STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	R 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE 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 07/28/2025, Surveyors conducted a verification visit and 2 complaint investigations at Raymond House. Seven (7) citations of noncompliance were issued. One (1) of 7 citations was a repeat citation of noncompliance from SOD #S5IW12. Two (2) of 2 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 8	{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 misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure immediate steps were taken to ensure the safety of all residents when there was a report of an allegation of abuse. The provider did not take action to safeguard Resident 2 when s/he reported allegations of mistreatment from Caregiver K. Findings include: From 07/28/2025 to 07/29/2025, Surveyors conducted 2 complaint investigations alleging mistreatment to residents from the provider's caregivers. The following concerns were identified: Example 1 - Resident 2: On 07/28/2025 at approximately 8:00 a.m., Surveyor reviewed reports from law enforcement that documented the following: - Report, dated 06/23/2025: Rescue services were dispatched to the facility because Resident 2 had fallen out of bed. The report documented that Resident 2 shared concern with rescue personnel and law enforcement that Caregiver K was physically and mentally abusive to him/her. Resident 2 reported that earlier that morning, Caregiver K had slammed his/her legs and wrists against the railing of his/her bed, causing pain, while changing Resident 2. Resident 2 also verbalized occurrences of Caregiver K cursing at Resident 2. The report documented Resident 2 was transferred to a local hospital for assessment. - Report, dated 06/25/2025: Law enforcement returned to the facility to interview Caregiver K,	N 158		

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N 158	Continued From page 2	N 158		

who denied any mistreatment to Resident 2. Caregiver K reported Resident 2 frequently yelled out during cares that s/he was being hurt and that s/he consistently had thoughts that everyone hated him/her. The report indicated a message was left for Administrator J to discuss abuse allegations.
- Report, dated 06/26/2025: Law enforcement received hospital records which indicated Resident 2 had a lunate fracture to his/her right wrist. The record indicated Administrator J contacted law enforcement via email at 11:31 p.m. stating, "Good Evening [Officer] - I can honestly say [Caregiver K] would never harm a resident. [Resident 2] is constantly making accusations about my staff and even myself. [S/he] will intentionally harm [him/herself] such as throwing [him/herself] out of [his/her] wheelchair, out of [his/her] bed, trying to strangle [him/herself] etc. I actually issued [him/her] a 30-day discharge notice yesterday due to [him/her] harming [him/herself] to the point [s/he] now has a small fracture in [his/her] wrist, and accusing staff of causing it. I've had to staff 2 staff all 3 shifts now for the staffs safety and protection as well as [Resident 2]'s. We also want [Resident 2] safe and unfortunately no matter what we do [s/he] is still intentionally harms [him/herself] for attention and then states [s/he]'s abused. I take all [his/her] accusations seriously and look into them but in the end it's untrue. I'm close to losing my staff as they fear the accusations will cost them their licenses or jobs and could potentially ruin their lives if someone not involved in the situation believed everything. In the end my goal is the safety of [Resident 2] and the safety of my staff as well. I will definitely assist in any way possible."

On 07/28/2025 at approximately 1:00 p.m., Surveyor reviewed Resident 2's record. Resident

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N 158	Continued From page 3 2 admitted to the provider's facility on 02/18/2025. Resident 2's individual service plan (ISP), dated 06/24/2025, documented that Resident 2 had a history of calling the police in attempt to achieve his/her own desires and a history of harming self. Resident 2's behavioral support plan (BSP), not dated, documented that Resident 2 had a history of being manipulative, refusing cares and making false accusations toward staff. Resident 2's progress notes, dated 06/01/2025 to 07/28/2025, documented the following: - 06/24/2025: Returned from the hospital due to throwing him/herself out of bed. X-rays reviewed and s/he does have a small fracture in his/her wrist. - 06/28/2025: Resident reported to agency staff that the provider's staff throws him/her against the wall and rails on his/her bed. One staff member in particular does it all the time. On 07/28/2025 at 1:15 p.m., Surveyor requested documentation of any investigations related to abuse allegations from Consultant E. On 07/28/2025 at 1:45 p.m., Surveyor interviewed Resident 2. Resident 2 reported that Caregiver K broke his/her wrist by rushing Resident 2 during cares and swinging Resident 2's legs and body over to change Resident 2, causing Resident 2's wrist to hit the bed rail and fracture from the momentum of the swinging. Resident 2 stated s/he reported his/her concerns to Administrator J and was now supposed to have 2 caregivers present for cares if Caregiver K was providing cares. Surveyor asked Resident 2 if Caregiver K ever worked alone. Resident 2 informed Surveyor there were occurrences Caregiver K worked by him/herself overnight and during those times Resident 2 would remain soaked "head to toe" so s/he didn't receive care from Caregiver K.	N 158		

