications J5JP12, dated 09/27/2024 One of 1 complaint was substantiated, and 17 deficiencies were identified. Six of 17 deficiencies were repeat violations (see SOD TR1712, dated 12/05/2025). 1. 83.15(3)(a) Administrator Shall Supervise Daily Operation 2. 83.17(2)(a) Employees Screened For Communicable Disease 3. 83.19 Orientation 4. 83.21(1)-(3) All Employee Training 5. 83.32(3)(h) Rights Of Residents: Receive Medication 6. 83.35(3)(b) Service Plan Development: Parties Involved 7. 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	{N 196}		

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{N 196}	Continued From page 11 8. 83.36(2) Maintain Current Written Staffing Schedule 9. 83.38(1)(a) Personal Care 10. 83.38(1)(c) Leisure Time Activities 11. 83.41(3)(b) Food Safety 12. 83.42(2) Resident Records Safeguarded 13. 83.43(1) Environment Safe, Clean, And Comfortable 14. 83.47(2)(d) Fire Drills 15. 83.47(2)(e) Other Evacuation Drills 16. 83.48(1)(a) Smoke Detection System 17. 83.55(6)(b) Bath And Toilet Areas: Water Temperature J5JP13, dated 03/04/2025 Two of 2 complaints were substantiated, and 9 deficiencies were identified. Four of the 9 deficiencies were repeat violations (see SOD J5JP12, dated 09/27/2024). 1. 83.12(4)(d) Reporting Catastrophe Resulting In Damage 2. 83.12(5)(a) Notification: Incident, Injury, Changes 3. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 4. 83.14(2)(e) Notify Within 7 Days Of Administrator Change 5. 83.14(2)(h) Posting: License, Deficiencies, Revocations 6. 83.32(3)(h) Rights Of Residents: Receive Medication 7. 83.35(3)(b) Service Plan Development: Parties Involved 8. 83.36(2) Maintain Current Written Staffing Schedule 9. 83.36(2) Maintain Current Written Staffing Schedule	{N 196}		

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{N 196}	Continued From page 12 J5JP14, dated 10/02/2025 Three of 3 complaints were substantiated, and 13 deficiencies were identified. Seven of the 13 deficiencies were repeat violations (see SOD VQ5G11, dated 05/11/2022; TR1711, dated 09/20/2022; TR1712; dated 12/05/2022; J5JP12, dated 09/27/2024; and J5JP13, dated 03/04/2025). 1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect 2. 83.12(2)(c) Report To Law Enforcement And Coroner 3. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 4. 83.32(3)(h) Rights Of Residents: Receive Medication 5. 83.35(1)(a) Pre-Admission And Ongoing Assessments 6. 83.35(3)(d) Service Plans Updated Annually Or On Changes 7. 83.37(3)(c) Medication Storage: Locked Cabinet 8. 83.38(1)(a) Personal Care 9. 83.38(1)(c) Leisure Time Activities 10. 83.42(2) Resident Records Safeguarded 11. 83.43(1) Environment Safe, Clean, And Comfortable 12. 83.55(3) Bath And Toilet Areas: Hand Drying 13. 50.09(1)(L) Care. On 09/16/2025 at 10:30 AM, Surveyor interviewed Assistant Director (AD) K. AD K stated Regional Nurse (RN) C was at the facility 1 to 2 days per week and Administrator B was at the facility 3 to 4 days per week. On 09/16/2025 at 3:45 PM, Surveyor interviewed Administrator B, Regional Nurse (RN) C, AD D,	{N 196}		

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{N 196}	Continued From page 13 and AD K. Administrator B stated management was on-call for staff support and were having more oversight of the facility. Administrator A confirmed the Department issued Notice and Order letter with SOD J5JP13, dated 03/04/2025 that was issued on 03/26/2025, was sent to all resident Power of Attorneys (POAs)/Guardians and independent residents to review and sign on 04/02/2025. Surveyor observed the Notice and Order letter with SOD J5JP13 was posted on the bulletin across from the office for anyone to see. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. Concerns were reviewed and discussed with the VitaCare Living Bloomer II team. The team had to defer some questions asked by Surveyor to Administrator B, who was not able to be present at the exit conference. There were multiple conversations between management during the exit conference discussing the capabilities of their electronic charting system that RN C and AD D were not aware of. The team indicated they understood the concerns discussed and would work immediately to correct them. The licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF when 3 of 3 complaints were substantiated and 13 deficiencies were identified. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse Neglect N0160 DHS 83.12(2)(c) Report To Law Enforcement And Coroner N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication	{N 196}		

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{N 196}	Continued From page 14 N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0425 DHS 83.38(1)(a) Personal Care N0427 DHS 83.38(1)(c) Leisure Time Activities N0479 DHS 83.42(2) Resident Records Safeguarded N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0612 DHS 83.55(3) Bath And Toilet Areas: Hand Drying Y3244 Chapter 50.09(1)(L) Care	{N 196}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., 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 interview and record review, the provider did not ensure 1 of 1 resident reviewed (Resident 1) received his/her medication (warfarin) as prescribed multiple times in May and July 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) J5JP13, dated 03/04/2025 and SOD J5JP12, dated 09/27/2024. Findings include:	{N 352}		

