| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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<br><br>From 07/22/2025 to 07/25/2025, Surveyor conducted 2 complaint investigations and a verification visit at Alice & Louises II, a CBRF in Arpin.<br><br>Fourteen deficiencies were identified. Nine of 14 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) UK3M11, dated 09/11/2023 and UK3M12, dated 07/01/2024.<br><br>Two of 2 complaints were substantiated.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 5 | N 000 | | |
| N 239 | 83.20(2)(a)-(d) Department-approved training courses.<br><br>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.<br>Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety.<br>First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking.<br>Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter | N 239 | | |

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 |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 239 | Continued From page 1<br>medications shall complete training in medication administration and management prior to assuming these job duties.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure 3 employees obtained all department approved training as required.<br><br>Caregiver L and Caregiver M, who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties.<br><br>Caregiver P, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M12, dated 07/01/2024.<br><br>Findings include:<br><br>On 07/22/2025, Surveyor conducted a review of 6 employees to verify compliance with department approved training requirements. Surveyor requested training records from House Manager E, including the records for Caregiver M, Caregiver L and Caregiver P.<br><br>Medication Administration<br><br>On 07/22/2025 at approximately 10:00 a.m., Surveyor reviewed medication administration | N 239 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 239 | Continued From page 2<br>records, dated 03/01/2025 to 07/22/2025, which indicated Caregiver L administered residents' medications from March 2025 to July 2025 and Caregiver M administered residents' medications in April and May 2025.<br><br>The record for Caregiver L, hired 02/25/2025, indicated s/he received training in medication administration on 05/07/2025, after s/he had already been administering medications to residents. The record for Caregiver M, hired 04/03/2025, did not contain evidence of training or evidence of meeting an exemption for medication administration. On 07/22/2025, at approximately 10:15 a.m., Surveyor interviewed House Manager E. House Manager E confirmed Caregiver L and Caregiver M were responsible for medication administration duties prior to completing medication administration training and House Manager E thought that was acceptable if there was a trained staff member in the building. House Manager E confirmed the provider did not have evidence Caregiver L or Caregiver M completed or met an exemption for medication management training prior to assuming these job duties.<br><br>On 07/22/2025, Surveyor verified Caregiver M and Caregiver L were not on the Community-Based Care and Treatment training registry for medication administration.<br><br>Standard Precautions<br><br>On 07/22/2025 at 9:15 a.m., Surveyor reviewed the provider's schedule, which indicated Caregiver P had worked at the facility, receiving training, on 07/09/2025, 07/10/2025, 07/11/2025, 07/15/2025 and 07/17/2025. | N 239 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 239 | Continued From page 3<br><br>On 07/22/2025 at approximately 9:30 a.m., Surveyor reviewed Caregiver P's record provided by House Manager E. The record for Caregiver P, hired 07/09/2025, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 07/22/2025, at approximately 10:15 a.m., Surveyor interviewed House Manager E. House Manger E confirmed Caregiver P had been receiving training "on the floor" which would include job tasks that may expose the employee to blood or other bodily fluids. House Manager E confirmed the provider did not have evidence Caregiver P completed or met an exemption for standard precaution training prior to assuming these job duties and stated Caregiver P would be removed from the schedule until receiving training on 08/06/2025.<br><br>On 07/22/2025, Surveyor verified Caregiver P was not on the Community-Based Care and Treatment training registry for standard precautions.<br><br>House Manger E was given the opportunity to submit any additional evidence of training by 07/23/2025. Follow up documentation was not received. | N 239 | | |
