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	0013967	A. BUILDING: _____ B. WING _____	C 12/02/2025

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LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

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N 000	Initial Comments On 11/11/2025, Surveyors conducted a licensure survey and 6 complaints investigation at Liberty Village LLC. Data collection continued through 12/02/2025. Three of 6 complaints were substantiated. Ten deficiencies were identified. Four of 10 were repeat violations. See Statement of Deficiency (SOD) 77DQ11, dated 12/18/2019; 77DQ12, dated 06/02/2021; and 09N711, dated 04/26/2023. Census: 12	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 provider did not complete a caregiver background	N 219		

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

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N 219	Continued From page 1 check (CBC) for 2 of 5 staff sampled (Caregiver E and Caregiver F). Findings include: On 11/11/2025, Surveyor reviewed employee records. A complete CBC consists of 3 components: 1. A background disclosure (BID) filled out by the employee, 2. A criminal history record search from the Department of Justice (DOJ), 3. The Governmental Findings Report (GRF) letter to alert the employers to findings, restrictions and licenses from the Department of Health Services (DHS). Caregiver E was hired on 07/22/2025. Caregiver E's record did not include the date the BID was completed and had a DOJ dated 11/11/2025; 112 days after hire. Caregiver F was hired on 07/07/2025. Caregiver F's record did not include a BID and had a DOJ dated 11/11/2025; 127 days after hire. On 12/02/2025 at 10:00 AM, Surveyors interviewed Executive Director (ED) A. ED A stated for Caregiver E and Caregiver F they completed the DOJ on the day of survey after not being able to find one in their record. ED A stated they would be auditing employee records to make sure they were in compliance. Surveyor requested any background check documentation be sent by the end of the day. As of 12/02/2025 at 5:00 PM, Surveyor received via email from ED A a BID for Caregiver E, but it still did not have the date of completion on the bottom of the form.	N 219		

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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 4 of 5 employees reviewed had obtained documentation from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease, including tuberculosis (TB). Findings include: The provider is licensed to care for 22 non-ambulatory residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 11/11/2025, Surveyor conducted a review of 5 employees. Surveyor requested communicable disease screenings and TB tests from Executive	N 220		

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N 220	Continued From page 3 Director (ED) A. Assistant Administrator (AA) B was hired 03/31/2022 and had a TB test administered on 03/19/2021. An annual TB screening questionnaire was completed on 04/04/2024 and 03/03/2025. AA B's record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease. Caregiver E was hired 07/22/2025 and had a TB test administered on 11/12/2025. Caregiver E's record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease. Caregiver F was hired 07/07/2025 and his/her record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease nor evidence of a TB test. Caregiver G was hired 07/03/2025 and his/her record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease. On 12/02/2025 at 10:00 AM, Surveyors interviewed ED A. ED A stated s/he understood	N 220		

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N 220	Continued From page 4 the communicable disease screening was separate from the TB test and both documents were needed in employee's record. Surveyor requested any additional communicable disease screenings or TB tests be sent by the end of the day. As of 12/02/2025 at 5:00 PM, Surveyor did not receive any additional communicable disease screenings and TB tests for AA B, Caregiver E, Caregiver F, or Caregiver G.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide 2 of 5 (Caregiver F and Caregiver G) caregivers reviewed with orientation training, including: prevention and reporting of resident abuse, neglect and misappropriation of resident property, emergency and disaster plan and evacuation procedures, Community Based	N 230		

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N 230	Continued From page 5 Residential Facility policies and procedures, and recognizing and responding to resident changes of condition. Findings include: The provider is licensed to care for 22 non-ambulatory residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 11/11/2025, Surveyor conducted a review of 5 employees to verify compliance with training requirements. Surveyor requested orientation records from Executive Director (ED) A. Caregiver F was hired on 07/07/2025 and his/her record did not contain a signed job description and did not contain documentation to indicate s/he received training prior to performing job duties, in: -Prevention and reporting of resident abuse, neglect and misappropriation of resident property. -Emergency and disaster plan and evacuation procedures. -Community Based Residential Facility policies and procedures. -Recognizing and responding to resident changes of condition. Caregiver G was hired on 07/03/2025 and his/her record did not contain documentation to indicate s/he received training prior to performing job duties, in: -Prevention and reporting of resident abuse, neglect and misappropriation of resident property. -Emergency and disaster plan and evacuation procedures. -Community Based Residential Facility policies and procedures.	N 230		