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{N 352}	Continued From page 15 On 06/02/2025 the Department received a complaint alleging medication concerns. On 09/16/2025 at approximately 1:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/11/2015 and was his/her own decision maker. Resident 1 had diagnoses that included atrial fibrillation and chronic anticoagulation for prosthetic mitral valve replacement secondary to rheumatic fever. The individual service plan (ISP) dated 02/10/2025 indicated staff provided medication setup and gave verbal reminders to take his/her medications. "Most patients on warfarin do well with an INR between 2.0 and 3.0 ....If the INR falls below the therapeutic range, the risk of clotting is greater and if the INR rises above the therapeutic range, the risk of bleeding complications is higher." (Source: National Blood Clot Alliance Website, Warfarin, https://www.stoptheclot.org/about-clots/blood-clot-treatment/warfarin/#:~:text=If%20the%20INR%20falls%20below,to%20approximately%20once%20per%20month (retrieval date - 10/16/2025).) Surveyor reviewed Resident 1's medication administration record (MAR), warfarin orders for May 2025 through July 2025, and medication errors. An anticoagulation clinic note dated 05/21/2025 indicated Resident 1's INR was 4.3. The warfarin orders were for 14 mg on Monday 05/25/2025 and 12 mg of warfarin all other days until the next INR check on 05/28/2025.	{N 352}		

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{N 352}	Continued From page 16 An after-visit summary dated 05/26/2025 indicated Resident 1 was medically evaluated for an INR of 5.8. The orders were for Resident 1's warfarin to be held the night of 05/26/2025. The May 2025 MAR indicated on 05/22/2025 and 05/25/2025, staff charted under both 14 mg and 12 mg of warfarin, making it appear Resident 1 received a total of 26 mg of warfarin and not the 12 mg ordered. Staff notes on 05/26/2025 indicated Resident 1 did not receive 14 mg of warfarin as ordered due to the warfarin dosage tablets not being available. A medication error document dated 05/26/2025, indicated the provider only had 6 mg warfarin tablets available in the medication cart for Resident 1. Staff were instructed to call non-emergency medical services and Resident 1 was taken to the emergency room (ER) to be medically evaluated. The document indicated the medication was not entered into their electronic MAR correctly and the regional nurse (RN) would be following resident's INRs and making sure new orders were entered into the system correctly. A self-report submitted on 05/29/2025, indicated after reviewing the electronic MAR the provider determined an order error entry had occurred resulting in 2 documentation medication errors. Staff documented that Resident 1 received over the ordered doses on two dates. The self-report did not specify which two dates the medication errors occurred on. The self-report indicated the provider removed all the old warfarin orders from the electronic MAR so that new orders were entered as they came. The provider destroyed the warfarin that remained in the medication cart	{N 352}		

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{N 352}	Continued From page 17 and provided staff with education. An anticoagulation clinic note dated 07/16/2025, indicated Resident 1 was to receive 14 mg of warfarin on Friday (07/18/2025) and 12 mg all other days. An anticoagulation clinic note dated 07/30/2025, indicated Resident 1's INR was 3.6 and s/he was to receive 14 mg of warfarin every Wednesday and 12 mg all other days. The July 2025 MAR indicated staff did not chart warfarin was administered on 07/16/2025. The MAR indicated on 07/30/2025 there was no place for staff to chart 14 mg of warfarin was administered to Resident 1, making it appear s/he did not receive the dose. A medication error document dated 07/30/2025, indicated the 4 mg dose of warfarin was not listed on the MAR for staff to administer. The document indicated staff should have called management when the medication arrived and did not. Thus, the medication was not entered in the electronic MAR correctly. Staff were re-educated on the importance of double-checking medications. On 09/16/2025 at 3:45 PM, Surveyor interviewed Administrator B, Regional Nurse (RN) C, Assistant Director (AD) D, and AD K. Administrator B stated the pharmacy delivered daily between 6:00 PM and 7:00 PM. Administrator stated staff were to call management when medications arrived for management to push them through their electronic charting system. AD D stated s/he started his/her position in June 2025, and s/he would call, or staff would notify him/her of medication deliveries.	{N 352}		

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{N 352}	Continued From page 18 An email from Case Manager (CM) dated 09/25/2025 regarding warfarin, read in part, "Recently there had been some missed doses related to administration not checking in the correct dose ordering on time. Education was had between staff and administrators and a change in administration was also made. [S/He] was sent to the ER for evaluation precautionary and [his/her] anticoagulation team was always notified right away along with his [care team]. None have occurred to our knowledge since the change in administration." On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. RN C stated the past director was not putting an end date on the previous order, so both the old and new order were in the electronic MAR. Staff would not have had enough medication to give both doses in the electronic MAR but ended up charting both doses as administered. RN C stated at one point staff thought Resident 1 was only to receive his/her Lovenox injection and not his/her warfarin at the same time. This occurred 2 to 3 days. Another time, Resident 1 had to get sent to the ER because his/her ordered warfarin dose was not available in the medication cart. AD D stated one of the errors that happened in July 2025 was due to staff not notifying management to push the order through when the medication arrived at the facility. RN C stated moving forward they had made a new form for the medication pass process. RN C was also personally managing all residents on warfarin. Staff were supposed to reach out to RN C to make sure the warfarin dose in the electronic MAR was correct. RN C stated there had been no errors since July 2025.	{N 352}		

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N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF 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 shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not assess 1 of 1 resident (Resident 3) reviewed when they had a change in their needs, abilities, and/or physical and mental condition. Resident 3 did not have an assessment completed to determine s/he was taking his/her bedside medications correctly. Findings include: The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 09/16/2025 at 12:30 PM, Surveyor interviewed Resident 3. Resident 3 stated s/he kept his/her inhalers at his/her beside in case of an emergency. Surveyor observed the following	N 381		

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medications kept unsecured on Resident 3's bedside table:

Fluticasone prop 50 mcg - spray 2 sprays into alternating nostrils twice daily as needed for dry nose

Levalbuterol Hfa 45 mcg - inhale 2 puffs orally every 4 hours as needed for shortness of breath

Lactaid Fast Act 9,000 unit - take 1 tablet orally three times daily as needed before meals

On 09/16/2025 at approximately 1:00 PM, Surveyor reviewed Resident 3's record.

