STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	R-C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 03/12/2025, Surveyors conducted six complaint investigations and a verification visit at Eagles Rest at Pepin. Data collection continued through 04/09/2025. Five of 6 complaints were substantiated. Thirteen deficiencies were identified. Four of 13 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023, SOD ZTUE12, dated 11/09/2023, SOD XK2K11, dated 06/11/2024, and SOD XK2K12, dated 10/18/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 27	{N 000}		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by:	N 163		

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N 163	Continued From page 1 Based on record review and interview, the provider did not ensure the department was notified within 3 working days after Resident 2's whereabouts were unknown on 02/09/2025. Resident 2 was found outside after another resident informed staff that Resident 2 was observed outside of his/her window. Findings include: The provider is licensed to care for up to 50 residents in the client groups developmentally disabled, terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 02/19/2025, the department received a complaint regarding elopement. On 03/12/2025, at approximately 11:30 AM, Surveyors reviewed Resident 2's record via the provider's electronic documentation system. Resident 2 was admitted on 09/13/2024 with multiple diagnoses, including vascular dementia and insomnia. Resident 2's Individual Service Plan (ISP) indicated s/he was a wander risk and an elopement risk. Staff observation notes included the following: On 10/17/2024 at 5:00 AM: Resident 2 was last seen at 4:00 AM and at 4:15 AM. Staff could not find him/her. Staff called 911 while continuing to search. Resident 2 was found in another resident's bed. On 02/07/2025 at 9:30 AM: "We have tried redirecting [Resident 2] quite a few times today	N 163		

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N 163	Continued From page 2	N 163		

but [s/he] did not listen. [S/he] made it out the back door down the 200 wing. Had to walk [him/her] around the building to get [him/her] inside. [S/he] did not have a coat on ..."

On 02/09/2025 at 3:30 PM: "Around 1pm I was in a residents [sic] room and all other staff were helping other residents. When one of the residents came and found me and said [s/he] seen [sic] [Resident 2] outside [his/her] window. WE [sic] had to go outside and get [him/her] and once we tried to gguide [sic] [him/her] [s/he] became combative."

Surveyor reviewed Resident 2's incident reports and did not locate any incidents related to Resident 2's elopement.

The outdoor temperatures recorded on 02/09/2025 in the vicinity of the provider included a high temperature of 18 degrees Fahrenheit with a low temperature of -8 degrees Fahrenheit.

On 03/12/2025, at approximately 10:05 AM, Surveyor interviewed Administrator A about self-reports that need to be reported to the Department. Administrator A recently began employment and stated s/he was told the previous Administrator (Administrator H) was let go because s/he was not reporting everything.

On 03/12/2025, at approximately 1:15 PM, Surveyor interviewed Caregiver D. Caregiver D stated a resident saw Resident 2 outside of his/her window and informed staff of his/her observation. Caregiver D stated Resident 2 likely eloped through the exit door near the kitchen. Caregiver D stated that exit was the only exit without an alarm on it. Caregiver D stated the door had not had an alarm on it since s/he had

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N 163	Continued From page 3 been working there. Caregiver D stated Resident 2 was outside and was wearing socks, shoes, a t-shirt and pants. On 03/17/2025 at 1:17 PM, Surveyors received an email from the local police department with records pertaining to emergency contact visits with the provider. The report included the following: An incident report, dated 10/17/2024, with a classification of "Missing Person." The initial incident section stated a resident with severe dementia had been missing from the facility and was last seen at 4:20 AM wearing blue jeans, a green shirt, and slippers. It stated the resident was located by staff. The provider did not report to the Department when Resident 2's whereabouts were unknown.	N 163		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 1's legal	N 169		

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representative when his/her whereabouts were unknown.

Findings include:

The provider is licensed to care for up to 50 residents in the client groups developmentally disabled, terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's.

On 10/14/2024, the department received a self-report from the provider indicating Resident 1 had eloped from his/her facility on 10/09/2024. Law enforcement was called to assist and found Resident 1 by the train tracks. Resident 1 was returned to the facility.

On 01/10/2025, 02/19/2025, 02/25/2025, and 03/06/2025, the department received complaints regarding the supervision of residents.

On 03/12/2025, at approximately 11:30 AM, Surveyors reviewed Resident 1's record.

Resident 1 was admitted on 08/26/2024 with multiple diagnoses, including toxic encephalopathy due to methanol, partial complex seizure disorder without epilepsy, and heart failure. Resident 1 was discharged on 03/05/2025. S/he had a corporate guardian.