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N 230	Continued From page 6 -Recognizing and responding to resident changes of condition. On 12/02/2025 at 10:00 AM, Surveyors interviewed ED A. ED A stated they had a competency checklist all new employees filled out with their trainer and a lot of their training was done through an online platform. Surveyor requested any orientation documentation be sent by the end of the day. As of 12/02/2025 at 5:00 PM, Surveyor did not receive documentation to indicate Caregiver F and Caregiver G received required orientation training prior to performing any job duties.	N 230		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance	N 310		

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N 310	Continued From page 7 fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents admitted had a signed and dated admission agreement completed at the time of admission. Resident 3 did not have an admission agreement on file. Findings include: On 11/11/2025 at approximately 9:45 AM, Surveyor asked Executive Director (ED) A for names of residents discharged in the past six months. ED A informed Surveyor Resident 3 discharged over Labor Day weekend when s/he went home with family from the hospital. ED A further stated Resident 3 had recently transfered to the Community Based Residential Facility (CBRF) from the provider's Residential Care Apartment Complex (RCAC) and was at the facility approximately 1 month prior to discharge. On 11/11/2025, Surveyor requested to review Resident 3's record. Resident 3's face sheet	N 310		

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N 310	Continued From page 8 indicated Resident 3 had an admission date of 05/18/2023, a discharge date of 08/31/2025, and had an activated power of attorney for health care (POA). The record contained an admission agreement to the Residential Care Apartment Complex (RCAC). No admission agreement was available for Resident 3's admission to the CBRF. On 11/11/2025 at approximately 10:10 AM, Surveyor interviewed ED A and asked when Resident 3 moved to the Community Based Residential Facility (CBRF). ED A stated Resident 3 had moved to the CBRF from the RCAC "end of July, beginning of August 2025." Surveyor asked ED A if an admission agreement was completed upon Resident 3's admission to the CBRF. ED A stated, "There was no admission agreement completed when [s/he] moved to the CBRF from the RCAC. Coming to Wisconsin, I didn't know they needed a new one, so I did not do one for [Resident 3]."	N 310		
N 328	83.31(4)(c) Involuntary discharge notice requirements. 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 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	N 328		

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N 328	Continued From page 9 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide an involuntary discharge notice to Resident 2 that included the following requirements: a statement indicating the resident may ask for Department review, the contact information for the regional office's director, or the contact information for the regional office ombudsman program. This is a repeat deficiency. See Statement of Deficiency (SOD) 77DQ11, dated 12/18/2019. Findings include: The provider is licensed to care for 22 non-ambulatory residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 05/22/2025, the Department received two complaints regarding involuntary discharges. On 11/11/2025, Surveyor requested to review Resident 2's record, including the discharge notice issued by the provider.	N 328		

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Resident 2 had an admission date of 08/18/2021.

On 11/11/2025, Executive Director (ED) A informed Surveyor Resident 2 went to surgery for wounds on his/her feet and/or legs, and former Registered Nurse (RN) C went to assess Resident 2 after surgery and determined they could no longer meet his/her needs for wound care.

On 11/11/2025, Surveyor reviewed a copy of the 30-day discharge notice. The notice dated 05/08/2025 read:

"This letter is to inform you that we are issuing a 30-day notice of discharge for higher level of care. Pursuant to Wisconsin Administrative Code 89.29 (Administrative Code for CBRF's is DHS 83) the reasons for the termination of services are DHS 89.29(3) (1,3,5): (1) The tenant's needs cannot be met at the level of service which facilities are required to make available. (3) The tenants condition requires the availability of a nurse 24 hours/day. (5) The tenant's behavior or condition poses an immediate threat to the health safety of self or others. Mere old age, eccentricity or physical disability, either singly or together, are insufficient to constitute a threat to self or others.

Wisconsin Administrative Code 89.29(9)(c) requires that we inform you that you may file a grievance, within the next 10 days, per the grievance procedure outlined in the tenant service agreement. Your request should state why you disagree with this discharge.

Below is a list of alternative living options you may consider and that [sic] currently have availability ... [4 other facilities listed]."

