STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	R-C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 From 05/13/2025 to 05/16/2025, Surveyor conducted a verification visit, standard survey and 4 complaint investigations at DeForest Place, a CBRF in DeForest. Twenty-four deficiencies were identified. Three deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023. Three of 4 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 17	{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, interview and record review, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. Findings include: From 05/13/2025 to 05/15/2025, Surveyor conducted a verification visit, standard survey and 4 complaint investigations. The survey resulted in 3 substantiated complaints and 24 deficiencies. The following concerns were identified:	N 196		

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

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N 196	Continued From page 1 Environment: - Kitchen appliances were not kept clean and in good repair. - Weekly menus were not posted. - Food was not stored in a sanitary manner. - Areas of the ceiling and a resident bathroom were in need of repairs. - Two of 2 dryer vents were not connected. - Cleaning compounds were left accessible to residents. - The temperature was not regulated in the facility. Employees: - Background checks were not completed as required. - Employees provided care without having a tuberculosis test completed. - Employees did not have training in standard precautions prior to being exposed to bodily fluids. - The provider did not inquire about the disposition and request a criminal complaint when a caregiver had a charge of a serious crime within 5 years of hire. Resident Care: - Residents were admitted to the facility without a completed admission agreement. - Residents were admitted to the facility without a tuberculosis test completed 90 days prior to or 7 days after admission. - One of 3 residents reviewed did not receive medication as prescribed. - Individual service plan (ISPs) development did not include residents and/or legal representatives. - ISPs were not updated upon changes.	N 196		

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N 196	Continued From page 2 - Evacuation evaluations were not completed within 3 days of admission. - The facility was not always staffed with a qualified staff member (fully trained). - The facility did not have adequate staff to meet the needs of residents. - PRN psychotropic use was not included in the resident ISP and the effectiveness of the medication was not always documented. - A daily activity program was not provided. - Medications were not available for administration. On 05/13/2025 at approximately 2:20 p.m., Surveyor reviewed concerns and substantiated complaints with Consultant D. Consultant D explained that the facility was being operated by a company that had a pending application with the department. Consultant D stated his/her consulting firm took over management of the facility in early/mid-March after Administration A was "walked out." Consultant D did not share any involvement that the current licensee had with the facility, but rather that the owner who had a pending application in with the department to take over the facility was arriving to the facility tomorrow. Cross Reference: N0219 83.17(1) Licensee Conduct Caregiver Background Check N0220 83.17(2)(a) Employees Screened For Communicable Disease N0239 83.20(2)(a) Department-Approved Training Courses N0301 83.28(3) Provide Admission Agreement As Required N0302 83.28(4)(a)1. Resident Health Screening And Documentation N0352 83.32(3)(h) Rights of Residents: Receive	N 196		

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N 196	Continued From page 3 Medication N0387 83.35(3)(b) Service Plan Development: Parties Involved N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes N0393 83.35(5)(a) Initial Evaluation Of Evacuation Limits N0396 83.36(1)(a) Adequate Staff To Meet Resident Needs N0397 83.36(1)(b)2. Qualified Staff In Charge, On Duty And Awake N0408 83.37(1)(i) PRN Psychotropic Medication N0423 83.37(3)(g) Medication Storage: Controlled Substances N0427 83.38(1)(c) Leisure Time Activities N0432 83.38(1)(h) Medication Administration N0446 83.41(1)(b) Equipment N0450 83.41(2)(c)2. Nutrition: Menus N0452 83.41(3)(b) Food Safety N0481 83.43(1) Environment Safe, Clean, And Comfortable N0488 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 83.45(3) Toxic Substances N0509 83.46(1)(a) Ventilation Z0010 50.065(2)(bb) Determine Final Disposition Of Charge	N 196		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or	N 219		

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N 219	Continued From page 4 offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers reviewed had completed background checks at the time of hire. Caregiver E did not have a background information disclosure (BID) completed at the time of hire. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 05/13/2025 at 10:45 a.m., Surveyor reviewed the employee records of Caregiver E, Caregiver F and Caregiver G. Records indicated Caregiver E, hired 03/07/2025, did not complete his/her BID until 04/19/2025. Surveyor reviewed the provider's staff schedule from 03/16/2025 to 05/10/2025, which indicated Caregiver E worked	N 219		

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N 219	Continued From page 5 27 shifts prior to the completion of his/her BID. On 05/13/2025 at approximately 1:00 p.m., Surveyor reviewed concern with Consultant D that Caregiver E did not have a BID completed at the time of hire. Consultant D wrote down Surveyor's concern. Consultant D stated the facility was in great need of staff because many caregivers left with Administrator A when Administrator A was "walked out."	N 219		
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 3 of 3 caregivers reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Caregiver E, Caregiver F and Caregiver G did not have tuberculosis tests completed within 90 days before the start of employment.	N 220		

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N 220	Continued From page 6 Findings include: On 05/13/2025 at 10:45 a.m., Surveyor reviewed the employee records of Caregiver E, Caregiver F and Caregiver G. Records indicated the following: - Caregiver E was hired on 03/07/2025. Caregiver E's record included a communicable disease screen completed 03/14/2025 and a tuberculosis test completed 04/14/2025, greater than 1 month after his/her date of hire. The provider's schedule indicated Caregiver E worked and provided care prior to 04/14/2025. - Caregiver F was hired on 03/10/2025. Caregiver F's record included a communicable disease screen completed 04/22/2025 and a tuberculosis test dated 04/24/2025. The provider's schedule indicated Caregiver F worked and provided care prior to 04/24/2025. - Caregiver G was hired on 02/28/2025. Caregiver G's record included a communicable disease screen completed on 04/16/2025 and a tuberculosis test completed on 04/16/2025, greater than 1 month after his/her date of hire. The provider's schedule indicated Caregiver G worked and provided care prior to 04/16/2025. On 05/13/2025 at approximately 1:00 p.m., Surveyor reviewed concern with Consultant D that 3 of 3 caregivers reviewed had not had a communicable disease screen, including tuberculosis test, completed within 90 days prior to employment. Consultant D stated the facility was in great need of staff because many caregivers left when Administrator A was "walked out," so tuberculosis tests were completed as soon as the nurse affiliated with Consultant D was able.	N 220		

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N 239	Continued From page 7	N 239		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 caregivers reviewed receiving training in standard precautions before assuming responsibilities that may expose them to blood, body fluids or other moist body substances. Caregiver F and Caregiver G had not received training in standard precautions or met an exemption for standard	N 239		

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N 239	Continued From page 8	N 239		

precautions.