Staff observation notes, dated between September 2024 and January 2025, included the following:
On 09/04/2024: Resident 1 exited out the 200-hall door. Staff found him/her walking around the building.
On 09/10/2024: Resident 1 exited out the 200-hall door. Staff picked Resident 1 up by the café. RN

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stated s/he updated guardian and MCO (Managed Care Organization.)
On 09/15/2024: Resident eloped from the building around 9:00 PM. Police located him/her across town.
On 09/30/2024: Resident 1 got outside sometime during shift change. Resident 1 was "brought back by a random guy in a truck."
On 10/06/2024: Staff was sitting outside on break and observed Resident 1 around the corner ... "Nobody knew [s/he] was outside."
On 10/11/2024: Staff was told by another resident that Resident 1 had left the building. Staff was able to redirect Resident 1 back inside.
On 10/23/2024: On 10/22/2024, staff went to offer Resident 1 breakfast and realized Resident 1 was not in his/her room. Resident 1 was found about 1 block from the building talking to the police chief.
On 10/30/2024: Resident 1 left the building and was found by the hotel.
On 12/02/2024: Resident 1 left the building and was found by the school.
On 01/08/2025: Resident 1 was outside of the facility and walking around town. Staff located him/her by the fire station using his/her tracking device.

At approximately 1:15 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 had a history of elopements and would more often attempt elopements on the night shift.

On 03/21/25, at 3:45 PM, Surveyor interviewed Guardian F via phone. Guardian F stated s/he was Resident 1's guardian. Guardian F stated Resident 1 had a different guardian prior to him/her. Guardian F stated s/he was not aware of Resident 1's elopements until Adult Protective Services (APS) got involved. Guardian F stated s/he was aware of 2 elopements.

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N 169	Continued From page 6 On 03/25/2025, at 2:00 PM, Surveyor interviewed Guardian G via phone. Guardian G stated the provider did not update him/her regarding Resident 1's frequent elopements. Guardian G stated s/he was told about Resident 1's first elopement in August 2024, and 1 other elopement incident. Guardian G stated they heard nothing from the provider after that. Guardian G stated that sometime in January 2025, Guardian F was notified by APS that "something like half a dozen total elopements" occurred and the guardianship office was not notified of any.	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the provider and its operation complied with all laws governing the facility. Findings include: This is a repeat deficiency and is being cited for the third time. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023, and SOD ZTUE12, dated 11/09/2023. The provider is licensed to care for 50 adults in the client groups developmentally disabled, terminally ill, irreversible dementia/Alzheimer's,	N 196		

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N 196	Continued From page 7 advanced aged, and physically disabled. The provider was licensed on 12/05/2022. Between July 2023 and October 2024, the Department conducted 5 surveys at the facility. Four of 5 surveys were prompted by complaints. Complaint investigations resulted in the substantiation of ten of 14 complaints related to programming, investigating caregiver misconduct, reporting, physical environment, and care. The provider was issued a No New Admit Order on 09/14/2023. See Statement of Deficiencies (SOD) ZTUE11, dated 08/10/2023, SOD ZTUE12, dated 11/09/2023, XK2K11, dated 06/11/2024, and SOD XK2K12, dated 10/18/2024. The Department issued an Order to Comply with Requirements with the providers for 4 SODs that read, in part: "ORDER TO COMPLY WITH REQUIREMENTS ... effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request." See SOD XK2K11, dated 06/11/2024, and SOD XK2K12, dated 10/18/2024, SOD ZTUE12, dated 11/09/2023, and ZTUE11, dated 08/10/2023.	N 196		

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N 196	Continued From page 8 The Notice and Order that accompanied SOD ZTUE11 also included an order not to admit new or additional residents. The Special Orders read, in part: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS ... the licensee shall correct all violations identified in Statement of Deficiency (SOD) ZTUE11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License. IF the licensee has not achieved substantial compliance with all laws and administrative rules governing the facility and its operation AND IF the violations identified in SOD ZTUE11 remain substantially uncorrected, the PROBATIONARY LICENSE for Eagles Rest at Pepin may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE ..." The Notice and Order that accompanied SOD ZTUE12 extended the order not to admit new or additional residents until all violations were corrected from SOD ZTUE12. Special Orders read, in part: "...the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, the licensee shall achieve and maintain substantial compliance with all requirements prior to the expiration of the probationary license on 11/30/2023. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon	N 196		

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N 196	Continued From page 9 request. The current survey was prompted by 6 complaints. Five of 6 complaints were substantiated, and the following concerns were identified throughout the course of the survey: - The provider did not notify the Department when residents' whereabouts were unknown. - The provider did not ensure resident guardians or representatives were notified of incidents or changes to resident needs. - The provider permitted a condition of risk when 2 residents eloped from the home on several occasions. - Residents did not receive medications as prescribed. - The provider (without direction from local county health) restricted the resident's environment when instructions were given for residents to be confined to their rooms in response to a communicable disease outbreak, and resident doors were locked as an intervention for behaviors. - The provider did not assess residents prior to admission. - Individual service plans (ISP) were not developed with the resident and/or the resident's legal representative. - ISPs were not updated or accurate to resident needs. - The provider did not monitor the health of residents. - The provider did not ensure equipment was stored in a clean manner and in good repair. - Food was not stored properly or at safe temperatures. - The provider did not maintain electrical systems in a safe condition.	N 196		

