STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018751	A. BUILDING: _____ B. WING _____	R-C 06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD II	15497 PINEWOOD DRIVE HAYWARD, WI 54843

(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 06/10/2025, Surveyors conducted a standard survey, verification visit, and complaint investigation at Vitacare Living Hayward II. Data was collected through 06/24/2025. Two of 2 complaints were substantiated. Seven of 12 violations from Statement of Deficiency (SOD) JYPQ11 were corrected. Fifteen new violations were identified. Five violations were repeat deficiencies. See SOD JYPQ11, dated 08/08/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 1.	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the facility, and its operation complied with all laws governing the facility. Findings include: On 05/21/2025 and 06/05/2025, the Department received 2 complaints regarding resident care.	N 196		

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

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N 196	Continued From page 1 The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. The provider's previous licensing survey resulted in 12 deficiencies and enforcement action that included special orders. See Statement of Deficiency (SOD) JYPQ11, 08/28/2024. The provider failed to correct 5 of these 12 deficiencies at a subsequent verification visit on 06/24/2025, resulting in additional enforcement action. The special orders from SOD JYPO11 included the following: -The licensee shall ensure the administrator supervises daily operation and ensures the provision of services to meet residents' physical and mental health needs. The licensee will develop (or review/revise) written procedures and staff training (as appropriate) to address: Assessment, Care Planning, and Behavior Management. As a result of the survey conducted on 06/10/2025, Surveyors found the following: Two of 2 complaints were substantiated, 20 deficiencies were identified, 5 of 20 were repeat deficiencies, and the following issues were identified during the course of the survey: - Administrator did not oversee the program. - Communicable disease screening for staff was not completed prior to hire. - Continuing education was not completed. - Resident did not receive medications as ordered. - Service plans were not updated when changes occurred.	N 196		

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N 196	Continued From page 2	N 196		

- Accurate staff schedules were not maintained.
- The resident was not offered a daily activity program.
- The resident was not offered a posted menu.
- The resident's records were not adequately safeguarded against destruction, loss or unauthorized access or use.
- The exterior building was not maintained.
- The interior of the building was not in good repair.
- The electrical system was not maintained in a functioning condition.
- Toxic substances were not secured.
- Garbage cans were not supplied.
- Emergency exit diagrams were not posted
- Resident did not receive adequate and appropriate care within the capacity of the facility.
- Quarterly fire drills and an annual simulated sleeping hours fire drill were not completed as required.
- Safety drills (other than fire) were not completed semi-annually as required.
- Delayed egress signs were not posted at every delayed egress exit.

On 06/24/2025, from 12:41 to 1:29 PM, Surveyors interviewed Regional Director (RD) C, RD G, and Assistant Executive Director (AED) B. RD C stated that they were unaware of the special orders included in the previous survey (SOD JYPQ12) until Surveyor informed them and explained the contents. RD C stated s/he was unaware of any updated policies and procedures.

Cross references:
N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation
N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease
N0277 DHS 83.25 Continuing Education

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N 196	Continued From page 3 N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0396 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0427 DHS 83.38(1)(c) Leisure Time Activities N0450 DHS 83.41(2)(c) Nutrition: Menus N0479 DHS 83.42(2) Resident Records Safeguarded N0492 DHS 83.45(1)(a) Exterior Areas N0495 DHS 83.45(1)(d) Hazards N0496 DHS 83.45(1)(e) Electrical, Mechanical, Water Supply N0499 DHS 83.45(3) Toxic Substances N0501 DHS 83.45(5) Garbage & Refuse N0523 DHS 83.47(2)(b) Exit Diagram N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0650 DHS 83.59(4)(b) Delayed Egress: Locking Device Sign Posted Y3244 50.09(1)(L) Care	N 196		
{N 214}	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.	{N 214}		

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{N 214}	Continued From page 4 This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure an administrator supervised the daily operation of the facility, programming, and personnel in a way that ensured residents received proper care and treatment. This is a repeat violation. See Statement of Deficiencies (SOD) JYPQ11, dated 08/28/2024. On 05/21/2025 and 06/05/2025, the Department received complaints regarding resident care. Findings include: The provider is licensed to care for 13 residents in the client groups advanced aged, terminally ill, physically disabled, irreversible dementia/Alzheimer's disease, and developmentally disabled. The provider is located approximately 1/2 mile from another provider owned by the licensee. On 06/10/2025 at approximately 9:20 AM, Surveyors conducted an entrance meeting with Assistant Executive Director (AED) B. AED B discussed the provider's management structure and stated that s/he was responsible for the daily operations at the facility and the nearby facility as well. When beginning the entrance meeting, AED B began to cry. AED B stated that s/he had started in the AED position approximately 3 to 4 months ago, and that s/he felt that there was no training or support from upper management. AED B stated s/he felt s/he did not receive proper training for his/her position and was "winging it." AED B stated s/he was "ready to be done." AED B stated that s/he was on-call 24 hours a day,	{N 214}		