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N 158	Continued From page 4 Resident 2 stated, "[Caregiver K] just in my doorway makes my skin crawl." On 07/28/2025 at 2:00 p.m., Surveyor observed Caregiver K assist Resident 2 with donning his/her wrist splint and changing his/her shirt. Surveyor observed a second caregiver did not accompany Caregiver K while providing cares, although there was a 2nd caregiver present in the building, as well as Consultant E. On 07/28/2025 at approximately 2:00 p.m., Consultant E provided Surveyor with an incident report, dated 06/28/2025. The report referenced the 06/28/2025 progress note alleging mistreatment from the provider's staff. The report documented the following: - Immediate Action Taken: Resident redirected per behavioral support plan and monitored through shift. No injuries or signs of physical trauma observed. Report was documented and forwarded to Administrator. Allegation reported to Division of Quality Assurance. All staff scheduled during the alleged timeframe were notified and interviewed. - Follow Up/Next Steps: Continued implementation of behavioral support plan interventions. Review of allegation during next interdisciplinary team meeting. Ensure staff education and re-training on reporting, resident interaction and behavioral support plan implementation. Consider psychiatric and behavioral health re-evaluation if patten continues. Surveyor noted the incident report did not document immediate action taken to safeguard residents at the time of the allegations on 06/23/2025. Surveyor noted the incident report did not conclude whether the allegations were substantiated. Surveyor noted the report did not	N 158		

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include a copy of a report allegedly sent to Division of Quality Assurance. Surveyor noted department records did not include a report submitted by the department regarding Resident 2 and/or Caregiver K.

On 07/28/2025 at 2:53 p.m., Surveyor interviewed Caregiver K regarding Resident 2's cares. Caregiver K stated there should always be 2 staff present when providing cares for Resident 2. Caregiver K stated the "2 person cares" had been in effect for approximately 1 month.

On 07/28/2025 at 3:30 p.m., Surveyor reviewed concern with Consultant E and Owner M that Resident 2's documentation related to his/her allegations of abuse from Caregiver K did not include documentation of what steps were taken to safeguard residents and did not include a conclusion of the investigation. Consultant E stated the provider did not have the ability to staff 2 caregivers at all times and asked Surveyors if s/he was supposed to terminate caregivers after ever allegation. Owner M asked if the provider was expected to investigation every allegation of abuse when the resident had a history of manipulation.

On 07/29/2025 at 3:33 p.m., Consultant E emailed Surveyors with documentation s/he reported to have found in the facility's office. Documentation included interviews conducted with 3 caregivers and Resident 2. The documentation stated the plan moving forward was for caregivers to have a 2nd staff member assist or observe with Resident 2's cares when staffing allowed, review the behavioral support plan, monitor the situation and ensure Resident 2 felt safe and supported in his/her home environment. The new documentation provided

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N 158	Continued From page 6 did not include dates, times or details of the occurrence and action taken to safeguard residents while the investigation occurred. Cross Reference: N0172 DHS 83.12(6) Documentation Requirements For Written Report	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 provider did not ensure 1 of 2 occurrences of law enforcement being called to the CBRF for an incident that jeopardized the health, safety or welfare of residents or employees were reported to the department within 3 working days. The provider did not report law enforcement responding to the provider's facility related to an altercation between Resident 1 and Caregiver K. Findings include: From 07/28/2025 to 07/29/2025, Surveyors conducted 2 complaint investigations alleging mistreatment to residents from the provider's	N 164		

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caregivers.