Resident 3 was admitted on 10/09/2024 and was his/her own decision maker. Resident 3 had diagnoses that included hypercapnic respiratory failure, moderate persistent asthma, post COVID-19 condition, reactive airway disease with wheezing, shortness of breath, and sleep apnea with nocturnal BiPAP (bilevel positive airway pressure).

A physician order dated 12/19/2024, read in part, "Referral Order (Med at Bedside: Okay for [Resident 3] to keep Levalbuterol PRN inhaler at [his/her] bedside. Patient to let staff know when [s/he] is using it. If misused, medication will be given back to staff to manage." The fax cover sheet read in part, "[Resident 3] may also have [his/her] lactaide tablets at [his/her] bedside."

The ISP dated 02/11/2025, indicated staff were to administer all medications to Resident 3 per the physician orders.

The medication administration records (MARs) for March and April 2025 indicated all 3 PRN

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N 381	Continued From page 21 medications Resident 3 kept at his/her bedside (Fluticasone, Levalbuterol, and Lactaid) were not charted as given on any days for both months by staff. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, Regional Nurse (RN) C, Assistant Director (AD) D, Regional Director (RD) E, RD F, RN G, and RD H. RN C confirmed Resident 3 did not have a documented assessment for taking his/her beside medications correctly since admission.	N 381		
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 observation, record review, and interview, the provider did not ensure 1 of 1 resident's (Resident 3) individual service plan (ISP) was updated to include new interventions related to supplemental oxygen management and self-administration of some medications.	N 389		

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N 389	Continued From page 22 Findings include: On 04/03/2025 the Department received a complaint regarding supplemental oxygen management concerns. The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 09/16/2025 at 12:30 PM, Surveyor interviewed Resident 3. Resident 3 explained when s/he was admitted approximately 1 year ago with supplemental oxygen per a physician order. Resident 3 stated a few months ago staff told him/her that s/he did not need supplemental oxygen anymore and it was removed from his/her room. Resident 3 stated staff were testing his/her oxygen saturation level during his/her time without the supplemental oxygen. Resident 3 stated without his/her supplemental oxygen s/he was very distressed. Resident 3 indicated s/he did not remember how long s/he was without supplemental oxygen but was given a new order for supplemental oxygen after a hospitalization. Resident 3 stated s/he kept his/her inhalers at his/her beside in case of an emergency. Surveyor observed the following medications kept unsecured on Resident 3's bedside table: Fluticasone prop 50 mcg - spray 2 sprays into alternating nostrils twice daily as needed for dry nose Levalbuterol Hfa 45 mcg - inhale 2 puffs orally every 4 hours as needed for shortness of breath Lactaid Fast Act 9,000 unit - take 1 tablet orally	N 389		

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three times daily as needed before meals

On 09/16/2025 at approximately 1:00 PM, Surveyor reviewed Resident 3's record.

Resident 3 was admitted on 10/09/2024 and was his/her own decision maker. Resident 3 had diagnoses that included hypercapnic respiratory failure, moderate persistent asthma, post COVID-19 condition, reactive airway disease with wheezing, shortness of breath, and sleep apnea with nocturnal BiPAP (bilevel positive airway pressure).

A physician order dated 12/19/2024, read in part, "Referral Order (Med at Bedside: Okay for [Resident 3] to keep Levalbuterol PRN inhaler at [his/her] bedside. Patient to let staff know when [s/he] is using it. If misused, medication will be given back to staff to manage." The fax cover sheet read in part, "[Resident 3] may also have [his/her] lactaide tablets at [his/her] bedside."

The ISP dated 02/11/2025, indicated Resident 3 did not have respiratory equipment in use and had no further detail about supplemental oxygen and oxygen saturation checks. The ISP indicated staff were to administer all medications to Resident 3 per the physician orders.

A physician order dated 04/08/2025, indicated Resident 3's supplemental oxygen with concentrator was discontinued due to improvement of oxygenation and s/he no longer required supplemental oxygen.

An after-visit summary indicated Resident 3 was hospitalized from 05/07/2025 to 05/09/2025 with respiratory failure with hypoxia. Upon discharge, there were orders for Resident 3 to be on

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supplemental oxygen. The order indicated Resident 3 was to be on 2 LPM of supplemental oxygen continuously. The discharge paperwork indicated Resident 3's oxygen concentrator was delivered to the facility on 05/09/2025, the day s/he discharged from the hospital.

A service detail active 05/29/2025, indicated Resident 3's oxygen saturation was to be monitored and recorded monthly by staff. Staff were to notify the nurse if oxygen saturation less than 90%.

A staff progress note dated 06/03/2025, read in part, "Write [sic] called and spoke with [Resident 3's] Palliative Care team and requested an order to check [Resident 3's] oxygen 3 times a day."

On 09/16/2025 at 2:25 PM, Surveyor interviewed Caregiver J. Caregiver J stated Resident 3 was on oxygen saturation checks 4 times per day and staff were to document.

On 09/25/2025 at 1:57 PM, Surveyor received an email from Case Manager (CM) L. The email explained Resident 3 weaned off his/her supplemental oxygen and due to another hospitalization, a few months ago, s/he was re-prescribed for supplemental oxygen. The email indicated Resident 3's current order to check oxygen saturation levels was for 3 times per day and staff were to document the result. The email indicated Resident 3's current oxygen order was for 2 LPM and Resident 3 could use up to 4 LPM when s/he was short of breath.

