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 09/15/2025

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 On 09/09/2025, with information gathered through 09/15/2025, Surveyors conducted a verification visit and 3 complaint investigations at DeForest Place, a CBRF in DeForest. Twenty-six deficiencies were identified. Eighteen deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023 and SOD Q1UN12, dated 05/16/2025. Two of 3 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 16	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or	N 158		

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

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N 158	Continued From page 1	N 158		

misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not investigate 1 of 2 allegations of abuse from caregiver to resident.

Resident 13 had 2 documented allegations of abuse from a caregiver. On 08/20/2025, Resident 13 alleged that a caregiver punched him/her in the back. There was no documentation that the provider took immediate steps to ensure the safety of all residents or that this allegation was investigated.

Findings include:

On 09/09/2025, Surveyors conducted a verification visit and 3 complaint investigations. As part of the complaint investigation, Surveyor requested Resident 13's record.

At 11:21 a.m., Administrator M provided Surveyor with Resident 13's record. Resident 13 was admitted to the provider on 11/20/2024 with diagnoses including schizoaffective disorder, bipolar type.

Surveyor reviewed Resident 13's progress notes which documented:

- 08/20/2025, "Resident called 911 and made a claim that [Caregiver G] punched [him/her] in [his/her] back while pushing [him/her] back to [his/her] room..."

At approximately 2:00 p.m., Surveyor asked Administrator M for documentation of any

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N 158	Continued From page 2 investigations that the provider has completed in the last 2 months. At approximately 2:35 p.m., Administrator M provided Surveyor with an investigation from a peer to peer altercation. Surveyor asked for investigations of caregiver misconduct or abuse. Administrator M stated that s/he did not have any investigations of caregiver abuse or misconduct. There was no documentation that the provider took immediate steps to ensure the safety of all residents or that an investigation was conducted after Resident 13 alleged that a caregiver hit him/her in the back. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment	N 158		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the	N 164		

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N 164	Continued From page 3	N 164		

provider did not send a written report to the department within 3 working days after law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety or welfare of residents or employees.

Law enforcement was called to the CBRF multiple times from 07/13/2025 to 09/09/2025; 4 of 5 incidents involving Resident 13 were not reported to the department.

Findings include:

On 09/09/2025, Surveyors conducted a verification visit and 3 complaint investigations.

On 09/09/2025 at 11:21 a.m., Administrator M provided Surveyor Resident 13's record, which documented the following times law enforcement was called:

- 07/27/2025, Resident 13 called the police to report that a resident assistant had threatened him/her, alleging that the resident assistant told Resident 13, "your days are numbered."
- 07/29/2025, "Resident used another resident's cell phone to call emergency services/law enforcement for reasons unknown to writer."
- 07/31/2025, Resident 13 called the police to report s/he had missing mail.
- 08/20/2025, "Resident called 911 and made a claim that [Caregiver G] punched [him/her] in [his/her] back while pushing [him/her] back to [his/her] room."
- 08/23/2025, "...staff found the resident on a call with the police, falsely accusing the staff of withholding [his/her] medication...15mins later the police arrived."

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N 164	Continued From page 4 On 09/09/2025 at approximately 1:45 p.m., Surveyor looked at the facilities electronic file and did not see that the provider had reported to the department after law enforcement personnel were called to the facility on 07/27/2025, 07/29/2025, 08/20/2025 or 08/23/2025 for the safety and welfare of Resident 13. On 09/09/2025 at approximately 2:00 p.m., Surveyor asked Administrator M for documentation of incidents that were reported to the department in the last 3 months. On 09/09/2025 at approximately 2:25 p.m., Administrator M provided Surveyor with a police report, dated 08/21/2025, documenting that Resident 13 was charged with battery after hitting Resident 14 in the dining room. On 09/09/2025 at approximately 3:00 p.m., Surveyor reviewed concerns with Consultant N, Administrator M, House Manager K and House Manager L. Administrator M nodded his/her head but did not have a verbal response. No documentation of self-reports submitted to the department were received at the time of the survey. On 09/15/2025 at 2:26 p.m., Surveyor received an incident search from Police Dept S. The report documented that law enforcement responded to the provider's facility 32 times between 07/13/2025 and 09/09/2025. The incident search confirmed that law enforcement responded to the facility on 07/27/2025, 07/29/2025, 07/31/2025, 08/20/2025, and 08/23/2025. Police Dept S documented that they also responded to the provider on 07/28/2025, documenting the incident type as "Treats Complaint"; 08/21/2025, documenting the incident type as "Battery"; and	N 164		

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N 164	Continued From page 5 09/08/2025, documenting the incident type as "Civil Dispute". On 09/16/2025, Surveyor looked at the facilities electronic file and did not see that the provider had reported to the department after law enforcement personnel were called to the facility on 07/28/2025, 08/21/2025 or 09/08/2025 as a result of an incident that jeopardized the health, safety, or welfare of residents or employees. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment N0433 DHS 83.38(1)(i) Behavior Management	N 164		
{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. This is a repeat concern. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 07/02/2025, the provider received Statement of Deficiency (SOD) Q1UN12, which included an	{N 196}		

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{N 196}	Continued From page 6 "Order to Comply With Requirements," which stated the following: "Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request .... SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Deforest Place: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. The licensee shall develop and implement corrective measures to ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. WITHIN 45 DAYS of receipt of this notice, the licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency Q1UN12.	{N 196}		

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{N 196}	Continued From page 7 The licensee will develop (or review/revise) a procedure(s) to address: Adequate and Qualified Staff - At least one qualified resident care staff will be present in the CBRF when one or more residents are present in the CBRF. "Qualified resident care staff" means an employee who has successfully completed all of the applicable training and orientation required by Wis. Admin. Code ch. DHS 83. - Documentation of training will be maintained in personnel records and will include the date(s)/duration of training, the signature/qualifications of the instructor, and an outline of course content. -Staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., toileting, bathing, medication management, interventions to prevent falls, personal cares, meals), and to facilitate a safe evacuation of the building in the event of an emergency. -When a resident or residents (as a group) require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times. -Written staff schedules will be current and shall include each employee's full name, job assignment and time worked. Records will be amended, as necessary, to ensure an accurate and complete record of time worked by all facility employees, and/or employees of contract agencies providing routine services to facility residents. Medication Management and Administration	{N 196}		

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{N 196}	Continued From page 8 -Including how the provider will: (a) document medication orders, medication administration, and missed/refused doses; (b) administer medications to ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; (e) monitor for adverse side effects; (f) obtain prescription medications and refills in a timely manner; (g) ensure medications are securely stored; and (h) discontinue and dispose of medications. Additionally: The licensee will provide training to all managers and resident care staff on the corrective actions taken to resolve each deficient practice identified in Statement of Deficiency Q1UN12. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content." On 09/09/2025, Surveyors conducted a verification visit and 3 complaint investigations. During the survey, Surveyors identified 26 deficiencies, 18 of which were repeat deficiencies. Concerns identified included the following: Administrative: - The provider did not report 5 of 6 occurrences when law enforcement was called to the facility for the health, safety or welfare of residents or employees. - The provider did not notify the department of a change in administrator within 7 days. - The provider did not ensure a qualified care staff was present at the facility at all times. *Repeat	{N 196}		