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{N 214}	Continued From page 5 seven days a week, and that s/he also worked as front line staff. AED B stated that s/he gets called approximately 2 times every shift to assist with toileting and changing Resident 1, as staff frequently were unable to handle his/her behaviors. AED B stated Resident 1 was the only resident living at the facility. AED B expressed concerns that Resident 1 was left alone at the facility without other resident socialization. AED B stated the facility was "very neglected." On 06/19/2025, from 8:28 AM to 9:24 AM, Surveyors interviewed Power of Attorney (POA) D, who stated s/he holds Regional Director (RD) C and RD G responsible for Resident 1's neglectful care. POA D stated AED B was doing the best s/he could to oversee 2 buildings. POA D stated it was very difficult to get a hold of RD C or RD G and messages were not returned. POA D stated RD C and RD G were rarely at the program. Two of 2 complaints were substantiated, and the following issues were identified during the course of the survey: - Resident did not receive medications as ordered. - Resident did not receive adequate and appropriate care within the capacity of the facility. - Continuing education for staff was not maintained. - The resident's records were not adequately safeguarded against destruction, loss or unauthorized access or use. - Communicable disease screening for staff was not completed prior to hire. - Accurate staff schedules were not maintained. - The resident was not offered a daily activity	{N 214}		

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{N 214}	Continued From page 6	{N 214}		

program.
- The resident was not offered a posted menu.
- The exterior building was not maintained.
- The interior of the building was not in good repair.
- The electrical system was not maintained in a functioning condition.
- Toxic substances were not secured.
- Emergency exit diagrams were not posted.
- Quarterly fire drills and an annual simulated sleeping hours fire drill were not completed as required.
- Safety drills (other than fire) were not completed semi-annually as required.
- Delayed egress signs were not posted at every delayed egress exit.
- Garbage and refuse in inside areas were not kept in leak-proof, non-absorbent closed containers.

Cross references:
N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication
N0396 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes
N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule
N0427 DHS 83.38(1)(c) Leisure Time Activities
N0523 DHS 83.47(2)(b) Exit Diagram
N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease
N0277 DHS 83.25 Continuing Education
N0450 DHS 83.41(2)(c) Nutrition: Menus
N0479 DHS 83.42(2) Resident Records Safeguarded
N0492 DHS 83.45(1)(a) Exterior Areas
N0495 DHS 83.45(1)(d) Hazards
N0496 DHS 83.45(1)(e) Electrical, Mechanical,

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{N 214}	Continued From page 7 Water Supply N0499 DHS 83.45(3) Toxic Substances N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0501 DHS 83.45(5) Garbage & Refuse N0650 DHS 83.59(4)(b) Delayed Egress: Locking Device Sign Posted Y3244 50.09(1)(L) Care	{N 214}		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees were screened for clinically apparent communicable disease, including tuberculosis (TB). Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible	N 220		

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N 220	Continued From page 8 dementia/Alzheimer's disease, and physically disabled. On 06/10/2025 at approximately 9:30 AM, Surveyors requested staff records from Assistant Executive Director (AED) B and Regional Director (RD) C. Upon record review, Surveyors noted: -Caregiver A was hired 01/01/2022. Caregiver A's record did not indicate a TB test had been completed and no TB results were present in the record. On 06/10/2025 at 10:59 AM, Surveyor received an email communication from RD C that read, "Due to previous management ...a lot ...was not completed. We caught up what we could. So those may be missing ..." The provider did not ensure all employees had a completed TB test. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 220		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5)	N 277		

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N 277	Continued From page 9 Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 2 employees received continuing education in 2024. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 06/10/2025 at approximately 9:30 AM, Surveyors requested staff training records from Assistant Executive Director (AED) B and Regional Director (RD) C. Surveyors reviewed Caregiver A's training records. Caregiver A was hired in 2022. Surveyors were unable to find records that Caregiver A had completed fire safety, first aid, and emergency procedures continuing education in 2024. On 06/10/2025, Surveyors received an email from RD C stating "a lot" of 2024 continuing education was not completed, and that some of Caregiver A's continuing education "may be missing." On 06/17/2025, Surveyors interviewed RD C, who stated Caregiver A did not receive fire, first aid, and emergency procedures continuing education	N 277		