On 09/26/2025 at 5:12 PM, Surveyor received an email from Administrator B which included a service progress note updated 09/25/2025. The service progress note read in part, "Oxygen

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delivery as ordered: check for oxygen tubing placement, ensure that oxygen is being delivered at 2-4L [sic] nasal cannula and nasal cannula is in place on resident. Notify Hospice RN (nurse) if: oxygen <90% on 2-4L o2 [sic] or is short of breath/having difficulty breathing Qshift [sic] o2 [sic] checks." The progress note also indicated Resident 3 was to have his/her oxygen saturation checked 3 times per day and oxygen tubing/setting checks every 2 hours. It read in part for monthly respiratory equipment care, "ORDER oxygen supplies (for the next month) - tubing, humidification cannister, nebulizer supplies (replace all supplies on this same date with new supplies - date and initial new supplies."

On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, Regional Nurse (RN) C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. Administrator B stated they liked to have the whole care team present at ISP review meetings and previously the updated ISPs were just emailed to the care team.

On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. RD F confirmed Resident 3's ISP was not updated since 02/11/2025.

Resident 3 was admitted on 10/09/2024 with supplemental oxygen, and it was discontinued on 04/08/2025. After a hospitalization, Resident 3 had a supplemental oxygen order initiated on 05/09/2025. Resident 3 has had 3 medications kept at his/her bedside to self-administer and the ISP did not address this. Resident 3's ISP was not updated to reflect changes to his/her supplemental oxygen orders and self-administration of bedside medications.

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N 389	Continued From page 26 Cross Reference N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet	N 389		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medicine cabinets were kept locked. Findings include: The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 09/16/2025 at 10:16 AM, Surveyor observed the door to the medication room was unsecured. The medication room was in one of the main hallways opposite management's office, accessible to anyone in the facility. Surveyor observed the medication cart was locked and initially observed the medication refrigerator next to the door had a padlock securing it. On 09/16/2025 at approximately 12:00 PM, Surveyor was observing Caregiver I during medication pass and Caregiver I opened the medication refrigerator. Surveyor observed the hinge on top was broken that secured the padlock	N 419		

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to the refrigerator, leaving multiple medications unsecured. Surveyor observed the medication room door had a keypad and a sign posted on the door stating to keep it locked.

On 09/16/2025 at approximately 12:00 PM, Surveyor interviewed Resident 3. Resident 3 stated since s/he kept his/her inhalers at his/her beside in case of an emergency. Surveyor observed the following medications kept unsecured on Resident 3's bedside table:

Fluticasone prop 50 mcg - spray 2 sprays into alternating nostrils twice daily as needed for dry nose

Levalbuterol Hfa 45 mcg - inhale 2 puffs orally every 4 hours as needed for shortness of breath

Lactaid Fast Act 9,000 units - take 1 tablet orally three times daily as needed before meals.

Surveyor checked on the medication room door multiple times throughout the survey until 3:45 PM when the door remained unsecured.

The medication policy and procedure read in part under medication storage, "The ED or designee will ensure medications are stored in locked medication cart or other locked medication storage area. The locations(s) of each individual residents' medication storage will be identified within the resident assessment and viewable on the individual Medication Management Plan ...The ED or designee will ensure refrigerated medications are stored either in a locked refrigerator or in a locked box in a refrigerator that is used for other purposes."

On 09/16/2025 at 3:45 PM, Surveyor interviewed

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N 419	Continued From page 28 Administrator B, Regional Nurse (RN) C, Assistant Director (AD) D, and AD K. Administrator B stated the medication room door keypad was broke since yesterday and they had purchased a new one. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. RN C stated the keypad to the medication room door had already been fixed. RD F stated the medications at Resident 3's bedside should be marked as self-administered in their electronic charting system. RD H stated the electronic charting system should identify how to store and administer each medication. The provider did not ensure all resident medications were kept locked when 3 medications were kept unsecured in Resident 3's room and the medication room door keypad and refrigerator door lock were both broken leaving multiple medications which needed refrigeration unsecured.	N 419		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and	N 425		

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N 425	Continued From page 29 provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide personal care services adequate to meet the needs of Resident 5. This is a repeat deficiency. See SOD J5JP12, dated 09/27/2024. Findings include: On 06/02/2025, the Department received a complaint alleging residents were not receiving personal care services as indicated on their care plans. The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 09/16/2025 at 1:37 PM, Surveyor interviewed Caregiver I. Caregiver I stated Resident 5 did not get his/her scheduled shower yesterday (09/15/2025) as the overnight shift ran out of time. Caregiver I stated Resident 5 asked to get a shower today (09/16/2025) after lunch and s/he was going to try to complete it. On 09/16/2025, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 03/05/2025 and was his/her own decision maker. Resident 5 had diagnoses that included Parkinson's disease, acquired absence of right leg above the knee,	N 425		

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atherosclerotic heart disease, heart failure, chronic kidney disease stage 3, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes mellitus type 2, and ventral hernia. The resident profile indicated Resident 5 was to receive a shower in the AM on Mondays and Thursdays.

The individual service plan (ISP) dated 03/12/2025, indicated Resident 5 needed moderate assistance with 1 staff for bathing/showering. The ISP indicated Resident 5 needed staff assistance to wash and dry the areas s/he could not reach. The ISP indicated Resident 5 was unable to ambulate and required 2 staff assistance with Hoyer lift transfers.

Surveyor reviewed the service recap summary and staff progress notes for March 2025 through July 2025 and September 2025. The April 2025 through July 2025 and September 2025 service recap summaries did not include staff charting notes. Staff may have indicated in the service recap charting that a shower was completed, but an asterisk next to their initials would have given more detail if the shower was actually completed, a bed bath was done instead, etc. Surveyor did not receive from the provider the service recap summary, which included the additional detail charted by staff if an asterisk was next to staff's initials for April 2025 through July 2025.