On 07/28/2025 at approximately 8:00 a.m., Surveyor reviewed a report from law enforcement that documented the following:

- Report, dated 07/01/2025: Police responded to a disturbance at the facility. It was found that Resident 1 punched Caregiver K while Caregiver K was cleaning Resident 1. Administrator J advised police that Resident 1 would be getting evicted due to multiple safety incidents at the facility.

On 07/28/2025 at approximately 11:40 a.m., Surveyor reviewed the department records and was unable to locate documentation that the provider had submitted a self-report regarding the incident on 07/01/2025 when law enforcement was called to the CBRF for an incident that jeopardized the health, safety, and welfare of Resident 1 and Caregiver K.

On 07/28/2025 at approximately 12:00 p.m., Surveyor requested documentation of self-reports submitted to the department from 07/01/2025 from Consultant E.

On 07/28/2025 at approximately 3:30 p.m., Surveyors reviewed concern with Consultant E and Owner M. Consultant E stated that they had not been provided with documentation of a self-report related to law enforcement responding to the altercation between Resident 1 and Caregiver K on 07/01/2025. Consultant E stated s/he was still trying to connect with Former Administrator J, who left his/her position on 07/23/2025, to obtain documentation. Consultant E stated s/he had gone through Consultant E's email in attempt of locating the self-report but

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N 164	Continued From page 8 was unsuccessful. Consultant E was given until 07/29/2025 at 3:30 p.m. to provide follow up documentation. Surveyor did not receive documentation of a written report being sent to the department within 3 working days.	N 164		
N 172	83.12(6) Documentation requirements for written report All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure reports related to allegations of abuse included, at the minimum, the time, date, place, individuals involved, details of the occurrence, and action taken by the provider to ensure residents' health, safety and well-being. The provider's investigation of Resident 2's allegation that Caregiver K had abused him/her did not include details. Findings include: From 07/28/2025 to 07/29/2025, Surveyors conducted 2 complaint investigations alleging mistreatment to residents from the provider's caregivers. The following concerns were identified: On 07/28/2025 at approximately 8:00 a.m.,	N 172		

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N 172	Continued From page 9 Surveyor reviewed reports from law enforcement that documented the following: - Report, dated 06/23/2025: Rescue services were dispatched to the facility because Resident 2 had fallen out of bed. The report documented that Resident 2 shared concern with rescue personnel and law enforcement that Caregiver K was physically and mentally abusive to him/her. Resident 2 reported that earlier that morning, Caregiver K had slammed his/her legs and wrists against the railing of his/her bed, causing pain, while changing Resident 2. Resident 2 also verbalized occurrences of Caregiver K cursing at Resident 2. The report documented Resident 2 was transferred to a local hospital for assessment. - Report, dated 06/25/2025: Law enforcement returned to the facility to interview Caregiver K. The report indicated a message was left for Administrator J to discuss abuse allegations. - Report, dated 06/26/2025: Law enforcement received hospital records which indicated Resident 2 had a lunate fracture to his/her right wrist. The record indicated Administrator J contacted law enforcement via email at 11:31 p.m. stating, "Good Evening [Officer] - I can honestly say [Caregiver K] would never harm a resident. [Resident 2] is constantly making accusations about my staff and even myself. [S/he] will intentionally harm [him/herself] such as throwing [him/herself] out of [his/her] wheelchair, out of [his/her] bed, trying to strangle [him/herself] etc. I actually issued [him/her] a 30-day discharge notice yesterday due to [him/her] harming [him/herself] to the point [s/he] now has a small fracture in [his/her] wrist, and accusing staff of causing it. I've had to staff 2 staff all 3 shifts now for the staffs safety and protection as well as [Resident 2]'s. We also want [Resident 2] safe	N 172		

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and unfortunately no matter what we do [s/he] is still intentionally harms [him/herself] for attention and then states [s/he]'s abused. I take all [his/her] accusations seriously and look into them but in the end it's untrue. I'm close to losing my staff as they fear the accusations will cost them their licenses or jobs and could potentially ruin their lives if someone not involved in the situation believed everything. In the end my goal is the safety of [Resident 2] and the safety of my staff as well. I will definitely assist in any way possible."