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{N 196}	Continued From page 9 concern and identified to be addressed in Special Orders. Environment: - The provider did not ensure a safe, clean, comfortable and homelike environment was provided. *Repeat concern. - The provider did not ensure 2 of 2 dryer vents were made of rigid material. *Repeat concern. - The provider did not ensure cleaning compounds were stored secured. *Repeat concern. - The provider did not ensure the facility was able to maintain a comfortable temperature in Resident 1's room. *Repeat concern. - The provider did not ensure exits were not obstructed. Employees: - The provider did not ensure a complete background check was completed for 2 of 4 caregivers reviewed. *Repeat concern. - The provider did not ensure 3 of 4 caregivers were screened for communicable disease, including tuberculosis, within 90 days prior to the start of providing care. *Repeat concern. - The provider did not ensure 2 caregivers received training or met an exemption for department-approved training courses. *Repeat concern. Resident Care: - The provider did not ensure immediate steps were taken to ensure the safety of all residents following an allegation of abuse and the provider did not investigate the allegation. - The provider did not ensure a resident wase allowed to make decisions related to activities and daily routines to enhance self-reliance and support autonomy.	{N 196}		

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{N 196}	Continued From page 10 - The provider did not ensure residents were safeguarded from hazardous conditions. Resident 13 displayed physical and verbal aggression toward residents and caregivers. - The provider did not ensure 2 of 4 residents and/or their legal representatives were involved with the development of individual service plans (ISP). *Repeat concern. - The provider did not ensure 2 of 3 ISPs reviewed were updated annually. *Repeat concern. - The provider did not ensure the rational for use and detailed description of behaviors indicating the need for administration of a PRN psychotropic was included in 2 of 2 ISPs reviewed for residents prescribed a PRN psychotropic medication. *Repeat concern. - The provider did not ensure a daily activity program was provided. *Repeat concern. - The provider did not ensure 2 of 2 residents reviewed that received medications with parameters had their health monitored and documented in their record. *Repeat concern. - The provider did not ensure medication administration services were provided to meet the needs of residents. *Repeat concern and identified to be addressed in Special Orders. - The provider did not ensure services to manage a resident's behaviors were provided. - The provider did not ensure an adequate supply of food was provided to residents. - The provider did not ensure food was stored and prepared in a sanitary manner. *Repeat concern. - The provider did not ensure a weekly menu was posted and followed. *Repeat concern. On 09/09/2025 at 12:10 p.m., Surveyor interviewed Resident 14. Resident 14, who is	{N 196}		

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{N 196}	Continued From page 11 his/her own decision maker, noted that s/he has lived at the provider's facility for over 4 years and that things have gotten worse in the last few months, since the current management company has taken over. Resident 14 stated, "I don't think of this as my home anymore. They do whatever they want with us and our things, it's their home and their rooms." On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concerns identified during the verification visit and complaint investigations. Administrator M made note of Surveyors' concerns and stated several of the concerns were being addressed. Administrator M stated change in administration affected some of the identified concerns. Consultant N stated s/he had recently started working with the provider to address concerns. Throughout the survey neither the licensee, nor the licensee of the management company currently working with the provider participated in the survey process. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0348 DHS 83.32(3)(d) Right of Residents:	{N 196}		

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{N 196}	Continued From page 12 Freedom from Mistreatment N0355 DHS 83.32(3)(k) Rights Of Residents: Self-Determination N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0455 DHS 83.41(1)(a) Food Supply N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0509 DHS 83.46(2)(a) Ventilation N0637 DHS 83.59(1) Proper Exit Locations, Sidewalks, Driveways	{N 196}		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the department was notified of their change in administrator within 7 days. The provider did not notify the department when Administrator M began as administrator.	N 200		

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N 200	Continued From page 13 Findings include: On 09/09/2025, Surveyors conducted 3 complaint investigations and a verification visit. On 09/09/2025 at 9:40 a.m., Surveyor interviewed Administrator M and shared that department records indicated a different individual was administrator of the facility. Administrator M stated s/he had been the administrator since 08/01/2025. Surveyor requested documentation of the provider's notification to the department informing the department that Administrator M was the administrator effective 08/01/2025. On 09/08/2025 at approximately 1:00 p.m., Administrator M provided Surveyor with documentation of an email, dated 07/27/2025, informing the department that Consultant D was the administrator effective 07/22/2025. On 09/09/2025 at 3:00 p.m., Surveyor shared concern with Administrator M that documentation provided did not indicate that the provider updated the department regarding Administrator M becoming administrator on 08/01/2025. Administrator M replied, "I know."	N 200		
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	N 214		

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	0018519	A. BUILDING: _____ B. WING _____	R-C 09/15/2025

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N 214	Continued From page 14 treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review and interview, Administrator M did not supervise the daily operation of the CBRF to ensure that residents received proper care and treatment, that their health and safety were protected and that their rights were respected. Findings include: On 09/09/2025, Surveyors conducted 3 complaint investigations and a verification visit. On 09/09/2025 at 9:40 a.m., Surveyor met with Administrator M. Administrator M stated s/he had been the administrator of the facility since 08/01/2025. Administrator M stated s/he was present at the facility approximately 2 days per week, but that House Manager K was present daily. On 09/09/2025 at 9:05 a.m., Surveyor interviewed Resident 1. Resident 1 voiced concerns with the facility, particularly food supply maintenance concerns, medication availability and lack of services. Resident 1 stated there was a change in management and s/he wasn't sure who the current administrator was. On 09/09/2025 at 12:10 p.m., Surveyor interviewed Resident 14. Resident 14 stated s/he doesn't know who is in charge anymore, "There's been 4 different bosses in 4 months, what does	N 214		

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N 214	Continued From page 15 that tell you." On 09/09/2025 at 1:30 p.m., Surveyor interviewed Resident 3. Resident 3 stated s/he didn't know who the current administrator was. From 09/09/2025 at 9:40 a.m. to 3:00 p.m., Surveyors observed that Administrator M was having difficulty finding and providing Surveyors with documentation. Surveyors requested an employee list including dates of hires at 9:40 a.m. Surveyors were provided 3 different lists with caregivers and/or dates of hire missing. As of 1:00 p.m., Surveyors still did not have a complete list of employees with dates of hire. During the survey, Surveyors identified 26 deficiencies, 18 of which were repeat deficiencies. Two of 3 complaints were substantiated. Concerns identified included the following: Administrative: - The provider did not report 5 of 6 occurrences when law enforcement was called to the facility for the health, safety or welfare of residents or employees. - The provider did not notify the department of a change in administrator within 7 days. - The provider did not ensure a qualified care staff was present at the facility at all times. Environment: - The provider did not ensure a safe, clean, comfortable and homelike environment was provided. - The provider did not ensure 2 of 2 dryer vents were made of rigid material. - The provider did not ensure cleaning compounds were stored secured.	N 214		

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N 214	Continued From page 16 - The provider did not ensure the facility was able to maintain a comfortable temperature in Resident 1's room. - The provider did not ensure exits were not obstructed. Employees: - The provider did not ensure a complete background check was completed for 2 of 4 caregivers reviewed. - The provider did not ensure 3 of 4 caregivers were screened for communicable disease, including tuberculosis, within 90 days prior to the start of providing care. - The provider did not ensure 2 caregivers received training or met an exemption for department-approved training courses. Resident Care: - The provider did not ensure immediate steps were taken to ensure the safety of all residents following an allegation of abuse and the provider did not investigate the allegation. - The provider did not ensure a resident wase allowed to make decisions related to activities and daily routines to enhance self-reliance and support autonomy. - The provider did not ensure residents were safeguarded from hazardous conditions. Resident 13 displayed physical and verbal aggression toward residents and caregivers. - The provider did not ensure 2 of 4 residents and/or their legal representatives were involved with the development of individual service plans (ISP). - The provider did not ensure 2 of 3 ISPs reviewed were updated annually. - The provider did not ensure the rational for use and detailed description of behaviors indicating the need for administration of a PRN psychotropic	N 214		