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N 277	Continued From page 10 in 2024. The provider did not ensure that 1 of 2 employees received continuing education. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 277		
{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 record review and interview, the provider did not ensure Resident 1 received his/her medications as prescribed. This is a repeat violation. See Statement of Deficiencies (SOD) JYPQ11, dated 08/28/2024. Findings include: On 06/05/2025, the Department received a complaint related to medication services. On 06/10/2025, Surveyors requested Resident 1's records from Assistant Executive Director (AED) B and Regional Director (RD) C. Surveyors reviewed Resident 1's records, which indicated the following:	{N 352}		

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{N 352}	Continued From page 11 Resident 1 was admitted to the facility on 10/03/2023. Resident 1 was diagnosed with Alzheimer's Dementia. Resident 1's medication administration record (MAR), dated June 2025, indicated Resident 1's Quetiapine tablet (50 mg) should be taken twice daily, once at 8:00 AM and once at 8:00 PM. The 8:00 PM dose of medication on 06/04/2025 and the 8:00 AM dose on 06/05/2025 were not administered. A note on the MAR from 06/04/2025 stated, "We don't have this medication presently." A note on the MAR from 06/05/2025 stated, "waiting on reorder, none in stock." On 06/10/2025 at approximately 9:20 AM, Surveyors interviewed AED B. AED B stated the missed doses were due to a miscommunication with the pharmacy that delivered the medications. According to AED B, s/he had called the pharmacy, and discovered they thought Resident 1 was no longer at the facility and therefore did not deliver his/her medications. On 06/17/2025 at approximately 10:00 AM, Surveyors interviewed RD C and RD G. RD C stated the pharmacy had thought Resident 1 was discharged from the provider and did not deliver a refill of his/her Quetiapine. RD C stated s/he thought Resident 1 had only missed 1 dose of the medication. On 06/18/2025 at approximately 10:37 AM, Surveyor interviewed Caregiver F, who had been working at the provider on 06/05/2025. Caregiver F stated there was miscommunication with the pharmacy responsible for delivering medications. Caregiver F stated s/he realized that there was no	{N 352}		

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{N 352}	Continued From page 12 Quetiapine to administer for the AM dose. Caregiver F stated Power of Attorney (POA) D called to inquire about the medication. Caregiver F notified AED B, who contacted the pharmacy for a refill. Caregiver F stated Resident 1's medication was refilled and resumed that evening. Caregiver F stated s/he had immediately called AED B, and s/he reached out to the pharmacy. On 06/19/2025 from 8:28 AM to 9:24 AM, Surveyors interviewed POA D, who stated Caregiver F casually informed him/her there was no AM Quetiapine dose to administer. POA D stated Caregiver F did not know s/he was to call anyone about the medication. The provider did not ensure the resident received medication as prescribed. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	{N 352}		
{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	{N 389}		

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{N 389}	Continued From page 13 with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was updated when there was a change in condition and needs. On 05/21/2025, the Department received a complaint regarding negligent resident care. Findings include: This is a repeat violation. See Statement of Deficiencies (SOD) JYPQ11, dated 08/28/2024. The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 06/10/2025 at approximately 9:45 AM. Surveyors interviewed Assistant Executive Director (AED) B who stated sometimes staff were unable to get Resident 1 changed. AED B stated Resident 1's plan changed, and staff were to reach out to the other building, approximately 1/2 mile away and licensed by the same provider, to request assistance. AED B stated s/he was not sure if Resident 1's ISP had been updated with this intervention. At approximately 12:30 PM, AED B stated Regional Director (RD) C was responsible for updating the ISPs. On 06/10/2025, Surveyors reviewed Resident 1's	{N 389}		

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{N 389}	Continued From page 14 ISP. The ISP was dated 06/10/2025, the day of the survey. Resident 1's ISP included: -"Manage Behavior-Refusals ...Target Behavior ...Per POA offer a bowel [sic] of raisin bran or ice cream after completion of cares, reapproach, call POA ..." - ...Toileting ...Staff to assist [Resident 1] to and from bathroom every two hours as needed ...If resident is agitated or refuses, staff are to reapproach. Staff can call [family], if unable to change [Resident 1] after reapproaching." On 06/18/2025 from 8:28 AM to 9:24 AM, Surveyors interviewed Power of Attorney (POA) D who stated s/he posted a note on the kitchen door for staff to contact the other building when they were unable to change Resident 1. POA D stated from approximately May 1, 2025, to June 18, 2025, there were at least 20 incidents when POA D visited Resident 1 and found him/her soaked in urine. On 06/24/2025 from 12:41 PM to 1:29 PM, Surveyor interviewed RD C and AED B who confirmed that Resident 1's ISP was last updated in 12/2024. AED B stated on 05/15/2025 a meeting was held with the state ombudsman, POA D, managed care, and the provider regarding the challenges with Resident 1's toileting. The outcome included to post a plan (on the kitchen wall) to interchange staff, reach out to AED B in the other building licensed by the same provider, and reach out to POA D. RD C stated the updates were probably not added to the ISP and s/he attributed this to forgetting. The provider did not ensure Resident 1's ISP was updated when Resident 1's interventions were no longer effective and new interventions were used.	{N 389}		

