STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(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 02/11/2026, Surveyor conducted a standard survey, four complaint investigations and a verification visit at Milestone Senior Living Renee. Data collection continued through 02/18/2026. Five deficiencies were identified. Three of 5 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) SQWO11, dated 07/11/2026, and SOD TLWS11, dated 09/05/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 23	{N 000}		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or 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	N 219		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(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 219	Continued From page 1 provider did not ensure caregiver background checks (CBC) were completed for 1 of 3 staff reviewed. This is a repeat deficiency. See Statement of Deficiency TLWS11, dated 09/05/2023. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete CBC, 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) Caregiver Background Check - Governmental Findings Report (GFR). On 02/11/2026, Surveyor reviewed a sample of 3 employee records. Caregiver B was hired on 04/21/2025. Caregiver B's record did not include a DOJ or GFR report. On 02/11/2026 at 2:35 PM, Surveyor asked if Caregiver B's DOJ and GFR were completed upon hire. Administrator A stated there was no DOJ or GFR report available and s/he would complete the CBC on the date of survey.	N 219		
{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	{N 387}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 387}	Continued From page 2 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 3 of 5 residents were involved in developing the individual service plan (ISP), when the ISP was not signed by the resident and the resident's legal representative, as appropriate, acknowledging their involvement in, understanding of, and agreement with, the plan. This is a repeat deficiency. See Statement of Deficiency SQWO11, dated 07/11/2025. Findings include: On 02/11/2026 at approximately 2:00 PM, Surveyor requested a sample of 3 records. Resident 1 had an admission date of 02/27/2025. The record did not contain a signed ISP. Resident 2 had an admission date of 07/17/2025. The record did not contain a signed ISP.	{N 387}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 387}	Continued From page 3 On 12/11/2026 at 2:12 PM, Administrator A informed Surveyor there was not a signed ISP uploaded in Resident 1's or Resident 2's record, or in the nurse's office stack that needed to be uploaded. On 02/12/2026 at 10:27 AM, Surveyor requested an additional sample of 2 resident signed ISPs for review. Resident 5 had an admission date of 02/08/2025. The record did not contain a signed ISP. On 02/12/2026 at 4:23 PM, Administrator A informed Surveyor that Resident 5 had a completed ISP, dated 02/02/2026, and was signed that day (02/12/2026).	{N 387}		
N 443	83.39(5) Pets vaccinated. The CBRF shall ensure that pets are vaccinated against diseases, including rabies, if appropriate. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 pets were vaccinated against diseases, including rabies. Findings include: On 02/11/2026, Surveyor interviewed Administrator A and asked about pets. Administrator A stated there were three cats in the facility. Surveyor requested to see vaccination records for all 3 cats. Administrator A provided Surveyor Resident 3's pet vaccination record which expired on	N 443		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(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 443	Continued From page 4 10/21/2025. Administrator A stated s/he did not have Resident 4's pet vaccination for review and had placed a call with Resident 2's family to request the information. On 02/12/2026 at 12:11 PM, Administrator A emailed Surveyor Resident 4's pet vaccination which documented a re-vaccination due date of 03/22/2025. Surveyor asked for clarification and requested current documentation of vaccination status for Resident 4's cat. On 02/12/2026 at approximately 4:00 PM, Administrator A emailed Surveyor and confirmed s/he did not have a current vaccination on file for 3 of 3 cats owned by Resident 2, Resident 3, and Resident 4. Administrator A indicated s/he had reached out to all residents and/or representatives who had pets in the community and was in the process of obtaining updated documentation and/or scheduling necessary appointments.	N 443		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(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 525	Continued From page 5 simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted at least quarterly in 2025. Findings include: This is a repeat deficiency. See Statement of Deficiency TLWS11, dated 09/05/2023. On 02/11/2026, Surveyor requested fire evacuation drills conducted in 2025. At approximately 2:00 PM, Administrator A stated there was not a drill conducted in the last quarter of 2025 and a drill was scheduled the following week. Surveyor reviewed fire drill documentation for previously completed drills on 05/13/2025, 03/03/2025, and 01/30/2025. Documentation of fire drills did not include the time of the drill, and did not include a list of resident names who participated in the drill.	N 525		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(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
Y3244	Continued From page 6 to (I) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility for skin integrity. Findings include: On 10/29/2025, the Department received a complaint regarding resident care. On 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Caregiver C in the medication room. Caregiver C stated s/he was responsible for passing medications on the date of survey. Surveyor asked Caregiver C if staff were responsible for Resident 1's skin care. Caregiver C stated Resident 1 had a wound on his/her lower left leg and staff cared for his/her stomach folds twice daily by cleaning and washing the area, placing paper towels in the folds and treated with Nystatin powder. Caregiver C stated s/he did not complete the care, but	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(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
Y3244	Continued From page 7 Caregiver D had completed the task that morning. On 02/11/2026 at approximately 11:25 AM, Surveyor interviewed Caregiver D and asked about Resident 1's morning cares. Caregiver D stated staff were responsible for cleaning his/her stomach folds, applying Nystatin powder and placing a paper towel to keep them clean and dry. Caregiver D stated Resident 1's folds were not good and that the folds were "rashy and yeasty" in the mornings. Caregiver D then stated the paper towels get soiled and they have to change them frequently. Caregiver D stated s/he completed the task that morning. On 02/11/2026 at approximately 11:45 AM, Surveyor observed Resident 1 in his/her room. Registered Nurse (RN) E was providing wound care to his/her left lower leg. Surveyor asked Resident 1 if s/he had any other skin concerns. Resident 1 stated "yes" and lifted up his/her shirt and abdominal folds. Resident 1's folds were bright red, had yeast present, and there was no paper towel in place. Surveyor asked RN E what staff should be doing for Resident 1's abdominal folds. RN E stated staff were instructed to clean, dry completely, apply nystatin and place a paper towel in between folds twice daily to keep them dry. RN E informed Surveyor staff reported the previous week the area was worsening so s/he had updated the care plan. RN E instructed Caregiver D to wash the folds while toileting Resident 1. Caregiver D began to clean the area with a washcloth and Resident 1 expressed s/he was in pain with grimacing facial expressions and verbal groans. After the observation, RN E informed Surveyor the care task did not appear to have been	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RENEE	5510 RENEE DR EAU CLAIRE, WI 54703

(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
Y3244	Continued From page 8 completed that morning, and stated the area looked painful. RN E stated s/he would check charting to see if Caregiver D had documented completion of the task and would speak to Caregiver D if s/he found any discrepancies. On 02/11/2026 at approximately 2:45 PM, Surveyor discussed the above concern with Administrator A. Administrator A reviewed daily charting for Resident 1's skin care task as follows: "TWO TIMES PER DAY: Every AM shift during getups or after bath, on bath days; Every PM shift at bedtime 1. Remove any old Viva paper towel from abdominal folds and under breasts. 2. Cleanse under breasts and abdominal folds with soap and water, rinse well, and ensure area is COMPLETELY DRY before proceeding. 3 Once skin is dry, apply clotrimazole cream under breasts and abdominal folds. Get this from med passer if not kept in [his/her] room. 4. Place Viva paper towel under folds to soak up excess moisture throughout the day. ***Please report to RN if area continues to worsen***" Administrator A informed Surveyor Caregiver D did not complete the task per charting as the task was documented completed by Caregiver B. Caregiver B was not feeling well and had gone home for the day. Administrator A stated s/he would follow up with Caregiver B, and informed Surveyor staff should not be signing off on tasks they did not complete.	Y3244		