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N 214	Continued From page 17 was included in 2 of 2 ISPs reviewed for residents prescribed a PRN psychotropic medication. - The provider did not ensure a daily activity program was provided. - The provider did not ensure 2 of 2 residents reviewed that received medications with parameters had their health monitored and documented in their record. - The provider did not ensure medication administration services were provided to meet the needs of residents. - The provider did not ensure services to manage a resident's behaviors were provided. - The provider did not ensure an adequate supply of food was provided to residents. - The provider did not ensure food was stored and prepared in a sanitary manner. - The provider did not ensure a weekly menu was posted and followed. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concerns regarding administrative tasks, environmental concerns, employee-related concerns and resident care concerns. Administrator M made note of Surveyors' concerns. Administrator M stated the provider had explored contractor options for environmental concerns. Administrator M stated the previous administrator deleted records that affected his/her ability to provide Surveyors' with requests. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change N0219 DHS 83.17(1) Licensee Conduct	N 214		

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N 214	Continued From page 18 Caregiver Background Check N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0348 DHS 83.32(3)(d) Right of Residents: Freedom from Mistreatment N0355 DHS 83.32(3)(k) Rights Of Residents: Self-Determination N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0455 DHS 83.41(1)(a) Food Supply N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0509 DHS 83.46(2)(a) Ventilation N0637 DHS 83.59(1) Proper Exit Locations, Sidewalks, Driveways	N 214		
{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	{N 219}		

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{N 219}	Continued From page 19 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 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 2 of 4 caregivers reviewed had completed background checks at the time of hire. The provider did not have completed background checks for Caregiver O or Caregiver P. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. 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).	{N 219}		

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{N 219}	Continued From page 20 On 09/09/2025 at approximately 1:00 p.m., Surveyors requested the background checks of 4 caregivers, included Caregiver O and Caregiver P. On 09/09/2025 at approximately 1:55 p.m., House Manager K stated s/he was unable to provide documentation of background checks for Caregiver O and Caregiver P because the caregivers were hired under a previous administrator and House Manager K was unable to locate any records. On 09/09/2025 at 3:00 p.m., Surveyor reviewed concern with Administrator M, House Manager K, House Manager L and Consultant N that the provider did not have background checks for Caregiver O and Caregiver P. Administrator N confirmed s/he did not have any documentation of background checks to provide Surveyor.	{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.	{N 220}		

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{N 220}	Continued From page 21 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 caregivers reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Caregiver O, Caregiver Q and Caregiver R did not have tuberculosis tests completed within 90 days before the start of employment. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 1:00 p.m., Surveyor requested the communicable disease screens, including tuberculosis test, from House Manager K and House Manager L, for the following individuals: - Caregiver O, hired 07/02/2025 - Caregiver Q, hired 05/30/2025 - Caregiver R, hired 08/11/2025 On 09/09/2025 at approximately 2:00 p.m., House Manager K and House Manager L stated they did not have physical copies of tuberculosis tests for Caregiver O, Caregiver Q or Caregiver M, but Administrator M was checking clinic records. On 09/09/20205 at 3:00 p.m., Administrator M confirmed s/he was unable to locate communicable disease screens, including tuberculosis tests for Caregiver O, Caregiver Q or Caregiver M.	{N 220}		

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{N 239}	Continued From page 22	{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 Caregiver H received training in fire safety within 90 days after starting employment or met an exemption and did not ensure Caregiver H and Caregiver J received training in first aid and choking within 90 days of starting employment or met an exemption. Repeat deficiency from statement of deficiency	{N 239}		

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{N 239}	Continued From page 23 (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 11:45 a.m., Surveyor reviewed the employee records of Caregiver H, and Caregiver J. Records indicated the following: Fire Safety - Caregiver J was hired on 02/27/2025. Caregiver J's record did not include documentation of training in fire safety or an exemption for fire safety. On 09/09/2025 at approximately 12:00 p.m., Surveyor checked the WI CBRF Registry and was unable to locate documentation indicating Caregiver J had received training in fire safety. First Aid and Choking - Caregiver J was hired on 02/27/2025. Caregiver J's record did not include documentation of training in first aid and choking or an exemption for first aid and choking. - Caregiver H was hired on 04/09/2025. Caregiver H's record did not include documentation of training in first aid and choking or an exemption for first aid and choking. On 09/09/2025 at approximately 12:00 p.m., Surveyor checked the WI CBRF Registry and was unable to locate documentation indicating Caregiver H had received training in first aid and choking or that Caregiver J had received training in first aid and choking. On 09/09/2025 at approximately 3:00 p.m., Surveyor reviewed concerns with Consultant N, Administrator M, House Manager J and House Manager H. Administrator M stated that was the	{N 239}		

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{N 239}	Continued From page 24 previous administrator's responsibility.	{N 239}		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 14 was free from physical mistreatment. On 08/21/2025, Resident 13 hit Resident 14 in the dining room. Findings include: On 09/09/2025, Surveyors conducted a verification visit and 3 complaint investigations. The provider was licensed on 06/01/2022 as a class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 20 residents within the client groups of advanced age, terminally ill, and irreversible dementia/Alzheimer's. Surveyor reviewed the record of Resident 14. Resident 14 was admitted to the provider's facility on 02/25/2021 with diagnoses including multiple sclerosis, depression, and dementia. Resident 14	N 348		

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N 348	Continued From page 25 is his/her own decision maker. At 12:10 p.m., Surveyor interviewed Resident 14. Surveyor asked Resident 14 if s/he felt safe at the facility. Resident 14 shouted, "[expletive] no, I'm not safe here!" Resident 14 stated that s/he does not go down to the dining room for meals anymore because of Resident 13. Resident 14 stated that during a meal, Resident 13 wheeled over to Resident 14's table, demanded the ketchup, and then banged on his/her arm. S/he stated that a caregiver came over and pulled Resident 13 back, away from Resident 14, and then Resident 13 hit the caregiver so many times that s/he couldn't believe it. Resident 14 stated that s/he called the police because it was battery, and the police issued Resident 13 a $250 fine. Resident 14 stated, "That [wo/man] doesn't belong here, [s/he] should have been gone a long time ago!" Surveyor asked what was done to ensure his/her safety at meals and around Resident 13. Resident 14 stated, "Nothing! The staff holler at [him/her] but that's it." Resident 14 stated that Resident 13 continues to go on like that, and staff don't do anything, so s/he eats in his/her room. Resident 14 stated it doesn't feel like his/her home anymore. At approximately 1:30 p.m., Surveyor interviewed House Manager K and asked if s/he was aware of Resident 13 hitting Resident 14. House Manager K stated yes, and that Resident 13 continues to be rude to Resident 14, so now Resident 14 doesn't come down to meals because s/he is afraid to get hit. At approximately 2:25 p.m., Administrator M provided Surveyor with a police report, dated 08/21/2025, documenting that Resident 13 was charged with battery after hitting Resident 14 in	N 348		

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N 348	Continued From page 26 the dining room. S/he also provided documentation of Resident 13's involuntary discharge notice. Surveyor asked what interventions were in place to keep residents and staff safe while s/he was still here. Administrator M stated that staff try to redirect Resident 13 and reiterated that the provider has issued Resident 13 a 30 day involuntary discharge notice. Cross Reference N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0397 DHS 83.36(1)(b) Qualified Staff in Charge, Awake and On Duty N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0433 DHS 83.38(1)(i) Behavior Management	N 348		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 14 was allowed to make decisions related to activities and daily routines to enhance self-reliance and support his/her autonomy and decision making. Findings include:	N 355		