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{N 399}	Continued From page 15	{N 399}		
{N 399}	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain an accurate staffing schedule. This is a repeat violation. See Statement of Deficiencies (SOD) JYPQ11, dated 08/28/2024. Findings include: The provider is licensed to care for 13 residents in the client groups advanced aged, terminally ill, physically disabled, irreversible dementia/Alzheimer's disease, and developmentally disabled. The facility is located approximately 1/2 mile from another facility owned by the licensee. On 06/10/2025 at approximately 9:30 AM, Surveyors requested staff schedules from Assistant Executive Director (AED) B and timesheets from Regional Director (RD) C. On 06/12/2025, Surveyors reviewed the schedules provided for April through June 2025 and employee timesheets from April through June 2025. The schedules did not accurately list each employee's full name, job assignment, and time worked. Surveyors noticed several inconsistencies between time stamps on	{N 399}		

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{N 399}	Continued From page 16 timesheets and the times listed on the staffing schedule. There were 4 days in April, 7 days in May, and 6 days in June where staff had time reported on their timesheets but weren't scheduled. The 05/30/2025 schedule showed Caregiver F as working at a different location while his/her timesheet indicated s/he had worked at this facility. On 06/17/2025 at approximately 10:00 AM, Surveyors interviewed RD C and RD G. RD C stated that AED B was responsible for updating staffing schedules to reflect changes, and that s/he had failed to do so. The provider did not maintain a current written staffing schedule. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	{N 399}		
{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.	{N 427}		

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{N 427}	Continued From page 17 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity schedule was provided to residents. Findings include: On 05/21/2025, the Department received a complaint regarding activities. This is a repeat violation. See Statement of Deficiencies (SOD) JYPQ11, dated 08/28/2024. The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 06/10/2025 at approximately 9:00 AM, Surveyors observed that there was no posted activity schedule in the building. On 06/10/2025 at approximately 9:21 AM, Surveyors interviewed Assistant Executive Director (AED) B, who stated there was not an activity schedule posted. AED B stated s/he typically provided an activity schedule from the other building licensed by the same provider. On 06/18/2025, at approximately 10:37 AM, Surveyor interviewed Caregiver F, who stated there used to be an activity staff but that the provider eliminated the position. Caregiver F stated s/he did activities with Resident 1 but that there was currently no posted activity schedule. On 06/19/2025 from 8:28 AM to 9:24 AM,	{N 427}		

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{N 427}	Continued From page 18 Surveyors interviewed Power of Attorney (POA) D, who stated that at one point there was an activity board that included activities that were not consistent with Resident 1's ability. POA D stated a caregiver informed him/her that the State made the provider post the activities. The provider did not ensure a daily activity schedule was provided to residents. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	{N 427}		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not prepare weekly menus and make it available to the residents. Findings include: On 05/21/2025, the Department received a complaint regarding menus. The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible	N 450		

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N 450	Continued From page 19 dementia/Alzheimer's disease, and physically disabled. On 06/10/2025, Surveyors observed there was no current posted menu and that a menu on the refrigerator was dated January 2025. At 9:06 AM, Surveyors interviewed Caregiver A, who stated there was not a menu available and s/he made meals based off what was in the refrigerator or freezer. At approximately 9:45 AM, Surveyors interviewed Assistant Executive Director (AED) B, who stated staff were using an alternative menu, which meant the meals were not set. AED B stated that sometimes the nighttime staff would make large meals that could be divided up and individually portioned. At 12:30 PM, Surveyors interviewed AED B, who stated s/he thought s/he brought a menu to the program but was not sure where it went. On 06/19/2025, from 8:28 AM to 9:24 AM, Surveyors interviewed Power of Attorney (POA) D, who stated they often served Resident 1 reheated meals from the other program licensed by the same provider. POA D recalled that there was no bread in the facility and the caregiver reached out to the neighboring provider, but they also did not have any bread. POA D stated s/he went to the grocery store and bought chicken, fruit, potatoes, and bread to feed Resident 1. The provider did not prepare and post the weekly menu. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall	N 450		

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N 450	Continued From page 20 Supervise Daily Operation	N 450		
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 1's record was adequately safeguarded. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 06/10/2025 at approximately 11:00 AM, Surveyors observed that the staff office containing confidential resident information was unlocked and unmonitored. On 06/17/2025 at approximately 10:00 AM, Surveyors interviewed Regional Director (RD) C and RD G, who stated Resident 1's paper file was missing. RD C stated it had been left out and staff could not locate it. On 06/19/2025 from 8:28 AM to 9:24 AM, Surveyors interviewed Power of Attorney (POA) D, who stated Resident 1 had been moved to a new facility and that the administrator informed POA D that RD C called him/her, asking if Resident 1's paper file had shown up there. POA D stated RD C had implied s/he may have taken	N 479		