| N 328 | 83.31(4)(c) Involuntary discharge notice requirements.<br><br>Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the | N 328 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 328 | Continued From page 4<br>department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 involuntary discharge notices reviewed included a statement regarding the right to ask the department to review the involuntary discharge, contact information for the department's regional office director and contact information for the regional office of the board on aging and long-term care's ombudsman program.<br><br>Findings include:<br><br>On 07/22/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 7's record. Resident 7 admitted to the provider's facility on 05/12/2025 and discharged on 07/05/2025. Resident 7's record included a letter, dated 06/10/2025, that stated, "With the change in condition for [Resident 7], [provider] is issuing a 30-dya notice to vacate for the following reasons: increased | N 328 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 328 | Continued From page 5<br>falls, 2 person assist needed (we are staffed 1 per shift), verbal aggression to staff and racist comments to staff. On this day, June 10, 2025, is the start of the 30-day and will need to be moved out on or before July 10, 2025. - [House Manager E]."<br><br>On 07/22/2025 at approximately 11:00 a.m., Surveyor reviewed concern with House Manager E that Resident 7's involuntary discharge notice did not inform Resident 7's ability to have the department review the notice or provide contact information for the department's regional office or the regional office of the board on aging and long-term care's ombudsman program. House Manager E stated Resident 7's involuntary discharge notice was his/her first one and s/he hoped to never do one again. | N 328 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed received his/her medications as prescribed. Resident 6 did not receive her Atorvastatin and Levothyroxine as prescribed.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M11, dated 09/11/2023 and | N 352 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 352 | Continued From page 6<br>SOD UK3M12, dated 07/01/2024.<br><br>Findings include:<br><br>On 07/22/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider's facility on 11/04/2022. Resident 6's record indicated the provider administered his/her medications. Resident 6's Medication Administration Record (MAR), dated 03/01/2025 to 07/22/2025, documented the following missed medications:<br><br>- Atorvastatin 40 mg (Start Date: 12/19/2024) - 1 tablet daily was not administered 04/12/2025 through 04/15/2025, 04/21/2026 through 04/23/2025, 04/26/2025 through 04/27/2025 and on 04/30/2025. Notations in the MAR documented the medication was unavailable for administration.<br>- Levothyroxine 150 mcg (Start Date: 12/19/2024) - Take 1 tablet daily was not administered 04/09/2025 through 04/13/2025. Notations in the MAR documented the medication was unavailable for administration.<br><br>On 07/22/2025 at approximately 11:00 a.m., Surveyor interviewed House Manager E and shared concern that Resident 6 did not receive his/her medications as prescribed. House Manager E confirmed Resident 6 had missed medications and stated it was due to poor communication regarding the physician and pharmacy. | N 352 | | |
| N 355 | 83.32(3)(k) Rights of Residents: Self-determination<br><br>In addition to the rights under s. 50.09, Stats., | N 355 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 355 | Continued From page 7<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure residents were provided the right to make decisions relating to care, activities and daily routines. Resident 6's food choices were restricted and/or limited by the provider.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M12, dated 07/01/2024.<br><br>Findings include:<br><br>On 07/22/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider's facility on 11/04/2022. Resident 6 had an activated Health Care Power of Attorney (HCPOA). Resident 6's individual service plan, dated 04/23/2025, stated s/he would eat food independently with no seconds unless it was fruits or vegetables. The ISP did not document a specialty diet or limits on snacks. Resident 6's ISP did not include the signature of his/her HCPOA. Resident 6's record did not include a physician order regarding food limitations. Resident 6's progress notes, dated 03/01/2025 to 07/22/2025, documented the following concerns:<br><br>- 03/22/2025: " ...Resident has been very demanding regarding [his/her] snack. The amount was not enough for [him/her], staff | N 355 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 355 | Continued From page 8<br>assured [him/her] this is just a snack and we will be having dinner."<br>- 07/11/2025: "Resident stole a cinnamon roll this evening while Director was in the office ... Director confronted [Resident 6] about why [s/he] went and took the cinnamon roll ... Director asked [Resident 6] if [s/he] was supposed to do that especially after [s/he] had just had a snack. [Resident 6] said [s/he] did it because [s/he] wanted it. Director told new staff that [Resident 6] is a food seeker and has diabetes, and that [s/he] will see what [s/he] is allowed to get away with while new staff is starting. Director told the newer staff that they need to confront [Resident 6] immediately so [s/he] is aware [s/he] can't manipulate them."