On 07/28/2025 at approximately 1:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 admitted to the provider's facility on 02/18/2025.Resident 2's progress notes, dated 06/01/2025 to 07/28/2025, included a note, dated 06/28/2025 stating Resident 2 reported to agency staff that the provider's staff threw him/her against the wall and rails on his/her bed. The note stated one staff member in particular did it all the time.

On 07/28/2025 at 1:15 p.m., Surveyor requested documentation of any investigations related to abuse allegations from Consultant E.

On 07/28/2025 at approximately 2:00 p.m., Consultant E provided Surveyor with an incident report, dated 06/28/2025. The report referenced the 06/28/2025 progress note alleging mistreatment from the provider's staff. The report documented the following:

- Immediate Action Taken: Resident redirected per behavioral support plan and monitored through shift. No injuries or signs of physical trauma observed. Report was documented and forwarded to Administrator. Allegation reported to Division of Quality Assurance. All staff scheduled

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during the alleged timeframe were notified and interviewed.
- Follow Up/Next Steps: Continued implementation of behavioral support plan interventions. Review of allegation during next interdisciplinary team meeting. Ensure staff education and re-training on reporting, resident interaction and behavioral support plan implementation. Consider psychiatric and behavioral health re-evaluation if patten continues.

Surveyor noted the incident report was dated 06/28/2025, 5 days after Resident 2's initial report of abuse allegations and 3 days after law enforcement had reached out to Administrator J regarding abuse allegations. The report did not include details regarding when actions were taken, who was interviewed and whether the concerns were substantiated. Surveyor noted the report did not include a copy of a report allegedly sent to Division of Quality Assurance. Surveyor noted department records did not include a report submitted by the department regarding Resident 2 and/or Caregiver K.

On 07/28/2025 at 3:30 p.m., Surveyor interviewed Consultant E and shared concern that the 06/28/2025 report provided regarding Resident 2's 06/28/2025 abuse allegations did not include details. Consultant E stated s/he was still trying to connect with Former Administrator J to see if s/he had additional records that were not in Resident 2's record.

Consultant E was given until 3:30 p.m. on 07/29/2025 to provide follow up documentation. Documentation was not received.

On 07/29/2025 at 3:33 p.m., Consultant E

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N 172	Continued From page 12 emailed Surveyors with documentation s/he reported to have found in the facility's office. Documentation included interviews conducted with 3 caregivers and Resident 2. The documentation stated the plan moving forward was for caregivers to have a 2nd staff member assist or observe with Resident 2's cares when staffing allowed, review the behavioral support plan, monitor the situation and ensure Resident 2 felt safe and supported in his/her home environment. The new documentation provided did not include dates, times or details of the occurrence and action taken. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 172		
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 record review and interview, the licensee did not ensure the CBRF and its operation comply with all laws governing the CBRF. Findings include: On 07/28/2025, Surveyors conducted a verification visit and 2 complaint investigations. The facility has a class CNA (non-ambulatory) probationary license, effective 08/01/2024, as a community based residential facility (CBRF) able to serve up to 8 residents within the client groups	N 196		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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of irreversible dementia/Alzheimer's, physically disabled, emotionally disturbed/mental illness, traumatic brain injury, and advanced age.

Surveyors have conducted the following surveys since the change of ownership on 08/01/2024:

Statement of deficiency (SOD) S5IW11, dated 03/18/2025

Probationary/standard survey resulting in the following deficiencies:

-83.15(3)(a) Administrator Shall Supervise Daily Operation

-83.17(2)(a) Employees Screened for Communicable Disease Screen

-83.22(1)-(4) Task Specific Training

-83.28(3) Provide Admission Agreement As Required

-83.32(3)(h) Rights of Residents: Receive Medication

-83.35(2) Temporary Service Plan

-83.35(3)(c) Implement, Follow the Individual Service Plan

-83.35(3)(d) Service Plans Updated Annually or on Changes

-83.36(1)(a) Adequate Staff to Meet Resident Needs

-83.36(1)(b) Qualified Staff In Charge, On Duty and Awake

-83.44(1)(a) Adequate Laundry Appliances Available

-83.45(3) Toxic Substances

-83.47(1)(c) Safety Requirements: No Safe Evacuation

-83.47(2)(b) Exit Diagram

-50.065(2)(b)intro Entity Background Check Requirements

SOD S5IW12, dated 06/03/2025

Verification visit resulting in the following

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	0020255	A. BUILDING: _____ B. WING _____	R 07/30/2025