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N 355	Continued From page 27 On 09/09/2025, Surveyor reviewed the record of Resident 14. Resident 14 was admitted to the provider's facility on 02/25/2021 with diagnoses including multiple sclerosis, depression, and dementia. Resident 14 is his/her own decision maker. At 12:10 p.m., Surveyor interviewed Resident 14 and asked if s/he felt safe at the facility. Resident 14 shouted, "[expletive] no, I'm not safe here!" Resident 14 stated on Saturday s/he went to church and when s/he got back to his/her room, everything was moved out. Resident 14 stated that no one told him/her they would be in his/her room and did not consent for anyone to go in and move his/her belonging. Resident 14 stated, "I was crying, they hurt me so bad!" Resident 14 stated s/he asked the staff where his/her belongings were, and that the caregiver told him/her that they don't know where his/her stuff is, that only the boss has keys, and s/he wasn't going to be back for a while. Resident 14 stated that when the boss got back s/he opened the door to a room next door and Resident 14's stuff was locked in there. Surveyor noted that Resident 14 had a lot of items in his/her room and asked if his/her personal possessions had been returned. Resident 14 stated yes, but not the way they should have been. Resident 14 pointed to his/her closet and stated the staff shoved everything on the top shelf of the closet, so s/he cannot reach it. Resident 14 pointed at a small, wooden chair with a broken back. S/he stated that the chair was an antique from his/her family and that they broke it while moving things, "They came in without permission and started moving things around." Resident 14 stated they were reckless, and s/he does not know why they would do this to him/her. Resident 14 stated that s/he is nervous to find a glass doll that was meaningful to him/her	N 355		

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N 355	Continued From page 28	N 355		

because s/he is afraid they broke it. S/he stated that s/he doesn't believe anything the caregivers say anymore and that s/he cannot trust them. Surveyor asked if Resident 14 locks his/her door to safeguard his/her personal belongings. Resident 14 stated, "I lock my door, but it doesn't matter because they have a key and come in whenever they want. I don't think it's my home anymore, it's theirs, even this room." Resident 14 stated that they moved his/her calendar when they moved things around. Resident 14 could not find his/her calendar, so s/he missed his/her cardiology appointment and had to reschedule it. Resident 14 stated they moved everything, that s/he is now missing parts for his/her sewing machine, a box of silverware is gone, the cotton balls s/he uses between his/her toes are gone. Towels were stuffed under a nightstand and on the floor. Resident 14 was crying and reiterated, "They just want to hurt me."

At approximately 3:00 p.m., Surveyor reviewed concerns with Consultant N, Administrator M, House Manager K and House Manager L. Surveyor asked if anyone was aware of staff going into Resident 14's room and moving his/her belongings. House Manager K stated yes, and that s/he was the one who cleaned out Resident 14's room. House Manager K stated that Resident 14 collects things and there was a lot in his/her room. Surveyor asked House Manager K if s/he asked for Resident 14's permission to go into his/her room or notified Resident 14 that they would be cleaning his/her room when out. House Manager K stated no. Surveyor asked if House Manager K was aware that some of Resident 14's belongings were placed out of his/her reach, like on the top shelf of a closet. House Manager K stated yes, and that s/he understands the concern.

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N 355	Continued From page 29 Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 355		
{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: Based on record review and interview, the provider did not ensure 2 of 4 residents reviewed had the resident and the resident's legal representative, as appropriate, involved in the development of the individual service plan (ISP) and had the ISP signed to acknowledge their involvement, understanding and agreement with the plan. Resident 15's ISP was not signed by him/her	{N 387}		

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{N 387}	Continued From page 30 when s/he was his/her own decision maker. Resident 3's ISP was not signed by his/her legal guardian. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023 and SOD Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: - Resident 15 was admitted to the provider's facility on 07/21/2025. Resident 15 was his/her own decision maker. Resident 15's ISP, dated 07/23/2025, was not signed by him/her. - Resident 3 was admitted to the provider's facility on 03/03/2025. Resident 3 had a legal guardian. Resident 3's ISP, dated 05/13/2025, was signed by him/her, but was not signed by Resident 3's legal guardian. On 09/09/2025 at 1:00 p.m., Surveyor discussed concern with House Manager K that resident ISPs were not signed by the legal decision maker to acknowledge their involvement, understanding and agreement with the plan. House Manager K stated s/he was still working on updating all ISPs since recently taking over operations in the facility.	{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	{N 389}		

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{N 389}	Continued From page 31 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 record review and interview, the provider did not ensure 2 of 3 individual service plans (ISP) reviewed were updated annually. Resident 9 and Resident 2's ISPs had not been updated in greater than 1 year. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023 and SOD Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 9: Resident 9 admitted to the provider's facility on 11/15/2022. Resident 9's ISP was last signed by him/her on 08/30/2024, indicating the ISP had not been reviewed by Resident 9 in greater than 1 year. Example 2 - Resident 2:	{N 389}		

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{N 389}	Continued From page 32 Resident 2 admitted to the provider's facility on 03/05/2021. Resident 2's ISP was last signed by him/her on 08/30/2024, indicating the ISP had not been reviewed by Resident 2 in greater than 1 year. On 09/09/2025 at 1:00 p.m., Surveyor interviewed House Manager K. Surveyor discussed concern that resident ISPs had not been updated in greater than 1 year. House Manager K stated s/he was still working on updating all ISPs since recently taking over operations in the facility.	{N 389}		
{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.	{N 397}		

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{N 397}	Continued From page 33 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. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at approximately 1:00 p.m., Surveyors reviewed employee records and identified the following: - Caregiver H, hired 04/09/2025, had not received training or had an exemption for first aid and choking. - Caregiver J, hired on 02/27/2025 had not received training or had an exemption in first aid and choking or fire safety. - Caregiver F, hired 08/11/2025, did not complete fire safety until 09/05/2025 and first aid and choking until 09/08/2025. Caregiver F did not have training in medication administration. 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. The staff schedule, dated 08/21/2025 to 09/09/2025, identified the following concerns: - Caregiver J and Caregiver F, neither of whom were fully trained, were the only caregivers present on 08/23/2025 from 7:00 a.m. to 7:00 p.m. Caregiver F, who did not have training in	{N 397}		

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{N 397}	Continued From page 34 medication administration, was then the other only caregiver present from 7:00 p.m. to 11:00 p.m. - Caregiver J, who was not fully trained, was the only caregiver present from 7:00 a.m. to 10:00 a.m. on 08/30/2025. Caregiver H and Caregiver J, neither of whom were fully trained, were then the only caregivers present from 10:00 a.m. to 3:00 p.m. On 09/09/2025 at approximately 2:00 p.m., Surveyor interviewed Caregiver J and asked if s/he had ever worked alone. Caregiver J replied, yes, that s/he worked third shift as the only staff member and s/he would never do that again. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concern that the provider had occurrences when the facility was staffed without a qualified staff member. Administrator M wrote down Surveyors' concern, but did not comment. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{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 administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use	{N 408}		

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{N 408}	Continued From page 35 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 2 of 2 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 and Resident 9's use of Hydroxyzine was not included in his/her ISP and the effectiveness was not always documented when administered. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 4: Resident 4 was admitted to the provider's facility on 12/26/2024. Resident 4 was hospitalized on 08/26/2025 and had yet to return to the facility.	{N 408}		