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N 479	Continued From page 21 the file. The provider did not ensure that Resident 1's record was adequately safeguarded against destruction, loss, or unauthorized access or use. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 479		
N 492	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF (community based residential facility) maintained the yard, sidewalks, driveways, and parking areas in good repair. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 06/10/2025, Surveyors toured the exterior of the building and observed the following: -landscaped area to the right of the front entrance was covered with cigarette butts -landscaped area to the right and left of the front entrance full of weeds -outdoor rugs covered in debris	N 492		

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N 492	Continued From page 22 -broken freezer to the right of the front door -outdoor porch light with no bulb -3 areas approximately 5-6 inches long of damaged siding -an exterior bedroom screen ripped several inches at the bottom -rugs at the back exit of building covered in debris -rotten bird suet hanging in feeder -various pieces of paper debris/garbage located in front and back of building -dumpster and semi-enclosed area had multiple weeds growing around them -dead flower in large flowerpot to the right of front entrance -the cement walkway in front of the home and the dumpster area had multiple broken areas with at least a half inch lip At approximately 2:18 PM, Surveyors interviewed Assistant Executive Director (AED) B who stated Maintenance E was responsible for the exterior of the building. AED B stated s/he was aware of the poor condition of the exterior of the building. The provider did not ensure the exterior of the building was maintained and in good repair. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 492		
N 495	83.45(1)(d) Hazards. Hazards. The CBRF shall maintain each building in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF (community based	N 495		

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N 495	Continued From page 23	N 495		

residential facility) maintained the building in good repair and free of hazards.

Findings include:

The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled.

On 06/10/2025 at approximately 9:00 AM, Surveyors observed multiple instances of disrepair in the facility:

- The linoleum in the pantry/laundry room was cracked and peeling in multiple areas including the main walking area and under the washer and dryer pads.
- The utility sink had a piece missing from its right side, approximately 6 inches wide and tapering to a point approximately 6-8 inches long.
- One resident room had a doorknob missing.
- One resident room had a smoke detector that was partially detached from the ceiling.

On 06/10/2025 at approximately 2:20 PM, Surveyors interviewed Assistant Executive Director (AED) B, who stated that Maintenance E was responsible for onsite maintenance but did not perform regular maintenance. AED B stated that his/her significant other did most of the maintenance repairs.

On 06/18/2025 at approximately 10:37 AM, Surveyor interviewed Caregiver F, who stated that s/he had broken the utility sink on 05/17/2025. S/he immediately took a photo of the damage and texted it to management. Caregiver F stated that Maintenance E was responsible for

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N 495	Continued From page 24 making repairs to the facility but that s/he was rarely there to perform maintenance. Caregiver F stated that if there were urgent repairs, such as a plumbing issue, Maintenance E would come to fix it in 1 or 2 days. The provider did not ensure the building was maintained in good repair and free of hazards. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 495		
N 496	83.45(1)(e) Electrical, mechanical, water supply Systems. The CBRF shall maintain all electrical, mechanical, water supply, plumbing, fire protection and sewage disposal systems in a safe and functioning condition. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF (community based residential facility) maintained all electrical and plumbing systems in a safe and functioning condition. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 06/10/2025, Surveyors observed in the main living/dining area, 6 wall sconces with 3 lights in each, were shut off causing the room to be dark.	N 496		

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N 496	Continued From page 25 At 11:02 AM, Surveyors interviewed Power of Attorney (POA) D, who stated that the lights begin flickering on and off if turned on. At approximately 11:05 AM, Surveyors observed all 6 wall sconces rapidly flickering on and off. At approximately 12:30 PM, Surveyors interviewed Assistant Executive Director (AED) B, who stated that when maintenance issues arise, staff make a list and report to Regional Director (RD) C. AED B stated there was a building remodel planned. AED B stated s/he thought there were serious plumbing issues due to Resident 1 flushing items down the toilet. AED B stated s/he thought the plumbing lines were under the floors and that would be a significant repair. AED B stated Maintenance E was going to contact an electrician regarding the flickering wall sconces. AED B stated they rarely saw Maintenance E and s/he would often ask his/her significant other to fix things. The provider did not maintain the electrical and plumbing in a safe and functioning manner. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0501 DHS 83.45(5) Garbage & Refuse	N 496		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.	N 499		