The March 2025 service recap summary indicated Resident 5 had showers scheduled for Mondays and Wednesdays at 3:00 PM. Staff charted the following:
03/05/2025 - "Will see if [s/he] wants one tomorrow."
03/10/2025 - "DECLINED: Got [his/her] shower on Sunday (last night)."

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03/12/2025 - "Not done today, I will notify AM shift."
03/17/2025 - "DECLINED: bed bath."
03/19/2025 - "Resident [S/He] had a bed bath."
03/24/2025 - Staff did not chart a shower was completed on this date.
03/26/2025 - "DECLINED: Per [his/her] request [s/he] would like showers on Fridays."
03/31/2025 - "DECLINED: Resident did not get out of bed this shift."

The March 2025 staff progress notes indicated the following:
03/09/2025 - "[Resident 5] had a shower this evening."
03/24/2025 - "Resident was given a bed bath today before lunch. [S/he] did request [his/her] hair to be washed so I told [him/her] if I get done with my other shower early enough I would bring [him/her] into the salon and get [his/her] hair washed up. I am working on getting [him/her] into the system a couple times a week for bed baths to be done."
03/28/2025 - "Resident did request to have [his/her] shower tomorrow (Saturday) sometime in the morning or afternoon instead of tonight. [S/He] did say [s/he] was ok with getting a bed bath, as [s/he] waiting for [his/her] shower chair to come."
03/30/2025 - "["Resident 5] had a bed bath tonight, hair washed ..."

In March 2025 staff documentation indicated Resident 5 received approximately 1 shower and 4 bed baths.

The April 2025 service recap summary indicated Resident 5 had showers scheduled for Mondays and Wednesdays at 3:00 PM. On 04/24/2025, Resident 5's shower schedule changed to

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Mondays and Thursdays at 3:00 PM. Staff did not chart a shower was completed on 04/07/2025, 04/14/2025, and 04/23/2025. On 04/09/2025, staff had charted their initials with a circle around them indicating Resident 5 had declined a shower.

The April 2025 staff progress notes indicated the following:
04/09/2025 - "Resident happened to not want [his/her] bed bath this evening due to having one a few days ago."
04/23/2025 at 9:30 AM - "[S/He] also requested a bed bath as [s/he] has not had one at all the last week. [S/He] wanted it that second, but staff was busy passing medications before they are late and getting another resident up for the day."
04/23/2025 at 11:03 AM - "Resident was given a bed bath this morning, we NEED to be doing this on PM shift. We can not [sic] mark it as completed on charting it [sic] it's not being done. [S/He] as [sic] multiple open sores under [his/her] belly fold, breast's, [sic] [his/her] left armpit appeared to have a yeast like build up that looked like cottage cheese.
04/25/2025 - "Resident got a wonderful shower in [his/her] shower this evening as two staff had helped assist [him/her] using the shower chair with wheels and then put a cushion on the chair to help with [his/her] butt sores. [S/He] was very happy with [his/her] shower this evening. staff [sic] washer [his/her] hair, washed under [his/her] fold and armpits. Under [his/her] breasts [s/he] did have red marks from rubbing and [his/her] butt was very sore this evening."

In April 2025 staff documentation indicated Resident 5 received approximately 4 showers and 1 bed bath. Staff documentation also indicated Resident 5 had started to develop some

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skin breakdown under his/her breasts and on his/her buttocks.

The May 2025 service recap summary indicated Resident 5 had showers schedule on Mondays and Thursdays at 3:00 PM. Staff did not chart a shower was completed on 05/01/2025 and 05/05/2025.

The May 2025 staff progress notes indicated the following:
05/08/2025 - "Staff giving resident bed bath after assessment and will cleanse and dry area and apply barrier cream for protection." A home health referral for wound care was to be made.
05/13/2025 - "Staff giving resident bed bath after assessment."
05/15/2025 - "Resident was washed up this morning along with bandage changes ..."

In May 2025 staff documentation indicated Resident 5 received approximately 7 out of the 9 showers scheduled and 2 bed baths.

The June 2025 service recap summary indicated Resident 5 had showers scheduled on Mondays and Thursdays at 3:00 PM. Staff did not chart a shower was completed on 06/02/2025 and 06/16/2025.

The June 2025 staff progress notes indicated the following:
06/04/2025 - "Resident requested a shower tonight ..."
06/05/2025 - Home health assessed Resident 5's wounds and will continue to monitor weekly.

In June 2025 staff documentation indicated Resident 5 received approximately 7 out of the 9 showers scheduled.

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N 425	Continued From page 34 The July 2025 service recap summary indicated Resident 5 had showers scheduled on Mondays and Thursdays at 3:00 PM. Staff charted Resident 5 declined scheduled showers on 07/17/2025, 07/24/2025, and 07/31/2025. Staff did not chart a shower was completed on 07/10/2025 and 07/21/2025. Surveyor did not receive staff progress notes for July 2025. In July 2025 staff documentation indicated Resident 5 received approximately 4 out of the 9 showers scheduled. The September 2025 service recap summary indicated Resident 5 had showers scheduled on Mondays and Thursdays at 3:00 PM. On 09/15/2025 showers were changed to 7:00 AM for the same days of the week. Staff did not chart a shower was completed on 09/04/2025, 09/08/2025, 09/15/2025, and 09/29/2025. The September 2025 staff progress notes indicated the following: 09/11/2025 - "Resident got a shower at 2pm [sic] ..." 09/16/2025 - "After lunch resident requested to go back into bed and said [s/he] did not want [his/her] shower at the moment but would like one later, staff put [him/her] in bed per [his/her] request and will shower this afternoon." 09/18/2025 - "Resident told staff that [s/he] was not wanting to take [his/her] shower this morning and staff came to get writer, writer talked with [him/her] about morning [his/her] shower s [sic] [s/he] was wanting to take it at 4 pm [sic] this afternoon, writer talked to [his/her] about how its best for [his/her] for to take it in the morning as [s/he] was more alert and safe for [him/her], [s/he] agreed to take [his/her] shower, writer was later	N 425		

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informed by staff that they were unable to get [him/her] in the shower due to behaviors but did give a bed bath."
09/22/2025 - "resident [sic] had [his/her] shower done this morning by management."
09/25/2025 - "Resident's shower was done today a little before 2pm [sic]."

