STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 03/18/2026, Surveyor conducted an abbreviated survey and one (1) complaint investigation at Belgium Gardens. Additional information gathered through 03/19/2026. As a result of the survey eight (8) deficiencies were identified and 1 complaint was substantiated. Census:21	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 caregivers reviewed was screened for clinically apparent communicable disease, within 90 days before the start of employment. This is a repeat deficiency. See statement of deficiency (SOD) PY2C11, dated 04/28/2022. Findings include:	N 220		

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
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 220	Continued From page 1 On 03/18/2026 at approximately 10:00 AM, Surveyor requested Caregiver B's record from Manager A. Surveyor reviewed Caregiver B's employee record. Record indicated the following: - Caregiver B was hired on 12/02/2025. Caregiver B's record did not have documentation Caregiver B was screened for clinically apparent communicable disease. On 03/18/2026 at approximately 12:00 PM, Surveyor interviewed Manager A. Manager A stated, s/he would look for the free of communicable disease form. Surveyor informed Manager A s/he could send information to Surveyor by the end of the day. As of 03/19/2026, Surveyor did not receive documentation Caregiver B had been screened for communicable disease. The provider did not ensure that caregiver reviewed was screened for clinically apparent communicable disease, within 90 days before the start of employment.	N 220		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion,	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 243	Continued From page 2 retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed, obtained training as required within 90 days after starting employment.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 243	Continued From page 3 Cook C did not have training in resident rights; recognizing, preventing, managing and responding to challenging behaviors; and required client groups within 90 days after starting employment. This is a repeat deficiency. See statement of deficiency (SOD) PY2C11, dated 04/28/2022. Findings include: The provider is licensed to provide care and services to residents within the client groups of advanced aged, irreversible dementia/Alzheimer's, physically disabled and/or terminally ill. On 03/18/2026 at approximately 10:00 AM, Surveyor requested Cook C's record from Manager A. Surveyor reviewed Cook C's employee record to verify compliance with all employee training requirements. Record indicated the following: Cook C was hired beginning of December 2025. Cook C's record did not contain evidence of training or evidence of meeting an exemption for training in resident rights; recognizing, preventing, managing and responding to challenging behaviors; and client groups. On 03/18/2026 at approximately 12:00 PM, Surveyor interviewed Manager A. Manager A acknowledged s/he did not have all employee training for Cook C. Manager A stated s/he was unaware Cook C had to have all employee training. Manager A stated s/he will talk to Cook C and see if s/he had training from previous employment. Surveyor informed Manager A s/he could send information obtained to Surveyor by the end of the day.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 243	Continued From page 4 As of 03/19/2026 at 4:00 PM, Surveyor did not receive documentation Cook C had all employee training or evidence of meeting an exemption for training in resident rights; recognizing, preventing, managing and responding to challenging behaviors; and client groups.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 247	Continued From page 5 Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee reviewed had received dietary training within 90 days of starting employment. Findings include: On 03/18/2026 at approximately 10:00 AM, Surveyor requested Cook C's record from Manager A. Manager A acknowledged Cook C was hired in the beginning of December 2025. At 10:45 AM, Manager A stated s/he thought Cook C had obtained ServSafe certification. Surveyor requested evidence of the dietary training or that s/he met the exemption requirement from Manager A. Manager A stated s/he would reach out to Cook C to obtain a copy of the ServSafe Certificate. Surveyor informed Manager A s/he could send the certificate to Surveyor by the end of the day. Cook C did not evidence s/he had met the requirement for exemption from dietary training. As of 03/19/2026 at 4:00 PM, Surveyor did not receive evidence Cook C had obtained dietary training within 90 days of starting employment.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 419	Continued From page 6	N 419		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation, staff interview and record review the provider did not establish an effective procedure for the proper destruction and disposal of unused, discontinued, or outdated medications. The medication cart contained opened insulin pens for Resident 1, 2 and 3, with no dates the pens were started to determine the specific expiration date of the medication. Findings include: Division of Quality Assurance Insulin Storage Guide publication dated 11/2016 indicated, "...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows: ...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert...The following tables address specific expiration or beyond-use dating guidelines that apply to insulin products...Pens...Lantus Pen: label expiration date 28 days when seal is punctured...Tresiba Pen: label expiration date up to 56 days when seal is punctured ..." On 03/18/2026 at approximately 10:00 AM, Surveyor and Manager A observed the facility's medication cart. The med cart contained the following: * 1 open Tresiba insulin pen without a date or resident name	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 419	Continued From page 7 * 1 Lantus insulin pen for Resident 2 without a date opened * 1 Lantus insulin pen for Resident 3 without a date opened Surveyor shared findings with Manager A. Manager A pointed to Resident 1's name on the slot the Tresiba insulin pen was located but confirmed 3 of 3 pens were not dated when staff had started using them. Manager A confirmed staff should ensure the pens are labeled with the resident name and all pens should be dated when the pen was opened or when the pen would expire.	