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deficiencies:
-83.32(3)(h) Rights of Residents: Receive Medication - repeat
-83.35(3)(d) Service Plans Updated Annually or on Changes - repeat
-83.38(1)(g) Health Monitoring

SOD IF6611, dated 06/30/2025
Complaint investigation
-Complaint substantiated through previous SOD S5IW12
-No additional cites

SOD S5IW13, dated 07/29/2025
A verification visit and 2 complaint investigations resulting in the following deficiencies:
-83.12(2)(a) Caregiver: Investigating Abuse & Neglect
-83.12(4)(b) Reporting When Law Enforcement Is Called
-83.12(6) Documentation Requirements For Written Report
-83.14(2)(a) Licensee Ensures Facility Complies with Laws
-83.35(3)(d) Service Plans Updated Annually or on Changes - repeat
-83.38(1)(k) Transportation
-50.09(1)(e) Treatment

On 07/28/2025 at approximately 3:30 p.m., Surveyors reviewed concern with Consultant E and Owner M. Owner M stated that s/he is, "Obviously concerned, but I have nothing to say."

On 07/29/2025, the department determined the licensee for Raymond House will not be issued a regular license due to the licensee's continued non-compliance with all laws governing the CBRF.

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{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 individual service plans (ISP) were updated when there was a change in needs. Resident 2's ISP was not updated to include his/her need and/or preference for female caregivers and assist of 2. Repeat deficiency from statement of deficiency (SOD) S5IW11, dated 03/18/2025 and SOD S5IW12, dated 06/03/2025. Findings include: From 07/28/2025 to 07/29/2025, Surveyors conducted 2 complaint investigations and a verification visit. The following concerns were identified:	{N 389}		

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{N 389}	Continued From page 16 On 07/28/2025 at approximately 8:00 a.m., Surveyor reviewed police reports, obtained by Surveyor and dated 06/23/2025, 06/25/2025 and 06/28/2025, that documented Resident 2 alleged s/he had been mistreated by Caregiver K. The report included an email, dated 06/28/2025 at 11:31 p.m., from Administrator J to law enforcement that stated Administrator J had staffed 2 staff members for all 3 shifts for Resident 2's safety, as well as staff's safety. On 07/28/2025 at approximately 1:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 admitted to the provider's facility on 02/18/2025. Resident 2's ISP, dated 06/24/2025, did not indicate s/he required assistance of 2 caregivers for cares. On 07/28/2025 at 1:45 p.m., Surveyor interviewed Resident 2. Resident 2 stated Caregiver K broke Resident 2's wrist while providing cares and that Resident 2 now required assist of 2 people when Caregiver K was providing cares. On 07/28/2025 at 2:53 p.m., Surveyor interviewed Caregiver K and asked about providing cares for Resident 2. Caregiver K stated for approximately the past month; caregivers had been instructed to provide Resident 2's cares with 2 staff rather than 1. On 07/28/2025 at approximately 3:30 p.m., Surveyor reviewed concern with Consultant E that Resident 2 had required 2 staff to provide assistance with cares for approximately the past month; however, Resident 2's ISP was not updated to reflect the need for 2 staff. Consultant E stated s/he was unaware Resident 2 required assistance of 2 caregivers. Consultant E stated perhaps assist of 2 was a preference, but not a	{N 389}		

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{N 389}	Continued From page 17 need. Consultant E added it was also a preference for Resident 2 to have female caregivers provide cares if available. Surveyor stated that Resident 2's preference and/or need for 2 caregivers and/or female staff were not documented in the ISP. On 07/29/2025 at 10:29 a.m., Surveyor interviewed Caregiver L. Caregiver L stated Resident 2 had safety measures in place to have 2 staff providing cares if Caregiver K was involved. Caregiver L stated Administrator J should have updated Resident 2's ISP.	{N 389}		
N 435	83.38(1)(k) Transportation. 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: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange transportation when needed for Resident 1's neuropsychology	N 435		