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{N 408}	Continued From page 36 Resident 4's physician orders included Hydroxyzine Hcl 25 mg (Start Date: 08/06/2025) - Take 1 tablet every 6 hours as needed for anxiety and insomnia. The Medication Administration Record (MAR), dated 08/21/2025 to 08/26/2025, documented 12 administrations of Resident 4's Hydroxyzine PRN. Resident 4's current ISP (not signed and dated) 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 3 administrations did not document the effectiveness. Example 2 - Resident 9: Resident 9 admitted to the provider's facility on 11/15/2022. Resident 9's physician orders included Hydroxyzine Hcl 25 mg (Start Date: 08/03/2025) - Take 1 tablet every 6 hours as needed for anxiety. The MAR, dated 08/21/2025 to 09/09/2025, did not document administration of Hydroxyzine PRN. Resident 9's ISP, dated 08/30/2024, did not include the rational for use and a detailed description of behaviors indicating the need for administration of the Hydroxyzine. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concern that Resident 4 and Resident 9's ISPs did not include their PRN psychotropic use. House Manager K stated s/he was still working on updating all the ISPs.	{N 408}		
{N 427}	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	{N 427}		

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{N 427}	Continued From page 37 resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure a daily activity program was provided to meet the interests and capabilities of residents. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 9:00 a.m., Surveyor toured the provider's facility. Surveyor was unable to locate an activity schedule or calendar. On 09/09/2025 at 9:05 a.m., Surveyor interviewed Resident 1. Surveyor asked if the provider had been offering a daily activity program. Resident 1 stated there had no been any activities since a change in management months ago. On 09/09/2025 at 9:30 a.m., Surveyor interviewed Resident 7. Surveyor asked if the provider had been offering a daily activity program. Resident 7 replied, "No. They quit doing that when [Resident	{N 427}		

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{N 427}	Continued From page 38 13] came. [Resident 13] is too obnoxious." Surveyor then reviewed records, which indicated Resident 13 was admitted to the provider's facility on 11/20/2024. Resident 7 stated s/he spent his/her day sleeping or doing puzzles. From 8:45 a.m. to 3:00 p.m., Surveyors did not observe residents engaged in any sort of activity. Residents were observed sleeping and/or watching television in their rooms. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L. Surveyors shared concern that they were unable to locate a posting of activities and did not observe residents engaged in any sort of activity programing. Administrator M confirmed Surveyors' observations and stated the provider was aware of the issue and looking to hire activity staff.	{N 427}		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N	N 431		

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N 431	Continued From page 39 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of 2 of 2 residents that received medications with parameters had their health monitored and documented in their record. Resident 4's blood pressure was not documented 2 times daily when his/her Furosemide was administered. Resident 16's weight was not documented daily when his/her Furosemide was administered and his/her blood pressure was not recorded 2 times daily when his/her Metoprolol was administered. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023. Findings include: Example 1 - Resident 4: Resident 4 was admitted to the provider's facility on 12/26/2024. Resident 4 was hospitalized on 08/26/2025 and had yet to return to the facility. Resident 4's physician orders included Furosemide 60 mg (Start Date: 07/10/2025) - Take 2 times daily; hold if systolic blood pressure is <100. Resident 4's record, dated 08/21/2025 to	N 431		

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N 431	Continued From page 40 08/26/2025, documented Resident 4 was administered Furosemide but did not include a blood pressure reading for the following dates: 08/21/2025 PM, 08/22/2025 AM or PM or 08/25/2025 AM. Example 2 - Resident 16: Resident 16 was admitted to the provider's facility on 10/06/2023. Resident 16's physician orders included Furosemide 40 mg (Start Date: 09/02/2025) - Take 1 tablet daily; contact physician for weight gain >5 lbs within 24 hours. Resident 16's record did not document a weight on 09/04/2025 or 09/05/2025. Resident 16's physician orders included Metoprolol Tartrate 12.5 mg (Start Date: 08/22/2025) - Take 2 times daily; hold for heart rate less than 60 and systolic blood pressure less than 110. Resident 16's record did not document blood pressure and heart rate readings for 08/28/2025 PM or 08/29/2025 PM. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concern that the provider did not have documentation of vitals for medications with parameters. Surveyor asked if anyone at the facility was responsible for auditing or ensuring medication parameters were followed. Consultant N stated s/he was working on medication management.	N 431		
{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	{N 432}		

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{N 432}	Continued From page 41 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, record review, and interview, the provider did not ensure medication administration was provided to meet the needs of 4 of 5 residents reviewed. Resident 1 did not receive his/her Guaifenesin ER 600 mg, Iprat-Albuterol .5-3(2.5)Mg/3 ml or Oyster Shell Calcium 500 mg due to unavailability. Resident 9 did not receive his/her Tab-A-Vite Multivitamin with Iron due to unavailability. Resident 13 did not receive his/her Calcium 600-vit D3 10 mcg, Magnesium oxide 400 mg, Fish oil 1,000 mg, Minoxidil 2% solution, and Vitamin C 250mg due to unavailability. Resident 14 did not receive his/her Azelastine HCL 137 mcg, Triamcinolone acetonide 0.1%, or Centrum adult multivitamin due to unavailability. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 10:00 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 1:	{N 432}		

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{N 432}	Continued From page 42 Resident 1 was admitted to the provider's facility on 10/19/2022. Resident 1's ISP, dated 08/29/2025, indicated the provider's staff managed Resident 1's medication administration. Resident 1's Medication Administration Record (MAR), dated 08/21/2025 to 09/09/2025, identified the following concerns with medication administration: - Guaifenesin ER 600 mg tablet (Start Date: 07/21/2025) for cough/chronic obstructive pulmonary disease) - Take 1 tablet twice daily was documented as unavailable 32 times. - Iprat-Albuterol .5-3(2.5)Mg/3 ml (Start Date: 07/21/2025) for chronic respiratory failure) - Nebulize 1 vial 3 times daily was documented as unavailable 14 times. - Oyster Shell Calcium 500 mg (Start Date: 07/21/2025) - Take 1 tablet twice daily was documented as unavailable 37 times. Example 2 - Resident 9: Resident 9 was admitted to the provider's facility on 11/15/2022. Resident 9's ISP, dated 08/30/2024, indicated the provider's staff managed Resident 9's medication administration. Resident 9's MAR, dated 08/21/2025 to 09/09/2025, documented Tab-A-Vite Multivitamin with Iron (Start Date: 07/21/2025) - Take 1 tablet daily for anemia was unavailable 16 times. Example 3 - Resident 13 Resident 13 was admitted to the provider's facility on 11/20/2024. Resident 9's ISP, no date identified, indicated the provider's staff managed Resident 13's medication administration. Resident 13's MAR, dated 08/21/2025 to 09/09/2025, identified the following concerns with	{N 432}		