N 419		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure every interior floor, wall and ceiling were clean and in good repair. The carpet in the hallway was fraying in multiple areas, resident rooms with fraying/stained carpet, walls and ceiling are stained. Findings include: On 03/18/2026 at approximately 10:34 AM, Surveyor toured the facility with Manager A. Surveyor observed the hallway carpet to be fraying in multiple areas across the hallway and into resident rooms. Examples of interior floor, wall and ceilings was identified in the following areas: Resident 4's room carpet to hallway, carpet in	N 491		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 491	Continued From page 8 room was bubbling, caulk missing around toilet and shower, walls scuffed with drywall missing on corner Resident 5's room carpet to hallway, walls scuffed and pieces missing on corners Resident 6's room carpet to hallway Day room outlet with plugs not covering hole in wall, flooring transition missing by patio door, transition in dayroom from laminate flooring to carpet - strip with duct tape, carpet stained (white spots) in front of recliner and a couple dark spots on carpet in day room in front of med cart approximately 1" x 1" each, Laundry room sprinkler ring missing from sprinkler Resident 7's room carpet to hallway, walls and ceiling splattered with brown substance Resident 8's room carpet in doorway was snagged approximately 3' x 4' On 03/18/2026 at 12:30 PM, Surveyor interviewed Manager A. Manager A acknowledged Surveyors' observations and stated the carpet was replaced not long ago. Manager A stated Resident 7's room looked like s/he had a soda explode on the walls and ceilings. The provider did not ensure every interior floor was clean and in good repair.	N 491		
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.	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 9 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 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 quarterly fire drills were conducted with both employees and residents including holding one fire evacuation drill annually that simulates the conditions during usual sleeping hours in calendar years 2024 and 2025. This is a repeat deficiency. See statement of deficiency (SOD) PY2C11, dated 04/28/2022. Findings include: The provider is licensed as a Class CNA (non-ambulatory) CBRF (community based residential facility) able to serve up to 22 residents within the client groups of advanced aged, irreversible dementia/Alzheimer's, physically disabled and/or terminally ill. On 03/18/2026 at approximately 12:00 PM, Surveyor requested the fire drills that had been completed for 2024 and 2025 from Manager A. Surveyor observed fire drills were completed in 2024, but in 2025 there was no drill completed in	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 10 the 2nd quarter. The notes on the fire drills reflected the NOC drill completed in 3rd quarter for 2025 was simulated with staff, residents were not evacuated. On 03/18/2026 at 1:00 PM, Surveyor interviewed Manager A. Manager A acknowledged they missed the 2nd quarter drill of 2025 and confirmed the NOC drill was a simulated drill, but stated they will ensure to conduct the drills for 2026 including the NOC shift drill.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure evacuation drills, such as tornadoes, flooding or other emergency or disaster, were completed for 2024 and 2025. This is a repeat deficiency. See statement of deficiency (SOD) PY2C11, dated 04/28/2022. Findings include: The provider is licensed as a Class CNA (non-ambulatory) CBRF (community based residential facility) able to serve up to 22 residents within the client groups of advanced aged, irreversible dementia/Alzheimer's, physically disabled and/or terminally ill. On 03/18/2026, at approximately 12:00 PM, Surveyor requested the other evacuation drills for	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 526	Continued From page 11 2024 and 2025 from Manager A. Surveyor observed a tornado drill for 04/11/2024 and 07/05/2025. Manager A confirmed s/he did not have a 2nd half of 2024 and first half of 2025 other drill completed. On 03/18/2026 at 1:00 PM, Surveyor interviewed Manager A. Manager A acknowledged s/he missed doing the 2nd drill for 2024 and 2025.	N 526		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on interview and observation, the provider did not ensure 2 of 2 hot water heaters connected to sinks, showers and tubs used by residents, was set to 140 degrees Fahrenheit. Findings include: On 03/18/2026 at 10:39 AM, Surveyor toured the facility with Manager A. Surveyor observed 2 water heaters with temperatures of 136 on the left hot water heater and 130 on the right hot water heater in the mechanical room. Surveyor asked Manager A if the 136 and 130 reflected the temperature of the water in the hot water heater.	N 617		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012459	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGIUM GARDENS	432 SOUTH HERITAGE STREET BELGIUM, WI 53004

(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 617	Continued From page 12 Manager A stated s/he was unsure and reached out to maintenance. Manager A confirmed the hot water heaters were 136 and 130 and they had a mixing valve that adjusted the temperature before reaching the residents rooms to not exceed 115 degrees Fahrenheit. At 11:51 AM, Surveyor and Manager A went to the mechanical room and observed the left hot water heater to be 133 and the right hot water heater to be 130. Manager A stated s/he was unaware the hot water heaters were not set to at least 140 degrees Fahrenheit. Manager A stated s/he would reach out to maintenance and have the water adjusted to be at least 140 degrees Fahrenheit in the hot water heater. The American Society of Sanitary Engineering, (https://homeguides.sfgate.com/turning-water-heater-up-kill-bacteria-54596.html), recommends hot water heaters to be set between 135- and 140-degrees Fahrenheit to kill Legionella bacteria. Community Based Residential Facilities are required to have hot water heaters set at least 140 degrees Fahrenheit. The provider did not ensure the temperature of all hot heaters connected to sinks, showers and tubs used by residents maintained a temperature of at least 140 degrees Fahrenheit.	N 617		