Findings include:

On 05/13/2025 at 10:45 a.m., Surveyor reviewed the employee records of Caregiver E, Caregiver F and Caregiver G. Records indicated the following:

- Caregiver F was hired on 03/10/2025. Caregiver F's record did not include documentation of training in standard precautions or an exemption for standard precautions. The provider's schedule, dated 03/16/2025 to 05/10/2025, indicated Caregiver F was working as a caregiver.
- Caregiver G was hired on 02/28/2025. Caregiver G's record did not include documentation of training in standard precautions or an exemption in standard precautions. The provider's schedule, dated 03/16/2025 to 05/10/2025, indicated Caregiver F was working as a caregiver.

On 05/13/2025 at approximately 11:30 a.m., Surveyor checked the WI CBRF Registry and was unable to locate documentation indicating Caregiver F and Caregiver G had received training in standard precautions.

On 05/13/2025 at approximately 1:00 p.m., Surveyor reviewed concern with Consultant D that 2 of 3 caregivers reviewed had not received training in standard precautions prior to being exposed to blood, body fluids or other moist body substances. Consultant D stated the facility was in great need of staff because many caregivers left when Administrator A was "walked out," so some training was incomplete. Consultant D was unable to provide documentation of an exemption for standard precautions training for Caregiver F

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N 239	Continued From page 9 or Caregiver G.	N 239		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed had an admission agreement completed before or at the time of admission. Resident 6 and Resident 3 did not have an admission agreement completed at the time of admission. Findings include: On 05/13/2025 at 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: - Resident 6 was admitted to the provider's facility on 05/02/2025. Resident 6 had a legal guardian. Resident 6's record did not include an admission agreement. - Resident 3 was admitted to the provider's facility on 03/02/2025. Resident 3 had a legal guardian. Resident 3's admission agreement was signed and dated 04/09/2025, greater than 1 month after admission. On 05/13/2025 at approximately 1:00 p.m., Surveyor interviewed Consultant D regarding admission agreements. Consultant D stated Resident 6's admission agreement had been sent	N 301		

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N 301	Continued From page 10 to his/her legal guardian, but had yet to be signed. Consultant D stated Resident 3 was admitted under Administrator A, who was no longer with the facility. Consultant D explained, "[The admission] was very messy."	N 301		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before admission or 7 days after admission. Resident 3 and Resident 4 did not have a tuberculosis test completed within 90 days before admission or 7 days after admission. Findings include:	N 302		

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N 302	Continued From page 11 On 05/14/2025 at approximately 10:00 a.m., Surveyor reviewed resident records which indicate the following: - Resident 3 was admitted to the provider's facility on 03/02/2025. Resident 3's record did not include a tuberculosis test. - Resident 4 was admitted to the provider's facility on 12/26/2024. Resident 4's record did not include a tuberculosis test. On 05/14/2025 at approximately 12:00 p.m., Surveyor requested Resident 3 and Resident 4's tuberculosis tests from Consultant D. On 05/14/2025 at 12:58 p.m., Consultant D updated Surveyor that the provider had an order for a tuberculosis test for Resident 4 but the test had yet to be completed. On 05/14/2025 at approximately 2:20 p.m., Surveyor discussed concern with Consultant D that Resident 3 and Resident 4 did not have tuberculosis tests on file. Consultant D stated Resident 3 and Resident 4 were admitted under Administrator A, who was no longer with the facility. Consultant D stated, "[The admissions] were very messy."	N 302		
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.	N 352		

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N 352	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents received his/her medications as prescribed. Resident 6 did not receive his/her Symbicort inhaler as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023. Findings include: On 05/13/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider's facility on 05/02/2025. Resident 6 had a legal guardian. Resident 6's physician orders included Symbicort 160-4.5 inhaler (Start Date: 05/02/2025) - Inhale 2 puffs into the lungs 2 times/day for shortness of breath. On 05/13/2025 at 11:25 a.m., Surveyor and Caregiver E reviewed Resident 6's medications. Resident 6's medications included 1 Symbicort inhaler dated 05/02/2025. The inhaler indicated 116 of 120 inhalations were left in the inhaler. Surveyor then reviewed Resident 6's Medication Administration Record (MAR), dated 05/02/2025 to 05/13/2025, which documented 16 administrations of the medication starting 05/05/2025 at 8:00 a.m. (16 administrations x 2 inhalations with each administration = 32 inhalations should have been used of the inhaler, leaving 88 inhalations in the inhaler). Surveyor asked Caregiver E if Resident 6 had arrived to the facility with a 2nd Symbicort inhaler that may have been used prior to the inhaler with 116 inhalations remaining. Caregiver E replied, "No. Just that one." Surveyor reviewed the MAR which	N 352		