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{N 432}	Continued From page 43 medication administration: -Minoxidil 2% solution (Start date: 07/21/2025) - Apply (1) Ml to the scalp twice daily. **staff to assist with application** was unavailable 37 time. -Calcium 600-vit D3 10 mcg (Start date: 07/21/2025) - Take (1) table twice daily was unavailable 35 times. -Magnesium oxide 400 mg (Start date: 07/21/2025) - Take (1) tablet twice daily was unavailable 37 times. -Fish oil 1,000 mg (Start date: 07/21/2025) - Take (1) capsule once daily was unavailable 19 times. -Vitamin C 250 mg tablet chew (Start date: 07/21/2025 - Chew & swallow (1) tablet twice daily was unavailable 33 times. Example 4 - Resident 14 Resident 14 was admitted to the provider's facility on 02/25/2021. Resident 14's ISP, dated 11/05/2024, indicated the provider's staff managed Resident 14's medication administration. Resident 14's MAR, dated 09/01/2025 to 09/09/2025, identified the following concerns with medication administration: -Azelastine HCL 137 mcg - twice daily was unavailable 10 times. -Triamcinolone acetonide 0.1% - twice daily was unavailable 10 times. -Centrum adult multivitamin liq was unavailable 8 times. At 2:24 p.m., Surveyor observed the medication cart with Caregiver J. Surveyor observed that not all medications listed on resident's MARs were in the medication cart. Caregiver J confirmed that Residents 1, 9, 13 and 14 had medications that were unavailable for administration. On 09/09/2025 at 2:38 p.m., Surveyors interviewed Consultant N, who stated s/he had	{N 432}		

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{N 432}	Continued From page 44 just started working with the provider mid-August. Consultant N stated s/he was aware residents were not receiving medications as prescribed because Consultant D and Nurse Consultant T, who had been assisting the facility prior to Consultant N, had identified the issue. Consultant N stated s/he was unsure of what steps Consultant D and Nurse Consultant T had done to ensure medication was available for residents, but stated some of the medication unavailability was due to insurance issues and some were due to needing a refill order. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 432}		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not provide services to manage the behaviors Resident 13. Resident 13 exhibited behaviors, affecting caregivers and residents, with no documented assessments or interventions to manage his/her behaviors. Findings include:	N 433		

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N 433	Continued From page 45 On 09/03/2025, the department received a complaint alleging concerns with the dosages of psychotropic medications. On 09/09/2025, Surveyors conducted a verification visit and 3 complaint investigations. The provider was licensed on 06/01/2022 as a class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 20 residents within the client groups of advanced age, terminally ill, and irreversible dementia/Alzheimer's. At 8:51 a.m., Surveyor observed Resident 13 shouting in the dining room. Surveyor asked Resident 13 how s/he was doing and Resident 13 replied that s/he was terrible. That the service is lousy, and the employees are terrible. Resident 13 stated that the caregivers are late to work, if they show up at all, and they're lazy. Surveyor observed Resident 13 yell derogatory comments to the staff in the kitchen until s/he left the dining room at 9:01 a.m. At 8:55 a.m., Surveyor interviewed Resident 7. Resident 7 stated not to listen to what Resident 13 says. Resident 7 stated that Resident 13 will start stuff with everyone. S/he stated that Resident 13 will sit and yell at residents and staff alike all day long. Resident 7 stated, "[Resident 13] doesn't belong here." At 11:21 a.m., Administrator M provided Surveyor with Resident 13's record and stated that Resident 13 was issued a 30 day notice, that s/he appealed it, but that was overturned so they are moving forward with an involuntary discharge. Resident 13 was admitted to the provider on	N 433		

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N 433	Continued From page 46 11/20/2024 with diagnoses including schizoaffective disorder, bipolar type. Surveyor reviewed Resident 13's incident reports which documented: - 07/27/2025, Resident 13 called the police to report that a resident assistant had threatened him/her, alleging that the resident assistant told Resident 13, "your days are numbered." - 07/31/2025, Resident 13 called the police to report s/he had missing mail. - 08/08/2025, "Resident was yelling at staff and causing a disturbance in the dining room. Staff asked resident to please go [to his/her] room if [s/he] continued to yell and be disruptive. Resident would not leave the area. Staff attempted to push resident in [his/her] wheelchair to [his/her] room, and [s/he] swung [his/her] fist back and hit staff in [his/her] chest area twice." -08/17/2025, "Resident asked why I took the keys to the med cart home with me. [S/he] couldn't understand how it was an honest mistake. Resident stated you should have left them here instead of running my fat [expletive] home to feed my fat [expletive] [family member]. The cook asked the resident to leave the area and go to [his/her] room, due to being so rude to staff. Then resident began to wing and punch at me. The resident came out of [his/her] room and accused me of unplugging [his/her] tv and phone and began wheeling towards me with a butter knife. I asked the resident to stop lunging the knife at me. Resident then began swinging the butter knife even harder and closer at me until another staff snatched the butter knife away from [him/her]." -08/20/2025, "Resident was saying inappropriate and hurtful words to staff member and other residents while finishing up a snack in the dining	N 433		

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room. Resident stated, 'Where are my meds you lazy [racial slur], and why are you taking so long? You are just a big, lazy, piece of [expletive]." Staff replied to resident by trying to redirect [him/her] to [his/her] room, as [s/he] had to administer [his/her] meds in [his/her] room, not out in the dining room. Staff brought resident back to [his/her] room as resident yelled at anyone that [s/he] passed on [his/her] way back to [his/her] room, "[expletive] you." Staff tried to calm resident down but had no success.
-08/21/2025, "Resident was upset due to having[sic] not having ketchup on [his/her] table. Resident went to another table and tried to take the ketchup from another resident. While resident was using the ketchup [s/he] got upset and hit the resident that was sitting at the table and using the ketchup. When staff tried to intervene, resident started hitting staff."
-08/22/2025, "While preparing lunch for the residents, one resident began loudly berating another over ketchup. The staff assured the resident that ketchup would be provided for [his/her] table. Upon turning around, I witnessed [Resident 13] attacking [Resident 14]. I quickly intervened to address the inappropriate behavior, separating the aggressor from the victim. Subsequently, [Resident 13] initiated physical assault against me, accompanying the aggression with verbal abuse."

Surveyor reviewed Resident 13's progress notes which documented:

- 07/29/2025, "Resident used another resident's cell phone to call emergency services/law enforcement for reasons unknown to writer...Staff from previous shift relayed to writer that this behavior was ongoing throughout the day."
- 08/20/2025, "Resident called 911 and made a

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N 433	Continued From page 48 claim that [Caregiver G] punched [him/her] in [his/her] back while pushing [him/her] back to [his/her] room. Resident also threatened staff with a butter knife. When asking resident when did the incident happen, [s/he] said it happened while finishing dinner and a snack. I asked [Resident 13] did anyone witness this happening, and [s/he] said no that [s/he] was in the dining area alone. [Resident 13] has also made several threats towards [Caregiver G] and other residents that [s/he] is going to tab [him/her] when [s/he] gets the chance. When checking [Resident 13's] blood sugar, as two workers are needed for this process, [s/he] continued using bad language toward [Caregiver G] calling [him/her] racial slurs and many other names." - 08/23/2025, "Staff were in the process of serving lunch to the residents when [Resident 13] began to behave disruptively, hurling insults at the staff members...agitated [Resident 13] retreated to [his/her] room continuously insulting the staff with derogatory terms. Upon delivering [his/her] medication and ice cream to [his/her] room, the staff found the resident on a call with the police, falsely accusing the staff of withholding [his/her] medication..." - 08/25/2025, "30-day notice emailed to care team and hand delivered to resident." - 08/26/2025, "...Resident called staff [expletive] and insisted that staff was incompetent. Staff tried to defuse but resident got even more agitated and aggressive towards any staff member." - 08/27/2025, "[Resident 13's] case worker called today with concerns about the resident behavior [Resident 13] called [his/her] case worker today admitted [his/her] behavior with staff and resident [s/he] will like for staff to contact the local police department if [Resident 13] become[sic] violent again if [s/he] is need[sic] some typo[sic] of psych attention..."	N 433		

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- 08/28/2025, "The resident is picking with [Resident 14] [s/he] has [him/her] afraid to eat meals in the dining area because [s/he] does not want to be hit again."