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N 328	Continued From page 11 The discharge notice was signed by ED A and included "cc: [the name of the Assisted Living Regional Director and the name of the Regional Ombudsman]." The discharge notice included the wrong DHS code, and did not include a statement indicating the resident may ask for Department review, the contact information for the regional office's director, or the contact information for the regional office ombudsman program. On 12/02/2025 at approximately 10:30 AM, Surveyor discussed the above requirements with ED A. ED A informed Surveyor Resident 2 was his/her own person and had received a copy of the notice in the hospital. ED A was not aware of the discharge notice requirements outlined in DHS 83.	N 328		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.	N 389		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not review and revise Resident 1's individual service plan (ISP), when there was a change in Resident 1's code status.

Findings include:

On 09/15/2025 and 09/18/2025, the department received a complaint alleging resident's code status was not updated.

On 11/11/2025 at 9:50 AM, Surveyors interviewed Executive Director (ED) A and asked if there had been any resident incidents in the past 3 months that required hospitalization. ED A stated Resident 1 had an incident where s/he went unresponsive while sitting at the dining room table. ED A stated staff called emergency medical services (EMS) and were instructed to perform CPR (cardiopulmonary resuscitation). ED A stated their policy was staff were not required to perform CPR unless they were comfortable taking instruction from EMS. ED A confirmed Resident 1 was a full code in the electronic charting system at the time of the incident. ED A stated they were not aware of Resident 1's change in code status to DNR (Do Not Resuscitate) prior to the incident. ED A stated after the incident they found Resident 1 had two POST (Provider Orders for Scope of Treatment) forms in his/her paper chart, with one indicating his/her change to DNR status. ED A stated someone must have stuck the most current POST form in Resident 1's paper chart and did not scan it into the electronic charting system. ED A stated now they were doing a quarterly audit to check resident code status. ED A stated their procedure was all medical forms were to go to their nurse, who then would update the resident's

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electronic record.

On 11/11/2025 at 11:40 AM, Surveyor interviewed Caregiver E. Caregiver E stated s/he would look in the electronic charting system for a resident's code status. Caregiver E stated if there were any changes to the resident's code status, Assistant Administrator (AA) B would update the electronic charting system.

On 11/11/2025 at approximately 12:40 PM, Surveyor interviewed Caregiver D. Caregiver D stated management was responsible for changing a resident's code status in the electronic charting system because staff did not have security access to make that kind of change.

On 11/11/2025, Surveyor reviewed Resident 1's record.

The face sheet indicated Resident 1 was admitted to the facility on 08/27/2024. S/he had multiple diagnoses including dementia, peripheral neuropathy, chronic coronary artery disease, orthostatic hypotension, transient ischemic attack (TIA), cerebral infarction, and history of falling. Resident 1 had an activated power of attorney for healthcare (POAHC) and the face sheet indicated s/he was full code.

An incident report dated 09/08/2025, indicated Resident 1 was sitting at the dining room table after the evening meal and slumped over becoming unresponsive. Staff contacted EMS and performed CPR per EMS instruction.

Resident 1's ISP, with a print date of 11/13/2025, indicated Resident 1's code status was full code.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 14 A POST form dated 08/26/2024 and signed by Resident 1's POAHC, indicated Resident 1 wanted CPR attempted if s/he was found without a pulse or was not breathing. This document indicated Resident 1 was a full code. A POST form dated 05/28/2025 and signed by Resident 1's POAHC, indicated Resident 1 no longer wanted CPR attempted if s/he was found without a pulse or was not breathing. This document indicated Resident 1's code status changed from full code to DNR. A history and physical dated 05/28/2025, indicated the DNR and POST form was filled out today and provided to family and the facility. On 12/02/2025 at 10:00 AM, Surveyors interviewed ED A. ED A stated their facility CPR policy was the same as prior to the incident on 09/08/2025, that staff were not required to perform CPR unless they felt comfortable being instructed by EMS. ED A stated Resident 1's ISP was updated prior to the incident on 09/08/2025 with his/her increased fall risk, but was not updated with the change in code status in May 2025. ED A stated it was the nurse's responsibility moving forward to update any changes to a resident's code status. ED A stated the code status would be changed in the electronic charting system on the resident's face sheet and understood it should be updated on a resident's ISP as well.	N 389		
N 443	83.39(5) Pets vaccinated. The CBRF shall ensure that pets are vaccinated against diseases, including rabies, if appropriate.	N 443		

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	0013967	A. BUILDING: _____ B. WING _____	C 12/02/2025