The September 2025 staff documentation indicated Resident 5 received approximately 3 out of 8 showers scheduled and 1 bed bath.

On 10/01/2025 at 12:17 PM, Surveyor interviewed Family Member (FM) M. FM M stated s/he Resident 5's care could be better that s/he was receiving from the provider. FM M stated Resident 5 had expressed s/he felt staff ignored him/her and s/he was left in bed longer than s/he wanted to be. FM M stated s/he felt Resident 5 received a lot of bed baths instead of a shower. FM M stated within the last week s/he was visiting Resident 5 and staff went to change Resident 5 and FM M observed Resident 5 had 3 pills stuck to his/her back. FM M stated s/he had concerns staff were not following through with Resident 5's cares.

On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, Regional Nurse (RN) C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. RN C stated the directors monitor resident services at least monthly. RN C stated they were still trying to figure out their electronic charting system's capability and staff were not all understanding their documentation process. RD H stated if a resident were to decline a shower, the expectation would be staff were re-offering and try to do it the next shift.

Cross Reference

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N 425	Continued From page 36 N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs	N 425		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not provide an activity program to meet the interests and capabilities of the residents. This is a repeat deficiency. See SOD J5JP12, dated 09/27/2025. Findings include: On 06/02/2025, the Department received a complaint alleging there was not a sufficient activity program. The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible	N 427		

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dementia/Alzheimer's disease, terminally ill, and physically disabled.

On 09/16/2025 at 10:30 AM, Surveyor interviewed Assistant Director (AD) K. AD K stated they currently did not have a designated activity staff and caregivers were expected to provide activities to residents.

On 09/16/2025 at 10:48 AM, Surveyor interviewed Resident 1 while s/he was working independently on a puzzle. Resident 1 stated there were no activities and was not aware of an activity calendar.

On 09/16/2025 at 10:58 AM, Surveyor interviewed Resident 2. Resident 2 stated there were no activities and would like exercise to be offered.

On 09/16/2025 at approximately 12:30 PM, Surveyor interviewed Resident 3. Resident 3 indicated s/he would participate in activities when they were offered. Resident 3 stated there were no activities and staff did not follow the posted activity calendar. Resident 3 stated s/he would like bingo to be offered more often.

On 09/16/2025 at 1:17 PM, Surveyor interviewed Resident 4. Resident 4 stated coloring was offered as an activity, but s/he would like to have scheduled walks with staff.

On 09/16/2025 at 1:37 PM, Surveyor interviewed Caregiver I. Caregiver I stated there were no activities scheduled for today and usually not much offered for group activities. Caregiver I agreed there could be more activities offered to residents.

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N 427	Continued From page 38 On 09/16/2025 at 2:17 PM, Surveyor observed Caregiver J sitting at the dining room table with a resident coloring. Surveyor observed the August 2025 activity calendar was still posted on the bulletin board in the dining room. On 09/16/2025 at 2:25 PM, Surveyor interviewed Caregiver J. Caregiver J stated when staff had time they would do activities with residents. Caregiver J stated not many of the residents would participate in activities, but a few residents would benefit from more activities being offered. On 09/16/2025 at 3:45 PM, Surveyor interviewed Administrator B, Regional Nurse (RN) C, AD D, and AD K. Administrator B confirmed they relied on caregivers to provide residents activities. Administrator B stated when caregivers had time they offered coloring, puzzles, taking residents for walks, and doing nails. Administrator B stated they have groups come in to do music for residents and AD D would do one-on-one activities with residents. Administrator B stated there were more activities done than before, but not as many were being done since the designated activity staff position was terminated. On 09/17/2025 at 9:29 AM, Surveyor received an email from Administrator B. Administrator B indicated the designated activity staff's last day worked was on 04/22/2025. On 09/25/2025 at 1:57 PM, Surveyor received an email from Case Manager (CM) L, which read in part, "They don't have an activity program at this time. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional Director (RD) E, RD F, RN G, and RD H.	N 427		

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(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 427	Continued From page 39 Licensee A stated activities were mostly staff led and staff had available for them to use a comprehensive life enrichment software on a tablet. Licensee A explained the software could also be resident led and included games, exercise groups, and opportunities to link to other communities. RD H indicated training for the software had been done with regional directors. Licensee A also indicated they were working with staff to significantly decrease smoke breaks and personal phone use to create more time for staff led activities.	N 427		
N 479	83.42(2) Resident records safeguarded. The licensee shall ensure all resident records are adequately safeguarded against destruction, loss or unauthorized access or use. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were adequately safeguarded against unauthorized access or use when records were stored in the unsecured medication room that had a broken keypad. This is a repeat deficiency. See SOD J5JP12, dated 09/27/2024. Findings include: The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 09/16/2025 at 10:16 AM, Surveyor observed the door to the medication room was unsecured. The medication room was in one of the main	N 479		

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	0018758	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

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N 479	Continued From page 40 hallways opposite management's office, accessible to anyone in the facility. Surveyor observed staff's computer screen was up and had resident information on it. On 09/16/2025 at approximately 12:00 PM, Surveyor was observing Caregiver I during medication pass and observed in the unsecured medication room resident binders on the shelves. Surveyor observed the medication room door had a keypad and a sign posted on the door stating to keep it locked. Surveyor checked on the medication room door multiple times throughout the day from 10:16 AM to 3:45 PM and the door remained unsecured. On 09/16/2025 at 3:45 PM, Surveyor interviewed Administrator B, Regional Nurse (RN) C, Assistant Director (AD) D, and AD K. Administrator B stated the medication room door keypad had been broke since yesterday. Administrator B stated they had purchased a new one and it had not been installed yet. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. RN C stated the keypad to the medication room door had already been fixed.	N 479		
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.	N 481		

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N 481	Continued From page 41	N 481		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not provide an environment that was safe, clean, comfortable, and homelike.

