STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 000	INITIAL COMMENTS On 01/28/2026, with information gathered through 01/30/2026, Surveyor conducted an abbreviated licensure survey at Kandoo 2. Three deficiencies were identified. Census: 2	M 000		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the licensee did not ensure the adult family home was clean, well-maintained, and provided a homelike environment. Findings include: The provider was licensed for client groups: advanced aged, physically disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and developmentally disabled. On 01/28/2026, at approximately 10:40 AM, Surveyor and Caregiver B toured the home and observed the following: Resident Shower room/Laundry Room:	M 276		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 276	Continued From page 1	M 276		

-Ceiling above shower displayed what appeared to be drywall patchwork that did not blend in with the remaining ceiling. There was a black like substance covering a drywall seam and there was what appeared to be tape hanging from the drywall.
-Shower curtain rod appeared to have a rust like appearance.
-Ceiling which appeared to be primarily white, had a brown substance around the electrical covers and covered approximately a 3-foot by 3-foot area. Surveyor asked Caregiver B if s/he knew what caused this appearance. Caregiver B stated s/he had worked for the provider for about a month, and the ceiling had always looked like that.

Common Area:
-The rooms appeared to be painted in a blue color and a bluish gray color along with a white ceiling. The blue paints marked up the white ceiling in significant amounts.
-The ceiling in the living room had what appeared to be drywall seam patch work completed the length of the ceiling, which was approximately 8 inches wide. The patchwork was a different color than the ceiling and did not blend in with the ceiling.
-A light switch and double electric outlet sat lower than the protective plate. The light switch flip was only 50% available and the space around the electric outlets could be a potential hazard.

Kitchen:
-The screws on the freezer door displayed a significant rust like appearance on the interior of the freezer door.

On 01/29/2026 at 1:56 PM, Surveyor emailed Licensee A and asked for clarification regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 276	Continued From page 2 the home environment concerns. On 01/29/2026 at 3:06 PM, Licensee A emailed Surveyor and stated, "The ceiling in the bathroom is scheduled for repair - our previous resident was semi-independent in [his/her] showering and because of [his/her] disabilities would regularly spray the ceiling during [his/her] daily showers, causing the damage. As for the drywall concerns if you could send me more info on that - yes the painters were sloppy but am unsure of the particular concern. As for the rust on the freezer portion. Are you questioning the area around the hinge due to condensation? Internally there is no rust?" On 01/30/2026 at 6:35 AM, Surveyor emailed Licensee A pictures of the environmental concerns and requested any quotes s/he had regarding the bathroom remodel. As of 01/30/2026 at 6:00 PM, Surveyor did not receive a response.	M 276		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician.	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 462	Continued From page 3 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident received prescribed medications in the proper dosage. Resident 1 did not receive his/her estradiol cream as prescribed. Findings include: On 01/28/2026, at approximately 11:30 AM, Surveyor and Caregiver B observed Resident 1's medications in the med cart. Surveyor observed 4 unopened tubes of estradiol cream. Surveyor asked Caregiver B where the current tube was that was being utilized for medication administration. Caregiver B explained that s/he had used the last of the current tube yesterday. Caregiver B explained that s/he tried to use the oldest tube when a new tube was started due to the excess supply. Surveyor read the directions on the tube which stated, "Insert 1 GM (gram) 2 times weekly." Surveyor asked Caregiver B where the applicators were located. Caregiver B explained that an applicator was sent with each tube and was to be reused. Surveyor observed a prepackaged applicator. Caregiver B showed Surveyor how the applicator was utilized, stating the end of the applicator was screwed onto the end of the tube. Caregiver B stated that s/he filled the applicator until it stated 1 gram, s/he stated the tube would be almost filled to capacity. Surveyor looked at the applicator and it had markings for up to 4 grams, but Caregiver B stated s/he filled the tube completely to administer 1 gram. On 01/29/2026, Surveyor reviewed Resident 1's Medication Administration Record, dated	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 462	Continued From page 4 12/01/2025 to 01/28/2026, provided by Licensee A, which documented: "Estradiol Cre (cream) 0.01% - Insert 2 times weekly" The MAR documented administration by Caregiver B on: 12/02, 12/06, 12/10, 12/18, 12/30, 01/03, 01/07, 01/15, 01/27 On 01/29/2026 at 1:56 PM, Surveyor emailed Licensee A and asked for clarification regarding the proper med administration of Resident 1's estradiol cream. On 01/29/2026 at 3:06 PM, Licensee A emailed Surveyor and stated, "The cream has been an issue with over ordering - [Caregiver B] the staff you met - did not understand how long a tube should last and ordered it 2x s thinking it should be used up in a month. The amount per MAR is 1 gram and it withdraws to the measured mark- And is then dispensed to be applied it is a measuring device not an applicator. Due to the pharmacy dispensing only 1 applicator per script." On 01/30/2026 at 6:36 AM, Surveyor emailed Licensee A and asked if s/he had concerns regarding the amount of estradiol cream Caregiver B appeared to be administering. As of 01/30/2026 at 6:00 PM, Surveyor did not receive a response. "It is very important that you use this medicine exactly as directed by your doctor. Do not use more of it, do not use it more often, and do not use it for a longer time than your doctor ordered. To do so may cause unwanted side effects. ... Get emergency help immediately if any of the following symptoms of overdose occur: Symptoms of overdose: Dizziness, drowsiness,	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 462	Continued From page 5 nausea, stomach pain, tenderness of the breasts, unusual tiredness or weakness, vomiting." (Source: Mayo Clinic website, Estradiol, January 01, 2026, https://www.mayoclinic.org/drugs-supplements/estradiol-vaginal-route/description/drg-20075648 (retrieval date - January 31, 2026).)	M 462		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the home was a safe environment and that residents were safeguarded from environmental hazards. The clothes dryer had a flexible vent pipe, causing a possible fire hazard. Findings include: The provider was licensed for client groups: advanced aged, physically disabled, emotionally disturbed/mental illness, irreversible	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 570	Continued From page 6 dementia/Alzheimer's, and developmentally disabled. On 01/28/2026, at approximately 10:40 AM, Surveyor and Caregiver B toured the home and observed the dryer in the laundry room / shower room. Surveyor observed a foil accordion style vent tubing from residential clothes dryer to vent duct. The vent was not marked to determine if it met the Underwriters Laboratories (UL) guidelines. On 01/29/2026 at 1:56 PM, Surveyor emailed Licensee A and explained his/her observation of the dryer vent. On 01/29/2026 at 3:06 PM, Licensee A emailed Surveyor and stated, "Dryer was recently repaired by our service company - I was unaware they had changed the vent tube and was not mentioned on the service ticket. I am assuming they did it when they pulled it out for repair." "The codes require that dryer vents be made of metal with smooth interior finishes, sections of vent duct be securely supported and firmly sealed together, and the total length of the vent duct not exceed 35 feet (shorter if there are turns or bends). Flexible transition ducts used to connect the dryer to the exhaust system are required to be not longer than 8 feet ... Flexible vents can twist, allowing lint to build up and catch on fire if it comes in contact with a sufficient amount of heat. ... Only flexible transition ducts that are listed by UL or another approved product safety testing agency should be used." (Source: The US Fire Administration - FEMA website, Clothes Dryer Fires in Residential Buildings (2008-1010), August 2012, https://www.usfa.fema.gov/downloads/pdf/statistic	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016497	A. BUILDING: _____ B. WING _____	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANDOO 2	12358 EAST STREET SOLDIERS GROVE, WI 54655

(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
M 570	Continued From page 7 s/v13i7.pdf (retrieval date - September 14, 2022).)	M 570		