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N 499	Continued From page 26 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds, polishes, insecticides, and toxic substances were stored in a secure area. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. Resident 1 has a diagnosis of Alzheimer's Dementia and independently ambulates. On 06/10/2025 at approximately 9:06 AM, Surveyors observed the door to the kitchen and utility room was open and unlocked. Located in the utility room was an unlocked cabinet containing the following substances: -2 boxes of ant killer bait that read, "KEEP OUT OF REACH OF CHILDREN CAUTION." -Over 5 cans of oven cleaner that read, "KEEP OUT OF REACH OF CHILDREN" and "DANGER." -13 bottles of toilet bowl cleaner that read, "PRECAUTIONARY STATEMENTS: HAZARDS TO HUMANS AND DOMESTIC ANIMALS. DANGER...IF SWALLOWED: Call a poison control center or doctor immediately." - 7 cans of glass cleaner that read, "KEEP OUT OF REACH OF CHILDREN." - 1 can of disinfectant aerosol.	N 499		

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N 499	Continued From page 27 - 1 jug of hand soap. At approximately 9:08 AM, Surveyors observed an unlocked cabinet under the kitchen sink containing the following substances: - 2 jugs of dish soap that read, "WARNING" and "KEEP OUT OF REACH OF CHILDREN." - a can of furniture polish that read, "DANGER!" At approximately 9:10 AM, Surveyors interviewed Caregiver A, who stated the door to the kitchen and utility room remained open. Surveyors inquired if there were concerns that Resident 1 could access unsafe substances. Caregiver A stated, "[Resident 1] never comes back here." From approximately 9:00 AM to approximately 3:00 PM, Surveyors observed the kitchen door remained open and the cabinet doors remained unlocked. The provider did not ensure cleaning compounds, polishes, insecticides, and toxic substances were labeled and stored in a secure area. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 499		
N 501	83.45(5) Garbage & refuse. Garbage and refuse. The CBRF shall dispose of garbage and refuse. Garbage and refuse in inside areas shall be kept in leak-proof, non-absorbent closed containers. Garbage and refuse in outside areas shall be in closed containers.	N 501		

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N 501	Continued From page 28 This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep garbage and refuse in leak-proof, non-absorbent closed containers in 2 of 3 bathrooms and the kitchen. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. Resident 1 has a diagnosis of Alzheimer's Dementia. On 06/10/2025 at approximately 10:50 AM, Surveyors observed the dining/living room bathroom did not have a garbage container in it. A bathroom near the kitchen had a sign posted next to it which read, "Staff Bathroom" and did not have a garbage container in it. There were 2 garbage and refuse bins in the kitchen that did not have lids on them, and the backdoor to the kitchen remained unlocked for the duration of the survey. Caregiver A stated the garbage containers were removed from the bathrooms because Resident 1 would remove refuse and stuff it down toilets. On 06/17/2025 at approximately 10:00 AM, Surveyors interviewed Regional Director (RD) C and RD G. RD C stated garbage containers were removed from bathrooms because Resident 1 took refuse out of the garbage containers and plugged toilets with it. RD C stated Resident 1 clogged toilets with garbage approximately 3 to 4 times.	N 501		

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N 501	Continued From page 29 The provider did not ensure garbage and refuse was kept in leak-proof, non-absorbent closed container. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0496 DHS 83.45(1)(e) Electrical, Mechanical, Water Supply	N 501		
N 523	83.47(2)(b) Exit diagram. Exit diagram. The disaster plan shall have an exit diagram that shall be posted on each floor of the CBRF used by residents in a conspicuous place where it can be seen by the residents. The diagram shall identify the exit routes from the floor, including internal horizontal exits under par. (f) when applicable, smoke compartments or a designated meeting place outside and away from the building when evacuation to the outside is the planned response to a fire alarm. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF (community based residential facility) posted an exit diagram in a conspicuous place where it could be seen by residents. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 06/10/2025, Surveyors observed there were	N 523		

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N 523	Continued From page 30 no emergency exit diagrams posted in the building. At approximately 10:15 AM, Surveyors interviewed Caregiver A, who stated s/he was not aware of any posted exit diagrams. Surveyors asked where s/he was to exit the building in the event of a fire. Caregiver A stated staff and residents would go to the front door. The provider did not ensure there were posted exit diagrams. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 523		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.	N 525		