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N 196	Continued From page 10 On 04/09/2025 at approximately 3:30 PM, Surveyor interviewed Licensee B to discuss survey findings and past non-compliance history of the facility. Surveyor asked if Licensee B felt s/he was fulfilling licensee duties. Licensee B stated, "Yeah, I think we are. I think we care for the residents and follow things through, and I think what we experienced with [Administrator H] and [Nurse K] was a result of false information being reported to me and living under false assumption, and 100% believe that. The conditions things are right now are entirely different than back then. We've diligently gone through all care plans; they've all been updated and in process of getting all signatures on them. I would tell you, as it sits right now, things are excellent. We've got our new nursing staff, it's really amazing and feel like we've made huge strides in addressing those things. I feel like things are really looking great." Surveyor asked Licensee B if s/he was made aware of past deficiencies. Licensee B stated s/he had "grown in them after the mock survey, having gone through things with new nursing staff, I can see areas that needed some serious improvement. They've been quickly addressed." Surveyor then asked Licensee B if s/he had plans to do anything differently moving forward with new management in place. Licensee B stated, "As the licensee I would typically visit with them every week and make sure things are going well. I used to talk to [Administrator H] daily, but I think part of the problem was we/I wanted to believe [him/her] rather than question [him/her]. I question now versus just trust them. I've been going to appointments with some residents and talking with care providers throughout the process to give me insight on what the professionals are	N 196		

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N 196	Continued From page 11 thinking. When I have the opportunity, I'll take them for a ride to go to their doctor appointment." Cross Reference: N0163 DHS 83.12(4)(a) Reporting When Resident's Whereabouts Unknown N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0205 DHS 83.14(2)(j) Not Permit A Condition Of Substantial Risk N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0356 DHS 83.32(3)(l) Rights Of Residents: Least Restrictive Environment N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plan Updated Annually Or On Changes N0431 DHS 83.38(1)(g) Health Monitoring N0446 DHS 83.41(1)(b) Equipment N0452 DHS 83.41(3)(b) Food Safety N0496 DHS 83.45(1)(e) Electrical, Mechanical, Water Supply	N 196		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on observation, record review, and	N 205		

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interview, the licensee permitted the existence or continuation of a condition which created a substantial risk to the health, safety or welfare of residents.

Resident 1 was admitted as a registered sex offender with suspected history of elder abuse. Resident 1 exhibited behaviors and successfully eloped from the facility on multiple occasions that required law enforcement intervention.

Resident 2 eloped from the facility after staff were aware of an unsecured exit door near the kitchen. The exit led to an unsecured outdoor patio area. Staff identified the unsecured door as the suspected mode of elopement for both residents, and the door remained unsecured at the time of survey.

Findings include:

On 01/10/2025 and 02/10/2025, the Department received complaints regarding elopements.

Example 1:

Interviews:

On 03/12/2025, at approximately 9:45 AM, Surveyors interviewed Administrator A. When asked about Resident 1, Administrator A stated Resident 1 was no longer residing with the provider. Administrator A stated that the night before Resident 1 moved, s/he attacked a staff member. When asked about Resident 1's elopement risk, Administrator A stated the provider was not doing much to deter elopements, and did not appear to have adequate interventions in place which resulted in "several elopements."

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N 205	Continued From page 13 At approximately 1:30 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 would often attempt elopements on the night shift. Caregiver D stated Resident 1 may have eloped through the same door as Resident 2. When asked about the door, Caregiver D stated there was an exit door near the kitchen that did not have an alarm on it. When asked how long the door had not been alarmed, Caregiver D stated it had not had an alarm for the duration of his/her time working for the provider. At approximately 1:45 PM, Surveyor interviewed Licensee B about Resident 1's elopements. Licensee B stated Resident 1 had eyes on him/her all the time when Resident 1 was awake and 15-minute checks while sleeping. Licensee B stated Resident 1 had a history of being "very abusive," including sexual offenses and offenses against the elderly. At approximately 2:30 PM, Surveyor interviewed Licensee K regarding door alarms. Licensee K stated they were not a locked facility but one door next to the kitchen dining room was not alarmed. Licensee K stated Resident 1 had a wander guard device but would frequently remove it, and Resident 2 had a wander guard device on his/her arm and ankle. Surveyor observed the door by the kitchen dining room with Licensee K which did not contain an alarm system. Licensee K informed Surveyor s/he had plans to create an enclosed fenced in area so residents would be able to enjoy the outdoors without the risk of eloping, but did not have a definitive timeline on when the project would start or be completed. On 03/12/2025, Surveyor reviewed Resident 1's record in the provider's electronic documentation	N 205		