<br>- 07/12/2025: "Resident had asked staff what dinner was and got upset because [s/he] thought it was tacos, dinner is chicken wraps for the night. Resident had continued to ask for other things after staff had told resident that [s/he] has had these before and liked them and that [s/he] will not be getting anything else. Resident had stopped, then a few minutes later went into the kitchen near staff and told staff that [s/he] was leaving. Staff had nicely told [him/her] three times that we were not talking about that right now because staff is busy. Resident got mad and raised [his/her] voice at staff. Director was notified and had spoken to resident about being disrespectful."<br><br>On 07/22/2025 at approximately 11:00 a.m., Surveyor reviewed the progress notes regarding Resident 6 being limited with food and denied an alternate meal. House Manager E stated Resident 6 could not help him/herself to food because s/he was restricted to fruits and vegetables as his/her "extra" food per Resident 6's HCPOA and physician. House Manager E | N 355 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 355 | Continued From page 9<br>stated s/he would provide Surveyor with a physician order. As Surveyor reviewed the 07/12/2025 note regarding Resident 6 wanting an alternate meal, House Manager E replied, "Oh my God," and stated that staff member was no longer employed with the provider.<br><br>House Manager E was given until 07/23/2025 to provide follow up documentation. Documentation was not received. | N 355 | | |
| N 381 | 83.35(1)(a) Pre-admission and ongoing assessments.<br><br>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure residents' needs, abilities and physical condition were assessed before admitting the resident or when there was a change in needs or condition.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M12, dated 07/01/2024. | N 381 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 381 | Continued From page 10<br>Findings include:<br><br>On 07/22/2025 at approximately 10:00 a.m., Surveyor reviewed resident records and identified the following concerns:<br><br>Example 1 - Preadmission Assessments:<br><br>- Resident 7 was admitted to the provider's facility on 05/12/2025 and discharged 07/05/2025. Resident 7's record did not include a pre-admission assessment.<br>- Resident 8 was admitted to the provider's facility on 09/30/2024. Resident 8's record did not include a pre-admission assessment.<br><br>On 07/22/2025 at approximately 1:45 p.m., Surveyor reviewed concern with House Manager E that neither Resident 7, nor Resident 8's record contained a pre-admission assessment. House Manager E stated s/he believed the record was at his/her house.<br><br>House Manager E was given until 07/23/2025 to provide follow up documentation. No documentation was received.<br><br>Example 2 - Falls:<br><br>Resident 7's record, dated 05/12/2025 through 07/05/2025, documented falls on 06/03/2025 x 2, 06/08/2025, 06/09/2025, 06/16/2025, 06/22/2025 and 06/25/2025. Resident 7's record included incident reports for the 06/08/2025, 06/09/2025, 06/16/2025, 06/22/2025 and 06/25/2025 falls; however, the incident reports did not include an assessment to determine if Resident 7 had a change in needs following the falls. Surveyor reviewed Resident 7's record and was unable to locate documentation of an assessment for falls. | N 381 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 381 | Continued From page 11<br><br>On 07/22/2025 at 1:45 p.m., Surveyor interviewed House Manager E. Surveyor reviewed Resident 7's falls and asked if the provider completed an assessment related to falls. House Manager E replied, "No. They pulled one over on me."<br><br>Example 3 - Smoking:<br><br>Resident 7's record included an incident report, dated 06/17/2025, that stated Resident 7 reported s/he was outside smoking his/her pipe and had started his/her apron and pants on fire from ashes that had fallen. The report stated Resident 7 rated his/her pain at a "7" and sustained a burn to inner thigh on left leg. The record did not contain an assessment related to Resident 7 smoking.<br><br>On 07/22/2025 at 1:45 p.m., Surveyor interviewed House Manager E regarding Resident 7's smoking. Surveyor asked if Resident 7 was assessed for his/her ability to smoke independently and reassessed after his/her incident on 06/17/2025. House Manager E replied, "No, we would just put eyes on [him/her] every 5 minutes or so because we think [s/he] fell asleep when [s/he] got burned."<br><br>The provider did not complete resident assessments prior to admission or upon changes. | N 381 | | |