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N 525	Continued From page 31 This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct fire evacuation drills at least quarterly in 2024 and 2025, and did not hold an annual fire evacuation drill that simulated the conditions during usual sleeping hours. Findings include: On 06/10/2025, Surveyors reviewed the provider's fire drill documentation for 2024 and 2025. In 2024, there was only one fire drill documented on 08/13/2024 from 7:45 PM to 7:49 PM. In 2025, there was only one fire drill documented on 03/14/2025 from 10:50 AM to 10:54 AM. The fire drill in March 2025 had 3 residents listed as participants who were not living at the facility. Additionally, there were no records indicating a fire evacuation drill that simulated the conditions during usual sleeping hours had occurred in 2024. On 06/10/2025 at approximately 9:21 AM, Surveyors interviewed Assistant Executive Director (AED) B, who stated a fire drill had not been conducted in over a year and that s/he had not been a participant in any fire drill at the facility. The fire drill in March 2025 listed AED B as a participant. On 06/10/2025, at approximately 10:15 AM, Surveyors interviewed Caregiver A who stated s/he was not trained in fire drill procedures and had never done a safety drill at the facility. S/he was unable to properly explain what staff should to do to evacuate residents in case of a fire. On 06/17/2025 at approximately 10:00 AM, Surveyors interviewed Regional Director (RD) C	N 525		

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N 525	Continued From page 32 and RD G. RD C stated that s/he could remember only 1 fire drill in 2024. The provider did not conduct fire evacuation drills at least quarterly, nor did they conduct at least one fire evacuation drill that simulates the conditions during usual sleeping hours annually. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct an "other" (other than fire) evacuation drill, at least semi-annually. Findings include: On 06/10/2025, Surveyors reviewed the provider's safety binder for "other" evacuation drills conducted in 2024. There were no "other" evacuation drills documented in 2024. On 06/10/2025 at approximately 10:15 AM, Surveyors interviewed Caregiver A, who stated s/he had not taken part in any tornado drills, but thought the residents should go into the bathroom if there was a tornado. On 06/10/2025 at approximately 10:10 AM, Surveyors interviewed Assistant Executive	N 526		

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N 526	Continued From page 33 Director (AED) B, who stated that no "other" evacuation drills had been completed since his/her start date of March 2024. The provider did not ensure safety evacuation drills (other than fire) were conducted at least semi-annually. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 526		
N 650	83.59(4)(b) Delayed egress: locking device sign posted Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: A sign shall be posted adjacent to the locking device indicating how the door may be opened. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF (community based residential facility) locking device signs were posted on 2 of 3 delayed egress exit doors. Findings include: The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled.	N 650		

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N 650	Continued From page 34 On 06/10/2025, Surveyors observed 3 exits in the building. A delayed egress sign was posted on the wall next to the rear exit door. The main exit door and the third exit did not have delayed egress signs posted adjacent to the locking device. On 06/17/2025, from 10:00 AM to 12:10 PM, Surveyors interviewed Regional Director (RD) C and RD G, who stated the 3 exit doors in the building were all delayed egress. RD C and G stated they must have been removed and would re-post the signage. The provider did not ensure delayed egress signage was posted on 2 delayed egress exits. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation Surveyor: Johansen, Madeleine	N 650		
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.	Y3244		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the resident received adequate and appropriate care.

On 05/21/2025, the Department received a complaint about Resident 1's care.

On 02/24/2025, all residents, except Resident 1, were discharged to a facility licensed by the same provider.

Findings include:

The provider is licensed to care for 13 residents in the client groups developmentally disabled, terminally ill, advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled.

On 06/18/2025, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 10/03/2023 and diagnosed with Alzheimer's Dementia. Resident 1 has an activated power of attorney (POA).

-An individualized service plan (ISP), dated 06/10/2025 read, " ...Toileting ...Staff to assist [Resident 1] to and from bathroom every two

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hours as needed ...If resident is agitated or refuses, staff are to reapproach. Staff can call [family], if unable to change [Resident 1] after reapproaching."

-Behavior History dated 05/01/2025 to 05/31/2025 read,
"05/04/2025-PM ...resident did not want to be bothered or changed ...
05/10/2025- Overnight ... resident has not allowed me to change [his/her] clothing or brief. Tried [sic] again several times later in the shift and [s/he] became more upset ...
05/10/2025-Overnight ...resident refused to be changed.
05/17/2025-AM ...resident is very aggressive and borderline violent, soaked head to toe but refuses to remove even [his/her] very heavy winter coat ...will reapproach.
05/17/2025-PM ...resident aggressively refused care during shift.
05/17/2025-Overnight ...resident became aggressive and physically lowered [him/herself] to eye level ...refusing to be changed throughout night, last time brief was changed was 10pm.
05/24/2025-PM ...for several hours attempted to get resident to the bathroom to be changed ...first 10 approaches met with extremely hostile anger ...resident was soaked in urine ...needed to be cleaned and changed. Two [sic] shifts of staff failed before this was accomplished.
05/24/2025-Overnight ...resident refused to be changed in the morning, last time changed 11:30 PM.
05/30/2025-AM ...Had to call the other facility to have 2 different staff ...on 2 separate occurrence [sic] assist with getting [Resident 1] up and changed ...
05/30/2025-PM ...resident refuses to be changed ..."