At approximately 1:30 p.m., Surveyor interviewed House Manager K, who wrote the progress note from 08/28/2025. Surveyor asked if Resident 14 was hit again in the dining room by Resident 13 on 08/28. House Manager K stated no that Resident 13 continues to be rude to Resident 14, so now s/he doesn't come down to meals because s/he is afraid to get hit. Surveyor asked what behavioral interventions were in place for Resident 13. House Manager K stated none that Resident 13 still acts like that, but s/he was given a 30-day notice.

Resident 13's individual service plan (ISP), no date noted, documented:
- BEHAVIORS-ACTIVE BEHAVIORAL ISSUES (Behavior Patterns/Aggressive/Combative)
Resident's Needs/Preferences: [Resident 13] has some behaviors including verbally abusing to staff and raising [his/her] voice when staff is trying to calm [him/her] down.
*The behaviors section of the ISP had a line drawn through the entry with a black marker.
- COMMUNICATION SKILLS (Social Participation/Communication)
Resident's Needs/Preferences: [Resident 13] is independent with communicating needs/wants. [Resident 13] speaks English and is able to voice concerns.

The provider did not have documentation that Resident 13's behaviors were assessed and there was no documentation of identified program services, frequency and approaches the CBRF would provide to manage Resident 13's behaviors

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N 433	Continued From page 50 that were harmful to themselves and others. Cross Reference N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0205 DHS 83.14(2)(i) Not Permit A Condition of Substantial Risk	N 433		
N 445	83.41(1)(a) Food supply. Food supply. 1. The CBRF shall maintain a food supply that is adequate to meet the needs of the residents. 2. Food shall be obtained from acceptable sources. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a food supply adequate to meet the needs of residents was maintained. Findings include: On 09/09/2025 at 8:45 a.m., Surveyors arrived to the facility and observed residents eating cereal, potato chips and bagels in the provider's dining room. Surveyors did not observe any residents drinking milk. On 09/09/2025 at 8:51 a.m., Surveyor interviewed Resident 13, who was eating a bag of potato chips. Surveyor asked Resident 13 what was offered for breakfast. Resident 13 stated 1/2 a bagel. Resident 13 noted that s/he is a diabetic and stated that the provider had run out of food again so there was no protein and no fruit.	N 445		

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Resident 13 stated s/he had to go to his/her room to get food so for breakfast s/he is having cold baked beans and chips. Resident 13 asked Surveyor, "Does that sound right for an assisted living facility? I don't think so!"

On 09/09/2025 at 8:55 a.m., Surveyor interviewed Caregiver R. Caregiver R stated s/he didn't have the ingredients to prepare what was on the menu that morning. Caregiver R stated the facility did not have bacon, blueberries, milk or eggs. Caregiver R stated the facility was on their last gallon of milk the last day s/he worked, which was 4 days prior. Caregiver R stated it wasn't unusual for the facility to run out of ingredients. Surveyor checked the provider's refrigerator and confirmed there was no milk, eggs or bacon.

On 09/09/2025 at 9:05 a.m., Surveyor interviewed Resident 1. Resident 1 stated the facility frequently ran out of ingredients such as milk, bread and eggs. Resident 1 stated his/her breakfast that morning was a leftover bagel and fruit.

On 09/09/2025 at approximately 11:00 a.m., Surveyor observed an individual carry grocery into the facility. The individual stated s/he worked for a grocery delivery service and was delivering groceries that had just been ordered.

On 09/09/2025 at 12:10 p.m., Surveyor interviewed Resident 14, who was in his/her room instead of the dining room. Surveyor asked Resident 14 if s/he was going to eat the provider's lunch. Resident 14 stated no that s/he goes to Walmart to buy food since there is never any food here and the food that they do serve is so bad. Resident 14 stated that there is never any milk and pulled open the door to the mini refrigerator

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N 445	Continued From page 52 in his/her room, showing Surveyor, his/her own supply of milk stating that s/he needs milk. Resident 14 stated for meals the caregivers make whatever is available, which isn't much. On 09/09/2025 at 1:30 p.m., Surveyor interviewed Resident 2. Resident 2 stated the facility frequently ran out of food, particularly milk. Surveyor observed Resident 2 had a large stock of his/her own food in his/her room. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concern that observations and interview indicated the provider frequently ran out of food. Administrator M wrote down Surveyors' concern. None of the individuals present provided information as to who was responsible for food supply or why the facility ran out of food. Cross Reference: N0450 DHS 83.41(2)(c) Nutrition: Menus	N 445		
{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, record review and interview, the provider did not ensure a weekly	{N 450}		

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{N 450}	Continued From page 53 menu was made available to residents and that deviations from the menu were documented on the menu. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 8:45 a.m., Surveyors arrived to the facility and observed residents eating cereal, potato chips and bagels in the provider's dining room. On 09/09/2025 at 8:49 a.m., Surveyor observed a daily menu posted that listed blueberry pancakes, sausage, and peaches for breakfast. As Surveyor took note of the menu, Caregiver P informed Surveyor that menu was incorrect. Caregiver P stated "Someone wrote that on there with marker. Caregiver P then showed Surveyor a weekly menu behind the kitchen counter that listed blueberry waffles with syrup, bacon, and bananas for breakfast. Caregiver P stated there was no menu posted for residents. On 09/09/2025 at 8:55 a.m., Surveyor interviewed Caregiver R. Caregiver R stated s/he served bagels, cream cheese and cereal for breakfast. S/he stated some residents had turkey and cheese with their bagel. Caregiver R stated s/he didn't have the ingredients to prepare what was on the menu. Caregiver R stated the facility did not have bacon, blueberries, milk or eggs. Caregiver R stated it wasn't unusual for the facility to run out of ingredients. Surveyor checked the provider's refrigerator and confirmed there was no milk, eggs or bacon. On 09/09/2025 at 9:05 a.m., Surveyor interviewed	{N 450}		

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{N 450}	Continued From page 54 Resident 1. Resident 1 stated s/he never knew what s/he was being served for meals and caregivers didn't know either. Resident 1 stated his/her breakfast that morning was a leftover bagel and fruit. On 09/09/2025 at 12:10 p.m., Surveyor interviewed Resident 14, who was in his/her room rather than the provider's dining room for lunch. Surveyor asked Resident 14 if s/he was going to eat lunch. Resident 14 stated that s/he was going to Walmart to buy his/her own food and only eats the provider's food if s/he likes what is being served. Surveyor asked Resident 14 if s/he was aware what was for lunch. Resident 14 stated, "I have no idea, when the aids come up in the morning, they don't know either." Resident 14 stated that the caregivers make whatever is available, which isn't much. Cross Reference: N0455 DHS 83.41(1)(a) Food Supply	{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.	{N 452}		

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{N 452}	Continued From page 55	{N 452}		

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.

This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025.

Findings include:

On 09/09/2025 at 8:50 a.m., Surveyor toured the provider's kitchen and observed the following in the provider's refrigerator:

- A bowl of pear slices left open to air.
- A Ziploc bag containing a head of lettuce that was brown in color.
- 3 containers covered in aluminum foil with no label of what the items were or when they were from.
- A plastic container of rice that did not have a date.
- A plastic container of green beans that did not have a date.
- A plastic container of bread that did not have a date.