| N 385 | 83.35(2) Temporary Service Plan.<br><br>Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan | N 385 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 385 | Continued From page 12<br>under sub. (3) is developed and implemented.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not prepare and implement a temporary service plan upon admission to meet immediate needs for 2 of 2 residents reviewed. Resident 7 and Resident 8 did not have a temporary service plan.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M12, dated 07/01/2024.<br><br>Findings include:<br><br>On 07/22/2025 at approximately 10:00 a.m., Surveyor reviewed resident records provided by House Manager E. Records indicated the following:<br><br>- Resident 7 was admitted to the provider's facility on 05/12/2025 and discharged 07/05/2025. Resident 7's record did not include a temporary ISP.<br>- Resident 8 was admitted to the provider's facility on 09/30/2024. Resident 8's record did not include a temporary ISP. Resident 8's ISP was dated 04/23/2025.<br><br>On 07/22/2025 at approximately 12:20 p.m., Surveyor interviewed House Manager E regarding the concern that neither Resident 7, nor Resident 8's record included temporary ISPs. House Manager E confirmed Surveyor's observation.<br><br>House Manager E was given until 07/23/2025 to provide follow up documentation. Documentation was not received. | N 385 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 386 | Continued From page 13 | N 386 | | |
| N 386 | 83.35(3)(a) Comprehensive Individualized Service Plan<br><br>Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed had a comprehensive individual service plan (ISP) completed within 30 days after admission. Resident 7 did not have an ISP.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M12, dated 07/01/2024.<br><br>Findings include:<br><br>On 07/22/2025 at 10:00 a.m., Surveyor reviewed resident records. Resident 7 was admitted to the provider's facility on 05/12/2025 and discharged on 07/05/2025. Resident 7's record did not include an ISP.<br><br>On 07/22/2025 at 11:00 a.m., Surveyor informed | N 386 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 386 | Continued From page 14<br>House Manager E that Resident 7's record did not include an ISP. House Manager E stated s/he had been unable to locate an ISP.<br><br>House Manager E was given until 07/23/2025 to provide follow up documentation. Documentation was not received. | N 386 | | |
| N 387 | 83.35(3)(b) Service plan development: parties involved<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 3 individual service plans (ISP) reviewed were developed with the involvement of the resident and/or the resident's legal representative. Resident 6's Health Care Power of Attorney (HCPOA) was not involved with the development of his/her ISP. | N 387 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 15<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M12, dated 07/01/2024.<br><br>Findings include:<br><br>On 07/22/2025 at 10:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider's facility on 11/04/2022. Resident 6 had an activated HCPOA. Resident 6's ISP, dated 04/23/2025, was not signed by Resident 6's HCPOA.<br><br>On 07/22/2022 at 1:45 p.m., Surveyor interviewed House Manager E and shared concern that Resident 6's ISP was not signed by his/her HCPOA. House Manager E stated the ISP was not signed because House Manager E had not seen the HCPOA to have the ISP signed. | N 387 | | |
| {N 389} | 83.35(3)(d) Service plans updated annually or on changes<br><br>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. | {N 389} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 389} | Continued From page 16<br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 3 individual service plans (ISP) reviewed were updated annually or on changes. Resident 6's ISP was not updated to include behaviors. Resident 4's ISP was not updated to include his/her auras.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M11, dated 09/11/2023 and SOD UK3M12, dated 07/01/2024.<br><br>Findings include:<br><br>On 07/22/2025 at 10:00 a.m., Surveyor reviewed resident records. Surveyor identified the following concerns regarding ISP updates:<br><br>Example 1 - Resident 6:<br><br>Resident 6 was admitted to the provider's facility on 11/04/2022. Resident 6's ISP, dated 04/23/2025, did not include documentation of behaviors. Resident 6's progress notes documented the following:<br><br>- 03/22/2025: " ...Resident has been very demanding regarding [his/her] snack. The amount was not enough for [him/her], staff assured [him/her] this is just a snack and we will be having dinner."<br>- 07/11/2025: "Resident stole a cinnamon roll this evening while Director was in the office ... Director confronted [Resident 6] about why [s/he] went and took the cinnamon roll ... Director asked [Resident 6] if [s/he] was supposed to do that especially after [s/he] had just had a snack. [Resident 6] said [s/he] did it because [s/he] wanted it. Director told new staff that [Resident 6] is a food seeker and has diabetes, and that [s/he] | {N 389} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 389} | Continued From page 17 | {N 389} | | |

will see what [s/he] is allowed to get away with while new staff is starting. Director told the newer staff that they need to confront [Resident 6] immediately so [s/he] is aware [s/he] can't manipulate them."