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N 352	Continued From page 13 indicated Caregiver E was the medication passer on 05/05/2025 at 8:00 p.m. On 05/15/2025 at 2:00 p.m., Surveyor interviewed Pharmacist I. Pharmacist I stated Resident 6's Symbicort inhaler was delivered to the facility on 05/05/2025 at 5:45 p.m. (Caregiver E worked this shift) indicating the provider did not have Symbicort to administer from 05/02/2025 through 05/05/2025 at 8:00 a.m. and that Resident 6 received only 2 administrations (4 inhalations) from 05/05/2025 at 8:00 p.m. to 05/13/2025 at 8:00 a.m. rather than 16 administrations (32 inhalations).	N 352		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by:	N 387		

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	0018519	A. BUILDING: _____ B. WING _____	R-C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 387	Continued From page 14 Based on record review and interview, the provider did not ensure 3 of 4 individual service plans (ISP) reviewed included the resident and/or their legal representative in the development of the ISP. Resident 3, Resident 4 and Resident 5's ISPs did not include the involvement of the resident and/or their legal representatives. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023. Findings include: On 05/13/2025 at approximately 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: - Resident 3 was admitted to the provider's facility on 03/02/2025. Resident 3 had a legal guardian. Resident 3's ISP was dated 03/10/2025, but did not include the signature of his/her legal guardian to indicate involvement with the development of the ISP. - Resident 4 was admitted to the provider's facility on 12/26/2024. Resident 4 was his/her own decision maker. Resident 4's ISP was dated 02/11/2025, but did not include the signature of Resident 4 to indicate the involvement with the development of the ISP. - Resident 5 was admitted to the provider's facility on 01/05/2017. Resident 5 had an activated Health Care Power of Attorney (HCPOA). Resident 5's ISP was dated 02/11/2025, but did not include the signature of Resident 5's HCPOA to indicate the involvement with the development of the ISP. On 05/13/2025 at approximately 1:00 p.m., Surveyor reviewed concern with Consultant D that 3 of 4 ISPs reviewed did not include the	N 387		

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N 387	Continued From page 15 involvement of the resident and/or their legal representative. Consultant D stated the consulting firm's RN had recently updated all the ISPs. Consultant D requested to follow up with his/her peers regarding signed ISPs. Consultant D was given until 05/15/2025 to provide follow up documentation. Documentation of ISPs was not received.	N 387		
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 3 of 5 residents reviewed had their individual service plan (ISP) updated upon changes. Resident 4's ISP was not updated to include his/her self-administration of a medication. Resident 5's ISP was not updated with his/her behaviors. Resident 11's ISP was not updated with his/her refusal for incontinence care overnight.	N 389		

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N 389	Continued From page 16 This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023. Findings include: From 05/13/2025 to 05/15/2025, Surveyor made observations, reviewed records and interviewed staff. The following concerns were identified regarding ISP updates: Resident 4: Resident 4 was admitted to the provider's facility on 12/26/2024. Resident 4's record included an assessment, dated 04/14/2025, for self-administration of medications. The record indicated Resident 4 self-administered his/her own testosterone. Resident 4's ISP, dated 02/11/2025, stated caregivers would continue to give all scheduled and PRN medications. The ISP was not updated to indicate Resident 4 administered his/her own testosterone. On 05/13/2025 at approximately 2:20 p.m., Surveyor reviewed concern with Consultant D that Resident 4's ISP did not include his/her self-administration of testosterone. Consultant D wrote down Surveyor's concern. Resident 11: Resident 11 was admitted to the provider's facility on 01/06/2023. Resident 11's diagnoses included mild cognitive impairment. Resident 11's ISP, dated 10/02/2024 stated Resident 11 sometimes became confused and got irritated and staff were to redirect. The ISP had "Not applicable" under self-concepts, maturation, attitude, interaction with others and aggressive/combative. The ISP	N 389		

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N 389	Continued From page 17 did not include Resident 11's behavior of demanding particular items. On 05/13/2025 from 10:15 a.m. to 10:45 a.m. Surveyor observed Resident 11 ambulating throughout the facility raising his/her voice and demanding toilet paper and oranges. Resident 11 continuously voiced frustration over not having oranges, raising his/her voice and insisting staff provide oranges in that moment. Resident 11 informed Surveyor s/he had paid for oranges and the facility was selling them to others. On 05/13/2025 at approximately 10:45 a.m., Surveyor observed an individual deliver oranges and Resident 11's demands subsided. On 05/13/2025 at 10:45 a.m., Surveyor interviewed Resident 7. Resident 7 stated Resident 11 demanding a certain item was a routine occurrence at the facility. Resident 7 stated once Resident 11 got the fruit s/he requested s/he stored it in his/her walker basket and let it get moldy. On 05/13/2025 at approximately 1:30 p.m., Surveyor interviewed Caregiver E. Caregiver E stated it was common for Resident 11 to get very irritated if the facility was out of items Resident 11 loved, such as coffee, bananas or oranges. Caregiver E stated when Resident 11 became irritated caregivers would attempt to redirect Resident 11 with an alternate item or have items s/he was requesting delivered to the facility via a delivery service. On 05/13/2025 at approximately 2:20 p.m., Surveyor reviewed concern with Consultant D that Resident 11's ISP did not include his/her behavior of demanding particular items.	N 389		

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N 389	Continued From page 18 Consultant D wrote down Surveyor's concern. Resident 5: On 05/13/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider's facility on 01/05/2017. Resident 5's ISP, dated 08/30/2024, stated s/he was incontinent of bowel and bladder and staff were to provide assistance. Resident 5's progress note included an entry, dated 04/29/2025, that stated Resident 5's mattress was stained and smelled of urine so the provider was replacing the mattress. On 05/13/2025 at approximately 2:20 p.m., Surveyor reviewed the progress note regarding Resident 5's incontinence with Consultant D. Surveyor asked if any interventions were put into place to manage Resident 5's incontinence after requiring a new mattress. Consultant D stated s/he believed the use of an incontinence pad was started, but requested to follow up with Surveyor after discussing with his/her peers. On 05/14/2025 at 5:45 p.m., Consultant D followed up with Surveyor and stated Resident 5 preferred not to be woken at night and tended to remove his/her brief, resulting in the soiled mattress. Consultant D stated s/he would update the care plan.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an	N 393		