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N 435	Continued From page 18 appointment on 07/01/2025. Findings include: On 07/10/2025, the department received a complaint alleging that transportation for medical appointments were not being arranged by the facility. On 07/28/2025 at approximately 2:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 07/24/2023 with diagnosis including chronic brain injury, depression, epilepsy, intractable seizures and impaired mobility. Surveyor reviewed a progress note entered by Administrator J, dated 07/01/2025 that documented, "Resident had an appointment this morning, Staff attempted to complete cares on resident and get [him/her] up and ready to go, when resident became agitated and punched staff in the stomach. Writer called and canceled the transportation as resident was refusing to get ready and assaulting staff. Writer informed clinic, residents[sic] [Family Member F] and [managed care organization]." At 2:57 p.m., Surveyor interviewed Consultant E and asked if s/he was aware of the incident on 07/01/2025 when Resident 1 missed his/her doctor appointment. Consultant E stated s/he remembered that Caregiver K notified Administrator J of Resident 1's aggression and that Administrator J went to the facility. Consultant E reviewed the progress note and stated that s/he believes that Administrator J would have arranged for transportation and then canceled it due to Resident 1's refusal. Consultant E stated s/he would have to check with Administrator J for	N 435		

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the details of what happened. Consultant E provided Transportation N's phone number stating that is the medical transportation company the provider uses.

On 07/29/2025, at 8:26 a.m., Surveyor interviewed Transportation N and asked if a medical transport was scheduled for Resident 1 on 07/01/2025. Transportation N stated no, "I can see the calls that came in and a transport was never set up." Transportation N stated s/he received a text message from Administrator J the morning of 07/01/2025 asking if Caregiver I had set up transportation for Resident 1's doctor appointment and Transportation N replied that transportation had never been requested or arranged.

At 9:16 a.m., Surveyor interviewed Case Manager RN O in regards to Resident 1's transportation on 07/01/2025. Case Manager O confirmed that the provider is responsible for providing transportation for medical appointments. Case Manager O stated that s/he spoke with Resident 1 after the missed neuropsychology appointment on 07/01/2025 and that Resident 1 denied that s/he refused to go to the appointment. Case Manager RN O questioned why Resident 1 would be up and ready to go, waiting for a ride, if s/he was refusing to go to the appointment. Case Manager RN O noted that communication between the managed care organization, provider and physicians are in healthcare link and that there was no documentation from the provider that Resident 1 had refused to go to the appointment or that the physician was notified of this. S/he stated that according to his/her knowledge and documentation, the physician was not contacted to cancel the appointment until after transportation was not provided for Resident

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1, when Family Member F called the clinic and then rescheduled the appointment for 08/05/2025.

At 10:18 a.m., Surveyor interviewed Family Member F, who was in the building and assisting Resident 1 on 07/01/2025. Surveyor asked Family Member F if s/he was aware that Resident 1 was refusing to go to his/her neuropsychology appointment and due to that, Administrator J canceled transportation to the clinic. Family Member F acknowledged that there was an incident on the morning of 07/01/2025, but stated that Resident 1 did not refuse to go to the appointment, "[S/he] was up and ready and we were waiting in the living room to go to the appointment." Family Member F stated that Administrator J and Caregiver L left the facility while Family Member F and Resident 1 were in the living room and as they left Caregiver L reassured Family Member F that transportation for Resident 1 was on the way. Family Member F stated that s/he took Resident 1 outside to wait for transportation, since it was confirmed that transportation was on the way. Family Member F stated that a few minutes after Administrator J left the facility an ambulance arrived and stated they were there to transport Resident 1 to the hospital. Family Member F clarified that Resident 1 did not need to go to the hospital, that s/he needed medical transport to scheduled clinic appointment. Emergency Medical Services (EMS) stated that they had received a call that Resident 1 was not feeling well and that s/he needed to go to the hospital. Family Member F stated s/he pointed to Resident 1 and told EMS that Resident 1 was not in distress and asked if they would transport Resident 1 to his/her neuropsychology appointment. EMS then stated that transportation to a clinic visit would have had to have been

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pre-planned and paid for in advanced; that if this was not an emergency transport, they could not assist Resident 1. Family Member F stated that then EMS left and s/he called to notify Resident 1's physician, reschedule the appointment, and notify Resident 1's managed care organization about the concerns with transportation. Family Member F added, "I called and let [Administrator J] of this neuropsychology appointment 2 to 3 weeks in advanced so transportation could be arranged." S/he stated that Resident 1 was in need of this neuropsychology appointment to assess the change in his/her cognitive issues due to increased seizures and memory loss adding that Resident 1 has been hospitalized twice in the last 3 weeks due to seizures.