- 07/18/2025: Resident kept stopping by the office during his/her walks to delay and staff had to continuously tell him/her to keep going. Resident began crying.

On 07/22/2025 at 11:00 a.m., Surveyor reviewed the above concerns regarding Resident 6 being denied additional food and denied a visit to the office while walking with House Manager E. House Manager E stated the above occurrences were a result of Resident 6's manipulative behavior. Surveyor reviewed concern that Resident 6's ISP was not updated to identify behaviors to try to get new staff in trouble.

Example 2 - Resident 4:

Resident 4 admitted to the provider's facility on 10/26/2023 and discharged on 05/16/2025. Resident 4's progress notes, dated 03/01/2025 to 05/16/2025, documented 40 occurrences of auras. Resident 4's ISP, dated 07/29/2024, was not updated to include his/her auras.

On 07/22/2025 at 1:20 p.m., Surveyor interviewed Caregiver O regarding Resident 4. Caregiver O confirmed Resident 4 experienced auras which would result in Resident 4 being silent, drooling from the mouth and/or shaking. Caregiver O stated the auras would typically last 1-2 minutes and Resident 4 would call for staff to come and monitor him/her for 5-10 minutes.

On 07/22/2025 at 1:45 p.m., Surveyor interviewed House Manager E and shared concern that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 389} | Continued From page 18<br>Resident 4's ISP was not updated to include his/her auras. House Manager E stated s/he was unable to locate an updated ISP.<br><br>House Manager E was given until 07/23/2025 to provide follow up documentation. Documentation was not received. | {N 389} | | |
| N 397 | 83.36(1)(b) Qualified staff in charge, on duty and awake.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure at least 1 qualified resident care staff was on duty and awake when | N 397 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 397 | Continued From page 19<br>residents were present.<br><br>Findings include:<br><br>The provider is licensed to serve up to 8 individuals with diagnoses including physically disabled, irreversible dementia/Alzheimer's, advanced age, emotionally disturbed/mental illness, terminally ill and developmentally disabled.<br><br>The Department defines a "Qualified Resident Care Staff" as an employee who has successfully completed all of the applicable training and orientation (Wis. Admin. Code DHS Chapter 83.02(43)).<br><br>On 07/22/2025 at 9:15 a.m., Surveyor interviewed Caregiver O. Caregiver O stated the provider typically staffed the home with 1 caregiver per shift.<br><br>On 07/22/2025 at 9:30 a.m., Surveyor reviewed employee records provided by House Manager E. Records indicated Caregiver N, hired 05/31/2025, had not completed training for fire safety. The provider's schedule dated 06/01/2025 to 07/05/2025, documented Caregiver N worked by him/herself on 06/21/2025, 06/22/2025, 06/29/2025 and 07/05/2025.<br><br>On 07/22/2025 at 1:45 p.m., Surveyor interviewed House Manager E regarding Caregiver N working alone prior to receiving all trainings. House Manager E reviewed Caregiver N's record and confirmed Caregiver N did not have evidence of training or evidence of meeting an exemption for fire safety.<br><br>House Manager E was given until 07/23/2025 to | N 397 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 397 | Continued From page 20<br>provide follow up documentation. Documentation was not received. | N 397 | | |
| N 409 | 83.37(1)(j) Proof-of-use record.<br><br>Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure 1 of 1 narcotics reviewed were audited on a daily basis. Resident 7's Morphine Sulf ER 30 mg was not audited daily.<br><br>Findings include:<br><br>On 07/22/2025 at 10:00 a.m., Surveyor reviewed Resident 7's record. Resident 7 admitted to the provider's facility on 05/12/2025 and discharged on 07/05/2025. Resident 7's physician orders include Morphine Sulf Er 30 mg (Start Date: 05/07/2025) - Take 1 tablet by mouth 2 times daily as needed for pain.