As Surveyor toured the remainder of the kitchen, Surveyor observed 4 drawers, containing cooking utensils, serving utensils, towels, cutting boards and cookware, contained dust and small food

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{N 452}	Continued From page 56 particles on the inside of the drawers. "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) On 09/09/2025 at 8:55 a.m., Surveyor interviewed Caregiver R, who stated s/he was responsible for cooking tasks and caregiving. Surveyor asked Caregiver R if s/he was aware of what the unlabeled food items were in the provider's refrigerator and when the unlabeled and open to air items were from. Caregiver R shook his/her head and said, "Nope. I haven't been here since [4 days prior]."	{N 452}		
{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. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025.	{N 481}		

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{N 481}	Continued From page 57 Findings include: On 09/09/2025 at 8:45 a.m., Surveyor toured the provider's facility and identified the following concerns: Dining Room: - The dining room wall had a scuff mark with an indentation which appears to be where a chair has been backed into it. Hallways: - Upon entrance there was 3 bags of garbage laying on the floor inside the front entrance of the facility. - Two sets of used blinds were propped up again the wall. - Hallway doors and walls had heavy, black scuff marks. - Hallway corners had broken and chipped off drywall. - The light outside of room 4 did not have a light bulb cover. - Ceiling and wall vents throughout the facility had a layer of dust on them. - Bag of garbage laying outside of Resident 1's room. - Discolored marks on the carpet outside of room #20. - Dark stains and frayed carpet outside of the elevator door on the second floor. Resident Rooms: - Resident 15's room had blue tape around the cabinet in the bathroom and around the baseboards. At 10:43 a.m., Surveyor asked	{N 481}		

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{N 481}	Continued From page 58 Resident 15 what all the tape was for. Resident 15 stated it has been here since s/he moved in and s/he supposed it was for painting. Surveyor asked if the provider has painted since s/he has moved in. Resident 15 stated no. Resident 15 had an admit date of 07/21/2025. - Resident bedroom and bathroom vents had a layer of dust on them. - Resident 7 and Resident 9's shared bathroom had a commode over the toilet that was missing the handrail on 1 side and a toilet paper holder missing 2 of 3 parts, leaving it unable to function as a toilet paper holder. Nurse Station: - 2 holes appear to have been broken into the door with force. There were scuff marks on the floor leading into the nurse station. At 2:21 p.m., Surveyor interviewed House Manager K and House Manager L, who were standing in the nurse station, what had happened to the door. House Manager K and House Manager L stated they were unsure and that the door has been like that for as long as they have both been at the facility. - Counter in the nurse station was broken and peeling on the edge of the counter. - The flooring was coming up and an approximate 2-foot patch was peeling away in the doorway from the nurse station to the medication room. - Discolored oval mark on the ceiling, approximately 2 feet. Sunroom: - The radiator cover was broken and coming off the wall. - There were several brown streak marks going down the walls between the windows.	{N 481}		

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{N 481}	Continued From page 59 - There was debris, cobwebs, and hair in the corners of the room. - There was a comforter sitting on a chair as well as a TV. At approximately 3:00 p.m., House Manager K stated that s/he believes that belonged to a resident who had passed away. - The windows and walls had water marks. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L. Surveyors shared the environmental concerns observed throughout the facility. When discussing water marks on the windows and walls in the sunroom, Surveyor asked if the leaks had been repaired that were identified during Surveyor's visit on 05/13/2025. Administrator M replied, "No." Administrator M stated the provider had been working on getting quotes from various contractors and was making a decision on who to have conduct repairs.	{N 481}		
{N 488}	83.44(1)(c) Clothes dryers enclosed and vented 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 2 of 2 dryers were vented with rigid material. Both dryer vents had semi-rigid venting.	{N 488}		

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{N 488}	Continued From page 60 This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025 at 9:00 a.m., Surveyor toured the provider's facility and observed 2 of 2 dryer vents were made with semi-rigid material. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L. Surveyor shared concern that 2 of 2 dryer vents were made of semi-rigid material rather than rigid material. Administrator M responded, "Hmm," and wrote down Surveyor's concern. House Manage K smiled and shook his/her head.	{N 488}		
{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. 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. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: The provider is licensed to serve up to 20 residents with diagnoses including advanced age, terminally ill and irreversible	{N 499}		

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{N 499}	Continued From page 61 dementia/Alzheimer's. On 09/09/2025 at 9:00 a.m., Surveyor toured the provider's facility and observed the laundry room door propped open with a bucket of detergent, leaving the following cleaning compounds accessible: - Arm and Hammer Laundry Detergent (Label: Causes serious eye irritation). - Clorox Disinfecting Spray (Label: HAZARDS TO HUMANS & DOMESTIC ANIMALS. WARNING: Causes substantial but temporary eye injury). - Lysol Power Clinging Gel (Label: Corrosive. Harmful if swallowed). - Mechanical Dish Detergent (Label: Keep out of reach of children). - Lo-Temp Sanitizer (Label: Danger ... If swallowed, call Poison Control Center). - Ultra Bleach (Label: Danger ... Keep out of reach of children). - Fabuloso Cleaner (Label: May irritate eyes ... Do not swallow). On 09/09/2025 at 9:02 a.m., Surveyor observed the provider's furnace room was unlocked and accessible, leaving the following cleaning compounds accessible: - Zep Carpet Spot - Zep Carpet Shampoo On 09/09/2025 at 11:33 a.m., Surveyor observed both rooms remained accessible. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L. Surveyor shared concern that cleaning compounds were left accessible to residents in the laundry room	{N 499}		

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{N 499}	Continued From page 62 and furnace room. Administration M and House Manager K stated they were constantly reminding staff to keep those rooms locked.	{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 Resident 1's room exceeded 74 degrees F. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025. Findings include: On 09/09/2025, Surveyor conducted a verification visit. On 09/09/2025 at 9:05 a.m., Surveyor interviewed Resident 1 and took the temperature of his/her room. The temperature outside was 59 degrees F and Surveyor observed the temperature in Resident 1's room was 75.9 degrees F. Resident 1 stated his/her room remained uncontrolled and was often too warm for his/her liking. Resident 1 stated s/he had slept with his/her door open the night prior to let cool air in from the hallway. Resident 1 stated s/he didn't like having the door open because s/he was a private person. On 09/09/2025 at 1:30 p.m., Surveyor followed up with Resident 1. Resident 1 had his/her door open in hopes of lowering the temperature in	{N 509}		

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{N 509}	Continued From page 63 his/her room. After having the door closed for approximately 5 minutes, Surveyor took the temperature of Resident 1's room. The temperature was 80.4 degrees F. The temperature outside was approximately 73 degrees F. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concern that Resident 1's room remained too warm for his/her preference and exceeded 74 degrees F. Administrator M stated the provider was exploring heating and ventilation issues.	{N 509}		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also	N 637		

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N 637	Continued From page 64 meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all exits were unobstructed. One of 2 exits from the 2nd floor of the facility was obstructed with resident belongings. Findings include: On 09/09/2025 at 9:13 a.m., Surveyor observed a desk and lamp in front of 1 of 2 exits on the 2nd floor of the facility. On 09/09/2025 at 3:00 p.m., Surveyors interviewed Administrator M, Consultant N, House Manager K and House Manager L and shared concern that 1 of 2 emergency exits were obstructed on the 2nd floor earlier in the morning. House Manager K acknowledged Surveyor's observation. House Manager K explained that the furniture belonged to Resident 1 and s/he had asked Resident 1 to move the furniture.	N 637		