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N 443	Continued From page 15 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure all pets were vaccinated. Findings include: The provider is licensed to care for 22 non-ambulatory residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 11/11/2025 at approximately 10:00 AM, Surveyors interviewed Executive Director (ED) A and inquired if there were any pets residing in the facility. ED A stated Resident 4 had a cat. Surveyor requested vaccination records for the cat. On 11/11/2025 at 1:00 PM, Surveyor interviewed Resident 4 and observed a cat in his/her room. At the end of survey on 11/11/2025 at 4:00 PM, Surveyor had not received vaccination records for the cat. On 11/14/2025 at 2:10 PM, Surveyor interviewed Executive Director (ED) A. ED A stated Resident 4's cat had passed away. On 12/02/2025 at 10:00 AM, Surveyors interviewed ED A. ED A stated they could not find the cat's vaccination records and they were not on file. The provider did not ensure all pets were vaccinated.	N 443		

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N 499	Continued From page 16	N 499		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were securely stored. This is a repeat deficiency. See Statement of Deficiency (SOD) 77DQ12, dated 06/02/2021 and 09N711, 04/26/2023. Findings include: The provider is licensed to care for 22 non-ambulatory residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 11/11/2025 at approximately 12:00 PM, Surveyor observed in the east wing under the unsecured kitchenette sink cabinet the following: -multi-surface cleaner -sanitizer -disinfectant -liquid dish washer soap. On 11/11/2025 at approximately 12:15 PM, Surveyor observed in the unsecured laundry room in an unsecured cabinet the following: -multi-surface cleaner -toilet bowl cleaner -disinfectant -floor cleaner.	N 499		

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N 499	Continued From page 17 On 11/11/2025 at approximately 12:40 PM, Surveyor observed in the west wing under the unsecured kitchenette sink cabinet the following: -liquid dish soap -sanitizer. On 11/11/2025 at approximately 12:40 PM, Surveyor interviewed Caregiver D. Caregiver D stated the cabinet under the kitchen sink was usually locked. On 12/02/2025 at 10:00 AM, Surveyors interviewed Executive Director (ED) A. ED A acknowledged the concerns related to the storage of toxic chemicals and would correct it immediately.	N 499		
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 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.	N 525		

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N 525	Continued From page 18 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drill documentation included residents having an evacuation time greater than the time allowed under s. DHS 83.35(5), and the type of assistance needed for evacuation in 2024 and 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) 77DQ12, dated 06/02/2021. Findings include: The provider is licensed to care for 22 non-ambulatory residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 11/11/2025, Surveyor reviewed the provider's drills. In 2024, there were two fire drills documented. The fire drill on 10/14/2024 indicated only the alarms were triggered and had a total evacuation time of 17 minutes. The fire drill on 11/13/2024 was concluded at 2:30 AM and had a total evacuation time of 40 minutes. A fire drill documented on 07/15/2024 indicated it was a "walking drill" where staff were educated on the fire evacuation process. In 2025, there were three fire drills documented so far. The fire drill on 01/27/2025 indicated the total evacuation time was 10 minutes. The fire drill on 03/07/2025 indicated the total evacuation time was 20 minutes. The fire drill on 09/19/2025 indicated the total evacuation time was 11 minutes. Fire drill documentation did not record residents having an evacuation time greater than the time allowed under s. DHS 83.35(5), and the type of assistance needed for evacuation.	N 525		

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N 525	Continued From page 19 On 12/02/2025 at 10:00 AM, Surveyors interviewed Executive Director (ED) A. ED A stated there were three fire drills completed in 2024 starting in April 2024. Surveyor did not have a documented fire drill for April 2024. ED A stated they had a NOC (overnight) simulated fire drill scheduled for 12/16/2025. ED A stated prior to his/her employment, approximately 2 years ago, fire drills were not being conducted. ED A stated residents did participate in fire drills and s/he had been educating staff about fire evacuation through staff meetings and walking through the process.	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 conduct tornado, flooding, or other emergency or disaster evacuation drills at least semi-annually in 2024 and 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) 77DQ12, dated 06/02/2021. Findings include: The provider is licensed to care for 22 non-ambulatory residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 11/11/2025, Surveyor reviewed the provider's emergency drills. The provider did not have any	N 526		

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N 526	Continued From page 20 documented emergency drills in 2024 and only one emergency drill documented in 2025. The emergency drill was done on 07/15/2025 for an elopement. On 12/02/2025 at 10:00 AM, Surveyors interviewed Executive Director (ED) A. ED A confirmed there were no emergency drills completed in 2024 and only the one emergency drill in July 2025 was completed so far.	N 526		