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N 393	Continued From page 19 unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed had their ability to evacuate the CBRF within 4 minutes evaluated within 3 days of admission. Findings include: On 05/13/2025 at 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: - Resident 3 was admitted to the provider's facility on 03/02/2025. Resident 3's evacuation assessment was dated 03/10/2025, greater than 3 days after his/her admission to the facility. - Resident 4 was admitted to the provider's facility on 12/26/2024. Resident 4's evacuation assessment was dated 01/31/2025, greater than 3 days after his/her admission to the facility. On 05/13/2025 at approximately 2:20 p.m., Consultant D stated Resident 3 and Resident 4 were admitted under Administrator A. Consultant D explained, "[The admissions] were very messy."	N 393		

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N 396	Continued From page 20	N 396		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure employees sufficient to meet the needs of residents were provided on a 24-hour basis. Two residents required assistance of 2 caregivers for cares. The facility staffed only 1 caregiver from 11:00 p.m. to 7:00 a.m. Findings include: The provider is licensed to serve up to 20 residents with diagnoses of terminally ill, advanced age and irreversible dementia/Alzheimer's. On 05/13/2025 at 10:00 a.m., Surveyor reviewed resident records, which stated the following: - Resident 3 was admitted to the provider's facility on 03/02/2025. Resident 3's individual service plan indicated s/he required 1+ assist for transfers and mobility. Resident 3's record included a "Member Centered Plan," dated 02/14/2025 that indicated s/he required a hoyer lift as needed. - Resident 6 was admitted to the provider's facility on 05/02/2025. Resident 6's record included a temporary care plan, dated 03/28/2025, that indicated s/he required assist of 2 for transfers. On 05/13/2025 at 11:45 a.m., Surveyor interviewed Caregiver E. Surveyor asked if any	N 396		

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N 396	Continued From page 21 residents required assistance of 2 for mobility. Caregiver E replied, "[Resident 3] and [Resident 6]." Surveyor asked if caregivers ever work alone. Caregiver E stated s/he had worked alone before, including overnight when only 1 caregiver was scheduled. Surveyor asked how s/he would provide cares for Resident 3 and Resident 6 when working by him/herself. Caregiver E stated the residents stayed in bed, but that s/he would need assistance of another caregiver if the resident required a complete bed change. On 05/13/2025 at approximately 2:20 p.m., Surveyor interviewed Consultant D. Consultant D stated Resident 3 required assistance of 2 for transfers, but that Resident 3 often stayed in bed. Surveyor asked Consultant D how caregivers would provide assistance for Resident 3 overnight when only 1 staff was present. Consultant D replied, "[S/he] stays in bed." When asked what caregivers would do if Resident 3 required a complete bed change when only 1 staff member was present Consultant D did not have a solution. Consultant D did not comment on Resident 6 requiring assist of 2. Consultant D stated, "Staffing is an issue. Both [Resident 3 and Resident 6] were admitted under Administrator A." On 05/13/2025 at approximately 2:40 p.m., Consultant D updated Surveyor that s/he spoke with Caregiver E, who stated s/he would be able to complete a bed change on his/her own with Resident 3 if needed. Surveyor noted the response was from the same caregiver that reported to Surveyor earlier that Resident 3 required assistance of 2 for cares, particularly when a complete bed change was needed. Consultant D did not comment on Resident 6 requiring assist of 2.	N 396		

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N 397	Continued From page 22	N 397		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure at least 1 qualified resident care staff was present in the facility at all times. Caregivers worked alone that were not fully trained. Findings include: On 05/13/2025 at 10:45 a.m., Surveyor reviewed the employee records of Caregiver E, Caregiver F and Caregiver G. Records indicated the following:	N 397		

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N 397	Continued From page 23 - Caregiver E was hired on 03/07/2025. Caregiver E's record did not include documentation of training or an exemption for training in the following topics: first aid and choking, fire safety and challenging behaviors. The record indicated dietary training was received on 04/15/2025 and client group training was completed on 04/18/2025. - Caregiver F was hired on 03/10/2025. Caregiver F's record did not include documentation of training or an exemption for training in first aid and choking, fire safety, standard precautions, challenging behaviors or personal cares. - Caregiver G was hired on 02/28/2025. Caregiver G's record did not include documentation of training or an exemption for training in first aid and choking, fire safety and standard precautions. The record indicated dietary training was received on 04/18/2025 and client group training was received on 04/18/2025. DHS Chapter 83.02(42) identifies "Qualified resident care staff" as an employee who has successfully completed all of the applicable training and orientation under subch. IV. On 05/13/2025 at approximately 11:30 a.m., Surveyor reviewed the provider's schedule, dated 03/16/2025 to 05/10/2025, which indicated caregivers worked the following overnights (11:00 p.m. to 7:00 a.m.) alone and without being fully trained: - Caregiver E: 03/23/2025 - Caregiver F: 03/16/2025, 03/17/2025 and 03/19/2025. - Caregiver G: 03/18/2025, 03/20/2025, 03/21/2025, 03/22/2025, 03/24/2025, 03/25/2025, 03/26/2025, 03/28/2025, 03/29/2025, 03/30/2025,	N 397		