This is a repeat deficiency. See SOD TR1712, dated 12/05/2022 and J5JP12, dated 09/27/2024.

Findings include:

The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled.

On 09/16/2025 at 11:08 AM, Surveyor observed a pile of dirty clothes were in Resident 2's bathroom with a strong smell like urine.

On 09/16/2025 at approximately 12:30 PM, Surveyor interviewed Resident 3. Resident 3 stated a few months ago s/he was taken out of the facility by a transportation driver for an appointment in his/her wheelchair. Resident 3 stated the driver hit a lip in the sidewalk and s/he fell out of the wheelchair hitting his/her face. Resident 3 stated the sidewalk had not been fixed since the incident.

On 09/16/2025 at approximately 1:00 PM, Surveyor reviewed Resident 3's record.

Resident 3 was admitted on 10/09/2024 and was his/her own decision maker. Resident 3 had diagnoses that included cervical radiculopathy, degenerative joint disease of cervical spine,

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greater trochanteric bursitis of left hip, foraminal stenosis of cervical region, myofascial pain, neurologic gait disorder, osteoarthritis of left hip, sacroiliac joint pain, spinal cord compression, spondylosis, and history of falls.

The ISP dated 02/11/2025, indicated Resident 3 was independent with transfers, ambulation, and using his/her wheelchair.

A self-report dated 03/04/2025, indicated on 02/27/2025 at 11:15 PM Resident 3 was being pushed by a transportation driver in his/her wheelchair out of the facility to a van and hit a bump. The report indicated the bump caused Resident 3 to put his/her feet down and s/he fell out of the wheelchair face first. Resident 3 was sent out to be medically evaluated due to knee and nose pain. The report indicated Resident 3 was diagnosed with a nose fracture and small laceration to his/her nose. The report indicated actions taken for prevention would be to make sure Resident 3 had his/her foot pedals on his/her wheelchair when going outside the facility.

On 09/16/2025 at 1:30 PM, Surveyor observed in Resident 4's bathroom the back toilet cover was sitting on the ground beside the toilet and a consistent loud whistling noise was heard coming from the toilet. Surveyor asked Resident 4 about the toilet, and s/he stated it needed new parts, and the whistling sound had been going on for 1 month.

On 09/16/2025 at 1:37 PM, Surveyor interviewed Caregiver I. Caregiver I stated Resident 4's toilet had been making a whistling sound for 1 week and Resident 4 kept taking the back cover off of it.

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N 481	Continued From page 43 On 09/16/2025 at 2:25 PM, Surveyor interviewed Caregiver J. Caregiver J stated the sidewalk lip in front of the facility was an issue when using a cart with wheels to transport groceries from the facility next door. Caregiver J stated the cart would catch on the uneven sidewalk lip and was potentially a trip hazard. Caregiver J stated there were some concerns with the kitchen range where the oven did not heat properly, only 2 burners worked on the stovetop, and the range hood did not work. On 09/16/2025 at 2:44 PM, Surveyor observed the kitchen range and confirmed the range hood did not turn on. On 09/16/2025 at 3:45 PM, Surveyor interviewed Administrator B, Regional Nurse (RN) C, AD D, and AD K. Administrator B stated they had notified maintenance about Resident 4's toilet. Administrator B stated staff did not let them know about the range and range hood not working properly. AD D stated they were working on task lists for staff and managers were doing room audits to check for cleanliness. Administrator B stated it was an expectation staff do resident room spot checks and clean their rooms on shower days. Administrator B stated the medication room door keypad was broke since yesterday and they had purchased a new one. On 10/01/2025 at 2:00 PM, Surveyor interviewed Maintenance P. Maintenance P stated s/he started 4 weeks ago and was responsible for maintenance at 4 of the company's facilities. Maintenance P stated there was a delay with work orders being completed due to waiting for corporate approval to get the funds. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional	N 481		

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N 481	Continued From page 44 Director (RD) E, RD F, RN G, and RD H. RN C stated the keypad to the medication room door had already been fixed. RN C stated they would have maintenance look at the sidewalk in the front of the facility. RN C stated maintenance had fixed Resident 4's toilet already. AD D stated Maintenance P had already looked at the range hood and was working on it. Cross Reference N0479 DHS 83.42(2) Resident Records Safeguarded	N 481		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 public bathrooms had enclosed paper towels, cloth towel dispensing units or electric hand dryers. Findings include: On 09/16/2025 at approximately 11:00 AM, Surveyor was touring the facility and observed the following: -Inside the beauty shop bathroom that served up to 16 residents, Surveyor observed the wall paper towel dispenser was empty of paper towel. Surveyor did not observe alternative paper towel	N 612		