<br><br>On 07/22/2025 at approximately 1:00 p.m., Surveyor requested the provider's daily audits of Resident 7's Morphine Sulf Er 30 mg from House Manager E. House Manager E stated each shift should have completed an audit, but that the | N 409 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 409 | Continued From page 21<br>numbers wouldn't be correct because the provider didn't know how to change the numbers in the electronic system. House Manager E attempted to pull up the daily audits in the provider's electronic computer system and was unable to do so. House Manager E stated s/he would need to reach out to a peer for assistance.<br><br>House Manager E was given until 07/23/2025 to provide follow up documentation. Documentation was not received.<br><br>On 07/25/2025 at 12:20 p.m., Surveyor interviewed Pharmacist Q. Pharmacist Q stated the pharmacy delivered the following quantities of Morphine Sulf Er 30 mg to the provider's facility for Resident 7: 14 tablets on 05/09/2025, 30 tablets on 05/27/2025 and 30 tablets on 06/11/2025.<br><br>The provider did not audit Resident 7's Morphine Sulf Er 30 mg daily. | N 409 | | |
| N 431 | 83.38(1)(g) Health monitoring.<br><br>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 | N 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 431 | Continued From page 22<br>8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had their health monitored and arrangements made to meet their needs. Resident 6's concerns regarding stomach and dental pain were not addressed. Resident 6's blood sugar was not monitored as ordered.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M11, dated 09/11/2023<br><br>Findings include:<br><br>On 07/22/2025, Surveyor conducted a complaint investigation alleging the provider does not address the health concerns of residents.<br><br>On 07/22/2025 at 10:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider's facility on 11/04/2022. Resident 6's record documented the following concerns regarding health monitoring:<br><br>Example 1 - Upset Stomach: | N 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 431 | Continued From page 23<br><br>Resident 6's progress notes documented the following:<br><br>- 03/01/2025: Resident came out of bathroom and stated s/he isn't feeling well. Resident stated his/her stomach is hurting.<br>- 04/14/2025: Resident came out to main living room saying s/he had been throwing up and having diarrhea for the past 2 hours. Staff have only heard him/her open his/her door once and in the bathroom once. S/he asked for Tums; s/he does not have Tums. Staff offered him/her a PRN Lorazepam to make him/her sleep. S/he states "that will make me more sick." Staff told him/her s/he is going to have to make it to the morning as there is not much else staff can do.<br>- 04/20/2025: Resident has been asking and commenting on having some Tums recently and has again asked for some tonight. Staff let him/her know that unless a doctor or family member requests some staff cannot and should not be giving him/her Tums in the meantime since s/he does not have any in house/prescribed for him/her personally.<br>- 05/04/2025: Resident came and told staff that s/he was throwing up last night. Resident reports not feeling good.<br><br>On 07/22/2025 at 1:45 p.m., Surveyor reviewed Resident 6's documentation of stomach pain and request for Tums with House Manager E. Surveyor reviewed Resident 6's physician orders which did not include an order for Tums. Surveyor asked House Manager E if Resident 6's request for Tums had been addressed. House Manager E replied, "This is the first I'm hearing about it."<br><br>Example 2 - Dental Care: | N 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 431 | Continued From page 24<br>Resident 6's progress notes documented the following:<br><br>- 04/05/2025: Resident has been complaining about pain in a tooth on the left side of his/her mouth. S/he seems to be chewing slower because s/he is in discomfort.<br>- 04/20/2025: Resident is still requesting a dentist appointment due to tooth pain.<br>- 05/09/2025: Resident had just made staff aware that when s/he was brushing his/her teeth last night a tooth had fallen out of his/her mouth. Staff checked his/her mouth and it looks like the back right side tooth is chipped in half.<br><br>On 07/22/2025 at 1:45 p.m., Surveyor reviewed Resident 6's documentation of dental concerns with House Manager E. House Manager E stated s/he had attempted to have Resident 6 seen by a dentist with no luck. Surveyor requested documentation of House Manager E's efforts.