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N 397	Continued From page 24 03/31/2025, 04/03/2025, 04/04/2025, 04/05/2025, 04/06/2025, 04/07/2025, 04/09/2025, 04/11/2025, 04/12/2025, 04/13/2025, 04/14/2025, 04/17/2025, 04/18/2025, 04/19/2025, 04/20/2025, 04/21/2025, 04/24/2025, 04/25/2025, 04/26/2025, 04/27/2025, 04/28/2025, 05/01/2025, 05/02/2025, 05/05/2025, 05/09/2025 and 05/10/2025. On 05/13/2025 at 11:45 a.m., Surveyor interviewed Caregiver E. Caregiver E stated s/he had worked alone at the facility. Caregiver E stated s/he had completed some online trainings, but was unable to specify what topics were covered. On 05/13/2025 at approximately 1:00 p.m., Surveyor reviewed concern with Consultant D that Caregiver E, Caregiver F and Caregiver G worked shifts alone without being fully trained. Consultant D stated the facility was in great need of staff because many caregivers left when Administrator A was "walked out," so some training was incomplete. Consultant D stated his/her peer who was working with the facility the past several weeks was unaware of the need for "qualified staff. Cross Reference: N0239 DHS 83.20(2)(a) Department-Approved Training Courses	N 397		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for	N 408		

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N 408	Continued From page 25	N 408		

administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed had the rational for use and a detailed description of behaviors indicating the need for administration of a PRN psychotropic identified in the individual service plan (ISP) and that the effectiveness of the PRN psychotropic was documented in the record when administered. Resident 4's use of Hydroxyzine was not included in his/her ISP and the effectiveness was not documented for 21 of 79 administrations reviewed.

Findings include:

On 05/13/2025 at 10:00 a.m., Surveyor reviewed resident records. Resident 4 was admitted to the provider's facility on 12/26/2024. Resident 4's physician orders included Hydroxyzine Hcl 25 mg (Start Date: 03/22/2025) - Take 1 tablet every 6 hours as needed for anxiety and insomnia. The Medication Administration Record (MAR), dated 04/01/2025 to 05/13/2025, documented 79 administrations of Resident 4's Hydroxyzine PRN.

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N 408	Continued From page 26 Resident 4's ISP, dated 02/11/2025, did not include the rational for use and a detailed description of behaviors indicating the need for administration of the PRN psychotropic. Resident 4's record indicated 21 of 79 administrations did not document the effectiveness. On 05/13/2025 at 1:00 p.m., Surveyor interviewed Consultant D. Surveyor shared observation that Resident 4's PRN psychotropic was not included in his/her ISP and the effectiveness of the PRN psychotropic was not always documented in the record. Consult D nodded his/her head in understanding and wrote down Surveyor's concern.	N 408		
N 423	83.37(3)(g) Medication storage: controlled substances. Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure schedule II drugs were kept separately locked within the locked medication area. The provider had 30 Morphine Sulfate tablets that were not seperately locked. Findings include: On 05/13/2025 at 11:25 a.m., Surveyor and Caregiver E reviewed the provider's medication	N 423		

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N 423	Continued From page 27 cart. Surveyor observed a package of 30 Morphine Sulfate 15 mg tablets with a date of 05/07/2025 in the "general" storage of the medication cart, rather than the double-locked compartment of the medication cart intended for schedule II medications. The package stated "31 to 60 of 60." Surveyor was unable to locate the 2nd package. Surveyor asked Caregiver E why the Morphine Sulfate was not stored in the compartment designated for schedule II drugs. Caregiver E replied, "Is this a narcotic" and placed the package in the compartment for schedule II drugs. On 05/13/2025 at approximately 2:00 p.m., Surveyor reviewed concern with Consultant D that the provider had Morphine Sulfate stored in the "general" storage of the medication cart and not double-locked. Surveyor also shared concern that the Morphine Sulfate package stated "31 of 60" and Surveyor was unable to locate "1 to 30." Consultant D took note of Surveyor's concern, stated the 1st package was likely in the facility's safe and stated s/he would follow up to ensure the medications were properly stored and added to the daily counts.	N 423		
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	N 427		

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N 427	Continued From page 28	N 427		

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, record review and interview, the provider did not ensure a daily activity program was provided to meet the interests and capabilities of residents.

Findings include:

On 05/13/2025, Surveyor conducted a complaint investigation that alleged the provider did not offer an activity program.

On 05/13/2025 at approximately 8:45 a.m., Surveyor toured the provider's facility. Surveyor was unable to locate an activity schedule.

On 05/13/2025 at 8:56 a.m., Surveyor interviewed Resident 8. Resident 8 stated activities occurred at the facility approximately 2 times per month.

On 05/13/2025 at 9:25 a.m., Surveyor interviewed Resident 7. Resident 7 stated the facility used to have activities, but they had "slowed up recently."

On 05/13/2025 at 9:35 a.m., Surveyor interviewed Resident 1. Resident 1 stated the provider had not led any activities since Administrator A left.

On 05/13/2025 at 11:45 a.m., Surveyor interviewed Caregiver E regarding the provider's activity program. Caregiver E stated s/he didn't know what happened with the activity calendar. Caregiver E stated the provider was going to start

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N 427	Continued From page 29 leading morning and evening activities. On 05/13/2025 at 1:40 p.m., Surveyor interviewed Resident 2 regarding the provider's activity program. Resident 2 stated s/he was unaware of any activities occurring since Administrator A left. On 05/13/2025 at approximately 2:00 p.m., Surveyor interviewed Consultant D regarding the provider's activity program. Consultant D stated his/her coworker was working on getting activities going in the facility. Consultant D stated Administrator A left the facility in early March 2025. Consultant D did not provide Surveyor with an activity schedule and had no further details to share regarding the activity programming.	N 427		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure medication administration was provided to meet the needs of residents. Resident 4, Resident 5, Resident 6 and Resident 12 did not have all ordered medications	N 432		