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Y3244	Continued From page 37 -Resident Notes read, "03/06/2025 10:38 PM Resident last night refused to let me change ... 03/08/2025 4:16 PM ...attempted to change ...refused ...reapproached about getting up ...allowing to change [his/her] brief but [s/he] still refused ...reached out to another staff member ...that was unsuccessful ... 03/09/20255:31 PM ...took several attempts to be able to change [him/her] throughout the day and evening. 03/09/2025 5:12 AM ...several attempts have been made to take [Resident 1] to the bathroom and change ... 03/25/2025 5:59 PM At shift change residents [sic] pants were soaked in urine [sic] both staff members tried to approach ...resident stated yelling 03/25/2025 9:44 PM ...resident was soaked through [his/her] jeans with urine ...resident refusing ...allowed resident to calm ...switched staff and got the same result ....finally able to ...change him closer to end of my shift. 03/26/2025 5:03 Resident was in urinated pants most of the day ... 04/25/2025 6:28 PM ...became aggressive when trying to change [him/her] out of [his/her] urine soaked pants. 06/08/2025 11:02 AM ...asked [Resident 1] to help me change [his/her] underwear ...but was getting upset ... On 06/10/2025 at approximately 9:40 AM, Surveyors interviewed Assistant Executive Director (AED) B who stated there was a meeting with the ombudsman, Resident 1's managed care organization (MCO), and Power of Attorney (POA) D, to discuss the provider's struggles when attempting to change Resident 1. POA D stated	Y3244		

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that if staff were struggling, they should reach out to him/her. AED B stated s/he lived 2 blocks from the provider and directed staff to call him/her for assistance. AED B stated successful toileting/brief changes with Resident 1 were based in the staff's approach. AED B stated s/he comes to the program approximately 2 times a day to assist with changes.

At approximately 12:30 PM, Surveyors interviewed AED B, who stated Caregiver H was often observed sitting on the couch on his/her phone. AED B expressed concerns that Caregiver H did not reach out for help when unsuccessful with toileting and changing Resident 1's briefs, which resulted in Resident 1 wearing soiled briefs for multiple hours.

On 06/16/2025 at 2:03 PM, Surveyors received an email communication from Registered Nurse (RN) I, from Resident 1's MCO, that read, " ...mid-May [POA D] had reported [Resident 1] was fully incontinent now and no longer used the toilet ...[POA D] reported [Resident 1] was sometimes resisting staff changing [him/her] ...Based off of [RN I] notes the incontinence has changed gradually ...over the past 6 months."

On 06/17/2025, from 10:00 AM to 12:10 PM, Surveyors interviewed Regional Director (RD) C, who stated POA D thought Resident 1 had become more incontinent, but s/he did not believe this was accurate. Resident 1 was on a 2-hour toileting schedule but when on home passes with his/her sons, they did not toilet. RD C stated Resident 1 got used to using adult briefs and that contributed to Resident 1 being resistive.

Surveyors inquired why there were so many days when no progress notes were entered. RD C

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stated it was due to staff not entering documentation despite multiple trainings and interventions.

On 06/19/2025, from 8:28 AM to 9:24 AM, Surveyors interviewed POA D, who stated there were multiple incidents of arriving to visit Resident 1 and finding him/her soaked in urine. POA D provided the following incidents:

-May 9 to May 11, 2025, Caregiver H worked 8-12 hours shifts and informed POA D that s/he had been unable to change Resident 1's brief during the 3 shifts and informed POA D that on 1 occasion the previous night shift, had been unable to change him.
-May 13, 2025, POA D arrived to visit Resident 1 and found him/her soaked in urine, wearing 3 pairs of pants, a T-shirt, and a sweatshirt all soaked in urine.
-May 20, 2025, at approximately 2:30 PM, Caregiver A informed POA D that s/he had been unable to get Resident 1 up for the day, fed, toileted, or changed. POA D found Resident 1 lying in bed. POA D stated the staff working the previous evening had not called for assistance, leaving Resident 1 in a wet brief from 5:00 PM the previous day when POA D had changed him/her.

POA D stated staff did not spend time with Resident 1 unless trying to toilet him/her. POA D stated that on more than 1 occasion s/he found Resident 1 soaked in so much urine that his/her slippers were soaked. POA D stated s/he found Resident 1 in a soaked bed and stated his/her padded chair was often soaked with urine. POA D stated staff would inform him/her that they tried to get Resident 1 changed. POA D stated that from May 1 to June 16, 2025, s/he had found Resident

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Y3244	Continued From page 40 1 soaked with urine. The provider did not ensure the resident received adequate and appropriate care. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	Y3244		