<br><br>House Manager E was given until 07/23/2025 to provide follow up documentation. No documentation was received.<br><br>Example 3 - Blood Sugar Monitoring:<br><br>Resident 6's physician orders included an order to test blood sugars once daily 2 times weekly (Start Date: 09/29/2024). The Medication Administration Record (MAR), dated 03/01/2025 to 07/22/2025, documented his/her blood sugar was not checked from 06/14/2025 through 06/26/2025 when due because the provider did not have test strips.<br><br>On 07/22/2025 at 1:45 p.m., Surveyor reviewed concern regarding missed blood sugars with House Manager E. House Manager E stated | N 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 431 | Continued From page 25<br>there were issues with orders between Resident 6's provider and the pharmacy. | N 431 | | |
| N 450 | 83.41(2)(c) Nutrition: menus.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure deviations from the planned menu were documented.<br><br>Findings include:<br><br>On 07/22/2025 at 9:30 a.m., Surveyor reviewed the provider's menu which documented grilled peanut butter and jelly sandwiches, salad and a fruit would be served for lunch.<br><br>On 07/22/2025 at approximately 10:50 a.m., Surveyor observed Caregiver O serve residents frozen pizza, chips and a salad. Surveyor asked Caregiver O why the residents were served a meal different from the menu and how the residents were informed of the change. Caregiver O stated the residents were served pizza because the overnight caregiver had not prepared the lunch meal and that Caregiver O notified residents of the change as s/he was serving the lunch meal. Surveyor shared that the posted meal was grilled peanut butter and jelly, | N 450 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 450 | Continued From page 26<br>which may not have required preparation by the overnight caregiver. Caregiver O replied, "I guess I decided to change it."<br><br>On 07/22/2025 at 1:45 p.m., Surveyor interviewed House Manager E and shared concern that residents were not served what was listed on the provider's menu. House Manager E stated Caregiver O typically worked second shift and wasn't much of a cook. | N 450 | | |
| N 481 | 83.43(1) Environment safe, clean, and comfortable<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the environment was safe, clean, comfortable and homelike. The provider's shower chair had feces on it and Resident 6's room was not clean.<br><br>Findings include:<br><br>On 07/22/2025 at 9:30 a.m., Surveyor toured the provider's facility. The following observations were made:<br><br>- The provider's shower chair, in a bathroom accessible to all residents, had a smear of feces on it.<br>- Resident 6's room, which s/he reported was | N 481 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017158 | A. BUILDING: _____ B. WING _____ | R-C 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALICE & LOUISES II | 8679 STATE HWY 186 ARPIN, WI 54410 |

| (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 481 | Continued From page 27<br>temporary, had white debris scattered on his/her carpeting. The bathroom attached to Resident 6's room had a broken toilet paper holder and a toilet with dark black build up along the water line and interior bowl.<br>- A bedside table in Resident 6's room had 2 urinals and a pair of boxers sitting on it.<br><br>On 07/22/2025 at 1:30 p.m., Surveyor showed House Manager E his/her concerns with the provider's shower chair and Resident 6's room. House Manager E stated there had not been any showers given on 07/24/2025, so the shower chair should have been cleaned by the overnight caregiver. House Manager E stated Resident 6 was temporarily staying in the room previously occupied by Resident 7, who discharged on 07/05/2025, and the items were left over from Resident 7. House Manager E stated Resident 6 had been moved to the room approximately 2 days prior to Surveyor's visit so Resident 6's room could be treated for bed bugs. Surveyor shared concern that the room didn't appear to have been thoroughly cleaned prior to Resident 6 moving into the room. House Manager E replied, "[S/he] doesn't use that bathroom anyway. [S/he] prefers the one in the hall." | N 481 | | |