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N 432	Continued From page 30 available for administration. Findings include: On 05/13/2025 at 11:25 a.m., Surveyor and Caregiver E reviewed the physician orders and medications for Resident 4, Resident 5, Resident 6 and Resident 12. The following concerns were identified: Resident 4: Resident 4 was admitted to the provider's facility on 12/26/2024. Surveyor and Caregiver E were unable to locate the following ordered medications for Resident 4: - Florajen Acidophilus 460 mg (Start Date: 01/28/2025) - Take 1 capsule 2 times/day - Naloxone Hcl 4 mg Nasal Spray (Start Date: 02/21/2025) - Instill 1 spray in each nostril as needed. - Albuterol Sulfate Inhaler (Start Date: 05/02/2025) - Inhale 2 puffs every 4 hours as needed Resident 4's Medication Administration Record (MAR), dated 04/01/2025 to 05/13/2025, documented Florajen Acidophilus 460 mg as unavailable 64 times. Resident 5: Resident 5 was admitted to the provider's facility on 01/05/2017. Surveyor and Caregiver E were unable to locate the following ordered medications for Resident 5: - Fluticasone Propionate 50 mcg (Start Date: 12/27/2024) - Instill 2 sprays each nostril daily.	N 432		

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N 432	Continued From page 31 - Acetaminophen 500 mg (Start Date: 04/01/2025) - Take 1 tablet daily as needed. - Diphenhydramine 2-.1% (Start Date: 12/27/2024) - Apply topically to affected area 4 times daily as needed. - Ibuprofen 200 mg (Start Date: 12/27/2024) - Take 1-2 tablets 3 times daily as needed. - Lidocaine 5% (Start Date: 12/27/2024) - Apply topically 4 times/day as needed. - Milk of Magnesia 400 mg/5 ml (Start Date: 12/27/2024) - Take 30 mls as needed. - Naproxen 375 mg (Start Date: 12/27/2024) - Take 1 tablet 2 times daily as needed. - Polyethylene Glycol 3350 17 gm (Start Date: 12/27/2024) - Take 17 gm 2 times daily as needed. Resident 5's MAR, dated 04/01/2025 to 05/13/2025, documented Fluticasone Propionate nasal spray as unavailable 25 times. Resident 6: Resident 6 was admitted to the provider's facility on 05/02/2025. Surveyor and Caregiver E were unable to locate the following ordered medications for Resident 6: - Albuterol Sulfate inhaler (Start Date: 05/02/2025) - Inhale 2 puffs every 4 hours as needed. - Duoneb (Start Date: 05/02/2025) - Inhale 1 via nebulizer every 8 hours as needed. - Milk of Magnesia (Start Date: 05/02/2025) - Take 30 mls daily as needed. Resident 12: Resident 12 was admitted to the provider's facility on 03/01/2022 and discharged on 05/03/2025.	N 432		

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N 432	Continued From page 32 Resident 12's record, dated 04/01/2025 to 05/03/2025 indicated the following medications were unavailable to him/her for administration: - Atorvastatin Calcium 40 mg (Start Date: 11/27/2024) - Take 1 tablet 1 time daily. *Documented as unavailable 27 times. - Citalopram 40 mg (Start Date: 12/27/2024) - Take 1 tablet daily. *Documented as unavailable 30 times. - Famotidine 20 mg (Start Date: 12/27/2024) - Take 1 tablet daily. *Documented as unavailable 31 times. - Ferrous Sulfate 325 mg (Start Date: 12/27/2024) - Take 1 tablet daily. *Documented as unavailable 30 times. - Mirtazapine 30 mg (Start Date: 12/27/2024) - Take 1 tablet daily. *Documented as unavailable 29 times. - Polyethylene Glycol 17 gm (Start Date: 12/27/2024) - Take 17 grams daily. *Documented as unavailable 29 times. - Triamterene Hctz 37.5-25 mg (Start Date: 12/27/2024) - Take 1 capsule daily. *Documented as unavailable 32 times. - Vitamin B-12 100 mcg (Start Date: 12/27/2024) - Take 1 tablet daily. *Documented as unavailable 31 times. On 05/13/2025 at 11:45 a.m., Surveyor interviewed Caregiver E regarding medications being unavailable. Caregiver E stated s/he had just been trained on completing cart audits the week prior. Caregiver E stated, "If the medication isn't available, the resident doesn't use the medication." On 05/13/2025 at 2:00 p.m., Surveyor interviewed Consultant D regarding the unavailability of medications. Consultant D stated Caregiver E	N 432		

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N 432	Continued From page 33 had just been trained on medication cart audits by the consulting firm's RN. Consultant D stated some medications were unavailable due to coverage issues. Consultant D explained that residents with managed care organization funding had received a debit card that they were unable to access or the pharmacy didn't accept so the residents didn't have coverage for over the counter (OTC) medications. Consultant D acknowledged that some of the medications unavailable were not OTC medications. Surveyor shared that his/her review of resident records did not include documentation of communication with residents, residents legal representatives, the provider's pharmacy and/or resident's physicians regarding coverage concerns and residents not receiving medications or having medications available to them as ordered. Consultant D was given until 05/15/2025 to provide follow up documentation. Documentation regarding Resident 4, Resident 5, Resident 6 and Resident 12's unavailable medications was not received.	N 432		
N 446	83.41(1)(b) Equipment. Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all kitchen equipment was in good	N 446		

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N 446	Continued From page 34 repair. The provider's chest freezer had a broken seal. Findings include: On 05/13/2025 at 8:45 a.m., Surveyor toured the provider's facility. Surveyor observed a chest freezer in the food storage room that was not properly sealed. The rubber seal of the chest was no longer attached to the top and exposed insulation (Photo 1, Photo 2, Photo 3). Surveyor observed the temperature in the freezer was 27.5 degrees F. On 05/13/2025 at approximately 1:00 p.m., Surveyor shared concern with Consultant D that the provider's chest freezer was not in good repair. Consultant D stated s/he had not seen the chest freezer. Consultant D asked if it would be acceptable for the chest freezer to be fixed rather than replaced.	N 446		
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 ensure a weekly written menu was made available to residents.	N 450		