At 10:29 a.m., Surveyor interviewed Caregiver L about transportation for Resident 1 on 07/01/2025. Caregiver L stated that yes, s/he called for emergency transport for Resident 1 on 07/01/2025. Caregiver L stated that Administrator J had called the ambulance first asking if they could transport Resident 1 to his/her appointment and that once they explained to him/her that it would have had to have been arranged previously as well as payment provided, Administrator J hung up and asked Caregiver L to call back and say Resident 1 was not feeling well and needed to go to the hospital. Caregiver L stated that s/he informed Administrator J that this was not correct and s/he stated that Resident 1 needs a ride, so Caregiver L needs to call the ambulance anyway.

On 07/01/2025, the provider did not arrange services adequate to meet the transportation needs of Resident 1 to attend his/her neuropsychology appointment.

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Y3234	Continued From page 22	Y3234		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 2 was treated with courtesy, respect and full recognition of their dignity and individuality. Findings include: From 07/28/2025 to 07/29/2025, Surveyors conducted 2 complaint investigations alleging mistreatment to residents from the provider's caregivers. The following concerns were identified: On 07/28/2025 at approximately 8:00 a.m., Surveyor reviewed reports from law enforcement that documented an email from Administrator J to law enforcement that stated, "Good Evening	Y3234		

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[Officer] - I can honestly say [Caregiver K] would never harm a resident. [Resident 2] is constantly making accusations about my staff and even myself. [S/he] will intentionally harm [him/herself] such as throwing [him/herself] out of [his/her] wheelchair, out of [his/her] bed, trying to strangle [him/herself] etc. I actually issued [him/her] a 30-day discharge notice yesterday due to [him/her] harming [him/herself] to the point [s/he] now has a small fracture in [his/her] wrist, and accusing staff of causing it. I've had to staff 2 staff all 3 shifts now for the staffs safety and protection as well as [Resident 2]'s. We also want [Resident 2] safe and unfortunately no matter what we do [s/he] is still intentionally harms [him/herself] for attention and then states [s/he]'s abused. I take all [his/her] accusations seriously and look into them but in the end it's untrue. I'm close to losing my staff as they fear the accusations will cost them their licenses or jobs and could potentially ruin their lives if someone not involved in the situation believed everything. In the end my goal is the safety of [Resident 2] and the safety of my staff as well. I will definitely assist in any way possible."

On 07/28/2025 at approximately 1:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 admitted to the provider's facility on 02/18/2025. Resident 2's ISP, dated 06/24/2025, indicated s/he required full assistance with personal cares, including dressing.

On 07/28/2025 at 1:45 p.m., Surveyor interviewed Resident 2. Resident 2 stated Caregiver K broke Resident 2's wrist while providing cares and that Resident 2 now required assist of 2 people when Caregiver K was providing cares. Resident 2 stated, "[Caregiver K] just in my doorway makes my skin crawl."

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Y3234	Continued From page 24 On 07/28/2025 at 2:00 p.m., Surveyor observed Caregiver K assist Resident 2 with donning his/her wrist splint and changing his/her shirt. Surveyor observed a 2nd caregiver was not present and Resident 2's door was left open while Resident 3 ambulated past Resident 2's room. On 07/28/2025 at 2:53 p.m., Surveyor interviewed Caregiver K and asked about providing cares for Resident 2. Caregiver K stated for approximately the past month; caregivers had been instructed to provide Resident 2's cares with 2 staff rather than 1. On 07/28/2025 at approximately 3:30 p.m., Surveyor reviewed concern with Owner M and Consultant E that Caregiver K provided cares to Resident 2 without a 2nd caregiver present and with the door open. Consultant E questioned the accuracy of Resident 2 requiring assistance of 2 for cares. Consultant E did not comment on Caregiver K changing Resident 2's shirt with the door completely ajar.	Y3234		