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N 612	Continued From page 45 to use for hand drying. -Inside the other public bathroom that served up to 16 residents, Surveyor observed the wall paper towel dispenser was empty of paper towel. Surveyor did not observe alternative paper towel to use for hand drying. On 09/16/2025 at 1:37 PM, Surveyor interviewed Caregiver I. Caregiver I stated they had been out of paper towels in the bathrooms and dining room napkins for a couple days. On 09/16/2025 at 2:25 PM, Surveyor interviewed Caregiver J. Caregiver J stated they had been out of paper towels in the bathrooms and dining room napkins for 1 week. Caregiver J stated supplies, such as paper towels and napkins, were ordered, but they did not receive all the supplies on the list due to being over budget. Caregiver J stated staff were using hand towels to dry there hands until more supplies were received. On 09/16/2025 at 3:45 PM, Surveyor interviewed Administrator B, Regional Nurse (RN) C, Assistant Director (AD) D, and AD K. Administrator B stated AD K was new to ordering supplies and they did not always know how the supplies would arrive to the facility and in what quantity. On 10/02/2025 at 10:00 AM, Surveyor interviewed Licensee A, RN C, AD D, Regional Director (RD) E, RD F, RN G, and RD H. RN C explained AD K was ordering supplies, but now AD D and Administrator B had taken over the task to make sure their was an adequate amount of supplies.	N 612		

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Y3244	Continued From page 46	Y3244		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide residents adequate and appropriate care within the capacity of the facility. Findings include: On 03/15/2025 and 06/02/2025, the Department received complaints regarding resident care. The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 09/16/2025 at 10:30 AM, Surveyor interviewed Assistant Director (AD) K. AD K	Y3244		

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stated Regional Nurse (RN) C was at the facility 1 to 2 days per week and Administrator B was at the facility 3 to 4 days per week. AD K indicated there was 1 resident (Resident 5) who resided at the facility that required 2 staff assistance for transfers with a Hoyer lift. AD K indicated they no longer had designated cook, activity, or housekeeper staff. Staff were responsible for these 3 tasks along with resident care.

On 09/16/2025, Surveyor reviewed Resident 5's record, the provider's policies, and staff schedule. Resident 5 was admitted on 03/03/2025 and was his/her own decision maker. Resident 5 had diagnoses that included Parkinson's disease, acquired absence of right leg above the knee, left foot drop, long term use of anticoagulants, generalized muscle weakness, peripheral vascular disease, transient ischemic attack, cerebral infarction without residual deficits, and type 2 diabetes mellitus with diabetic peripheral angiopathy. The individual service plan (ISP) dated 03/12/2025, indicated Resident 5 was unable to ambulate and required 2 staff to transfer him/her with a Hoyer lift. The resident evacuation assessment dated 03/03/2025, indicated Resident 5 needed full assistance from 2 staff during an emergency evacuation.

The Hoyer lift policy and procedure read in part, "2 staff members must be present to complete a transfer."

The staff schedule did not reflect when a caregiver would float over to the facility next door during their shift.

On 09/16/2025 at 10:58 AM, Surveyor interviewed Resident 2. Resident 2 described an example where s/he wanted ice cream the night

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Y3244	Continued From page 48	Y3244		

before at 7:45 PM and it took staff until 9:00 PM to receive it.

On 09/16/2025 at 12:30 PM, Surveyor interviewed Resident 3. Resident 3 expressed concern s/he sometimes had to wait too long for staff to respond to his/her call button, especially if it was an emergency. Resident 3 stated what s/he considered too long to wait for staff would be more than 10 minutes. Resident 3 also stated there were times where s/he could not find staff for help.

On 09/16/2025 at 1:17 PM, Surveyor interviewed Resident 4. Resident 4 expressed concern s/he sometimes had long wait times for staff to respond to his/her call button and sometimes staff forgot to come back.

On 09/16/2025 at approximately 2:00 PM, Surveyor interviewed Resident 6. Resident 6 expressed concerns with there not being enough staff and gave an example of a couple weeks ago s/he had to wait 20 to 30 minutes for staff to come help him/her to the bathroom. Resident 6 indicated s/he cannot wait that long and had incontinence due to staff not coming promptly.

On 09/16/2025 at 2:25 PM, Surveyor interviewed Caregiver J. Caregiver J stated staff had recently been mandated to work 12-hour shifts due to the provider being short staffed. Caregiver J confirmed 1 staff would float to the facility next door to watch the residents while the other staff from the facility next door would give a resident a shower. Caregiver J stated this would leave 1 caregiver in this facility for up to 30 minutes.

On 09/16/2025 at 3:45 PM, Surveyor interviewed Administrator B, RN C, AD D, and AD K.

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Administrator B stated they did temporarily change their staffing pattern 1 week ago from 8-hour shifts to 12-hour shifts. Administrator B stated management would help staff provide resident cares if needed during the work week on the day shift. Administrator B stated their plan was to start staffing 2 staff in the facility next door for each shift. Administrator B confirmed staff did float between the two facilities if there was an emergency or staff needed help next door.

On 09/17/2025 at 9:29 AM, Surveyor received an email from Administrator B. Administrator B indicated the designated activity staff's last day worked was on 04/22/2025 and the designated housekeeper staff's last day worked was on 07/30/2025. As of 07/30/2025, staff were responsible for activities, housekeeping, meals, and resident cares.

On 10/01/2025 at 12:17 PM, Surveyor interviewed Family Member (FM) M. FM M stated s/he felt Resident 5's care could be better that s/he received from the provider. FM M stated Resident 5 had expressed s/he felt staff ignored him/her and s/he was left in bed longer than s/he wanted to be.

The provider did not provide adequate and appropriate care within their capacity to meet the needs of the residents when 1 staff would float over to the facility next door leaving only 1 staff in the facility for up to 30 minutes at a time. Resident 5 required 2 staff assistance for transfers and emergency evacuation. Multiple residents had expressed concerns about staff responsiveness to their needs.