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N 450	Continued From page 35 Findings include: On 05/13/2025 at 8:30 a.m., Surveyor observed 2 residents eating breakfast. Surveyor observed there was a whiteboard area in the dining room for the menu to be listed. The breakfast menu was blank. The lunch and supper menus were complete. Surveyor was unable to locate a posted weekly menu. On 05/13/2025 at 8:56 a.m., Surveyor interviewed Resident 8 and asked about the provider's dietary services. Resident 8 stated s/he was never informed about what would be served for meals. Resident 8 stated s/he would ask a caregiver and they always responded, "I don't know." On 05/13/2025 at 9:25 a.m., Surveyor interviewed Resident 7 and asked about the provider's dietary services. Resident 7 stated s/he wasn't sure what would be served for lunch and supper that day until the cook came in approximately 1 hour before lunch. On 05/13/2025 at 9:35 a.m., Surveyor interviewed Resident 1 and asked about the provider's dietary services. Resident 1 stated residents didn't know what they were going to be served ahead of time because the menu wasn't completed until the cook came in. On 05/13/2025 at 10:15 a.m., Surveyor interviewed Cook H. Surveyor asked Cook H if there was a weekly menu posted in the facility for residents. Cook H replied, "No," and explained that s/he updated the daily menu when s/he arrived to the facility each day. Cook H stated s/he typically arrived around 9:00 a.m., but was late that day and hadn't been able to update the daily menu yet so the current menu was	N 450		

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N 450	Continued From page 36 yesterday's meals. On 05/13/2025 at approximately 2:00 p.m., Surveyor interviewed Consultant D and shared concern that the provider did not have a weekly menu posted. Consultant D wrote down Surveyor's concern and stated breakfast was "made to order."	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was prepared and stored under sanitary conditions for the prevention of food borne illnesses.	N 452		

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N 452	Continued From page 37 Findings include: On 05/13/2025 at 8:45 a.m., Surveyor toured the provider's facility and identified the following concerns with dietary services: Appliances: - The provider's stovetop and oven had food particles covering the surface. - The provider's coffee pot had hardened coffee covering the surface and wall near the coffee maker. - The refrigerator and freezer had food particles covering the surface. - The microwave had hardened liquid on the surface. Storage: - Drawers containing eating and cooking utensils had hardened liquid, dust and food particles covering the surface. - The dry food storage room had onion peels, food particles and wrappers scattered on the floor. Refrigerator: - An open bag of deli ham was not dated with the date it was opened. - An open carton of beef broth that was not dated with the date it was opened. The container read "Use within 14 days of opening." - An open bag of sausage links was not dated. - A mixing bowl of egg salad was covered in aluminum foil and not dated with the date it was prepared. - A Ziploc bag with ground raw meat was not labeled or dated.	N 452		

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N 452	Continued From page 38 "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) Freezer: - A box of mini muffins was left open to air and not sealed. "Proper packaging helps maintain quality and prevent freezer burn. Aluminum foil, freezer paper, plastic containers, and plastic freezer bags will help food maintain optimum quality in the freezer. Plastic wrap alone will not provide enough protection by itself, but can be used to separate foods within another package. When packaging food, press out as much air as possible to prevent freezer burn, and wrap tightly." (Source: USDA (United States Department of Agriculture) website, How should food be packaged for the freezer?, https://ask.usda.gov (retrieval date - March 29, 2023).) On 05/13/2025 at 10:15 a.m., Surveyor interviewed Cook H. Cook H stated s/he was relatively new with the company and had not yet had the chance to deep clean the kitchen and food storage. Cook H stated s/he and caregivers were responsible for making sure dietary areas were kept clean.	N 452		

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N 481	Continued From page 39	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe, clean, comfortable and homelike environment was provided. Findings include: On 05/13/2025 at 8:45 a.m., Surveyor toured the provider's facility and identified the following concerns: Ceiling: - Two ceiling tiles were missing, exposing plumbing and HVAC, outside the employee bathroom on first floor. - The ceiling near a heat detector on first floor had brown and gray markings, greater than 12 inches in diameter. On 05/13/2025 at 1:00 p.m., Consultant D stated the ceiling marks and missing tiles were due to old leaks and that maintenance was addressing the issues in three days. Bathroom: - The bathroom between Resident 7 and Resident 9's room had a broken toilet seat and	N 481		

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N 481	Continued From page 40 toilet paper holder. The toilet seat was resting against the wall next to the toilet. The toilet paper holder was missing 2 of 3 pieces. On 05/13/2025 at 2:00 p.m., Surveyor interviewed Caregiver E. Caregiver E stated Resident 7 did not use the bathroom connected to his/her room due to the door width. Caregiver E stated Resident 9 did use the bathroom but would walk to the common area bathroom in the event s/he needed to sit. Sunroom: On 05/13/2025 at 10:10 a.m., Surveyor was in the provider's sunroom, utilized by residents and staff. Surveyor heard water dripping. Surveyor observed rainwater streaming down the interior of a window. Cook H was present and quickly stated, "Oh, I'll shut it." Cook H and Surveyor then observed the water was not open and didn't have the ability to open. On 05/13/2025 at 10:22 a.m., Surveyor was reviewing records in the sunroom when rainwater began dripping on the records. Surveyor looked up to see rainwater dropping down from the ceiling in multiple places. On 05/13/2025 at approximately 11:30 a.m., Resident 10 observed that Surveyor had relocated to a new table at the facility and said, "Did you get sick of getting wet?" Resident 10 then jokingly offered Surveyor an umbrella and stated the sunroom leaking water was a known issue.	N 481		
N 488	83.44(1)(c) Clothes dryers enclosed and vented	N 488		

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	0018519	A. BUILDING: _____ B. WING _____	R-C 05/16/2025

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N 488	Continued From page 41 Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the dryer vent was clean and maintained. Two of 2 dryer vents were not clean and well maintained. Findings include: On 05/13/2025 at 8:45 a.m., Surveyor toured the provider's facility. Surveyor observed the laundry room door was propped open with a garbage can. Surveyor toured the laundry room and observed lint build up, greater than 1 inch in depth in areas, covering the laundry room sink, wall, vents and floors. Surveyor observed 1 dryer was not hooked up and had a sign to not use. Surveyor observed the 2nd dryer's vent was not securely fastened, allowing Surveyor to place his/her hand inside the vent. On 05/13/2025 at approximately 2:00 p.m., Surveyor toured the laundry room with Consultant D and shared concern regarding the dryer vents not being secured and lint build up throughout the laundry room. Consultant D stated s/he would reconnect the vent that afternoon and have maintenance follow up in 3 days.	N 488		
N 499	83.45(3) Toxic substances.	N 499		

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N 499	Continued From page 42 Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds were stored in a secure area. Findings include: The provider is licensed to serve up to 20 residents with diagnoses including terminally ill, advanced age and irreversible dementia/Alzheimer's. On 05/13/2025 at 8:45 a.m., Surveyor toured the provider's facility. Surveyor observed a housekeeping cart stored in an accessible stairway corridor/emergency exit that contained the following: - Clorox Disinfecting Spray (Label: HAZARDS TO HUMANS & DOMESTIC ANIMALS. WARNING: Causes substantial but temporary eye injury). - NeutraWork Cleaner (Label: Harmful if swallowed. Irritating to eyes and skin). - Fabuloso Cleaner (Label: May irritate eyes ... Do not swallow). - Old English Wood Protectant (Label: May cause eye irritation). - Stainless Steel Cleaner (Label: May be fatal if swallowed and enters airways. Causes skin irritation). Surveyor also observed the laundry room door propped open with a garbage can, which left 2 18 lb buckets of laundry detergent (Label: Causes	N 499		

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N 499	Continued From page 43 serious eye irritation) accessible to residents. On 05/13/2025 at 1:00 p.m., Surveyor shared concern with Consultant D that toxic chemicals were observed accessible in the laundry room and stairway corridor/emergency exit. Consultant D wrote down Surveyor's concern and asked if the housekeeping cart remained in the stairway corridor. On 05/13/2025 at 2:00 p.m., Surveyor observed the laundry room was locked and the housekeeping cart remained accessible in the stairway corridor.	N 499		
N 509	83.46(2)(a) Ventilation. All rooms and areas shall be well ventilated. Ventilation is not required in a refrigerated storage room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a comfortable temperature was maintained. The temperature in a common area and 2 residents rooms exceeded 74 degrees. Findings include: From 05/13/2025 to 05/15/2025, Surveyor conducted a complaint investigation alleging the facility could not regulate temperatures throughout the building. On 05/13/2025 at approximately 9:15 a.m., Surveyor was sitting in the provider's sunroom (fully enclosed) and observed the temperature was 87 degrees F.	N 509		

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N 509	Continued From page 44 On 05/13/2025 at approximately 9:35 a.m., Surveyor interviewed Resident 1. Resident 1 stated his/her room was the hottest room in the building and that management was aware. Resident 1 stated s/he was glad it was currently raining outside to cool his/her room down. Surveyor's thermometer had a reading of 81.8 degrees F while interviewing Resident 1 in his/her room. On 05/13/2025 at approximately 11:25 a.m., Surveyor interviewed Caregiver E. Caregiver E stated some rooms were known to be really hot regardless of the temperature outside. Caregiver E identified Resident 1, Resident 2 and Resident 4's room as the warmest. On 05/13/2025 at approximately 1:40 p.m., Surveyor interviewed Resident 2. Resident 2 stated his/her room was pretty warm and s/he preferred cooler temperatures. Surveyor's thermometer had a reading of 78 degrees F while interviewing Resident 2 in his/her room. On 05/13/2025 at approximately 2:00 p.m., Surveyor interviewed Consultant D regarding temperatures throughout the facility. Consultant D stated s/he noticed the office was really warm and that the facility still had the furnace on when s/he arrived earlier that morning. Consultant D stated s/he would follow up and check room temperatures on the second floor once the furnace was off.	N 509		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b)	Z 010		

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Z 010	Continued From page 45 indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure reasonable effort was made to determine the final disposition and request the criminal complaint for 1 of 1 caregiver charged with a serious crime within 5 years of	Z 010		

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Z 010	Continued From page 46 hire. The provider did not request additional information regarding Caregiver F's charge of 947.01 Disorderly Conduct. Findings include: On 05/13/2025 at 10:45 a.m., Surveyor reviewed the employee records of Caregiver E, Caregiver F and Caregiver G. Caregiver F's record indicated s/he was hired on 03/10/2025. Caregiver F's record included a Department of Justice (DOJ) report, dated 03/07/2025, that indicated s/he was charged with 947.01 Disorderly Conduct on 11/26/2021. The report did not list the disposition of the charge. Caregiver F's record did not include any follow up documentation, such as the criminal complaint, related to the charge. On 05/13/2025 at approximately 1:00 p.m., Surveyor reviewed concern with Consultant D that Caregiver F's DOJ report listed a charge of 947.01 Disorderly Conduct and asked if the provider had made an attempt to pull the criminal complaint. Consultant D stated the facility was in great need of staff because many caregivers left when Administrator A was "walked out," so some hiring steps were not completed. Consultant D was unable to provide Surveyor with documentation related to Caregiver F's charge of disorderly conduct.	Z 010		