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	0019052	A. BUILDING: _____ B. WING _____	R-C 04/09/2025

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system.
Resident 1 was admitted on 08/26/2024 with multiple diagnoses, including toxic encephalopathy due to methanol, partial complex seizure disorder without epilepsy, and heart failure. Resident 1 was discharged on 03/05/2025 and had a corporate guardian.

Staff observation notes, dated between August 2024 and March 2025, documented Resident 1's guardian requested s/he be transferred for admission by ambulance due to history of violence, and Resident 1 had six elopements beginning on the date of his/her admission which required assistance from law enforcement for his/her safe return. Resident 1 was located outside, several blocks away from the facility and was located in the next town (approximately 6 miles from the facility) by the sheriff's department.

POLICE REPORTS

On 03/17/2025, Surveyor reviewed police reports received from local law enforcement, requested on 03/13/2025. The following reports were received regarding elopements:

-08/27/2024: [Licensee K] called law enforcement but did not leave a message. [Licensee K] later texted detailing a time line [sic] in reference to a missing person. The person was located and returned by the Sheriff's office.

-09/07/2024: Facility staff contacted law enforcement in regards [sic] to missing person (Resident 1). Resident 1 was located at the Village Hall.

-09/14/2024: Resident 1 left the facility again and staff had been searching for approximately 20

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minutes. Resident 1 was located east of the intersection of 3rd and Boyd streets. Resident 1 reported s/he got lost.

-10/09/2024: Dispatched for Resident 1 who left the facility once again. S/he was reported to be missing for over an hour and was located near the fire department. Law enforcement stressed to the facility the importance of monitoring residents better.

-10/17/2024: Resident with severe dementia (Resident 2) reported missing from facility. Last seen around 4:20 AM wearing blue jeans, green shirt and slippers.

The Department received the following self-reports regarding Resident 1 from Administrator H:

-08/27/2024: Resident was in [his/her] room with nurse. Nurse stepped out to call guardian. Staff was getting a PRN (as needed medication) ready to give resident swo [sic] administrator walked down to [his/her] room and [s/he] was not in [his/her] room. Facility was checked inside and outside. Police notified. Staff began driving around to look for resident. Resident was located in a nearby town after receiving a ride from a passerby who also gave [him/her] money. Resident was then looking for another ride but did not find one so started walking back towards facility. Sheriff deputy picked [him/her] up and returned to facility. Resident now has a wander guard on as well as 5-minute checks.

-10/09/2024: Staff went to administer HS (hour of sleep) meds and resident was not in room. in [sic] building search done, exterior search done, additional staff drove around looking for [him/her].

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Call placed to dispatch as [s/he] was not found [sic] Officers found [him/her] by train tracks and brought [him/her] back to facility. [S/he] told staff that [s/he] was waling [sic] out of town and then returned to the tracks on [his/her] way back. No injuries but was tired [sic] [S/he] has a wander guard, apple watch and air tag that are used to monitor [his/her] whereabouts. [His/her] room has an alarm on it. all [sic] exit doors have alarms. [s/he] [sic] took off the watch and air tag and hid them in [his/her] room. [S/he] went out a door that the wander guard is not on. New locks have been ordered by owner."

The Department was not notified by the facility of the elopements that occurred on 09/07/2024, 09/14/2024, 10/17/2024, per law enforcement documentation.

Surveyor received a report via email from Adult Protective Services (APS) prior to the date of survey, dated 01/10/2025. APS reported they spoke with the Pepin police department prior to their investigation at the facility and noted the following incidents were not documented/or reported by the facility:

10/22/2024: "Had not been reported missing. Community contacts around 5AM where [s/he] went into the lion's [sic] club building and asked where [his/her] keys and hat were, then walked into the Amish inn [sic] motel and asked for a room but had no money or means to pay. [S/he] was missing for approximately 3 hours and returned by law enforcement."

01/08/2025: No police report. APS report completed by bystander who found [Resident 1].

The email further noted, "There is at least one

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other incident that we (APS) are aware of reported to Pepin County Sherriff's office where [Resident 1] was not reported missing, was missing 3-4 hours, and located in a neighboring town (Stockholm, WI)."

Example 2:

Resident 2 was admitted on 09/13/2024 with multiple diagnoses including vascular dementia and insomnia. Resident 2's Individual Service Plan (ISP) indicated s/he was a wander risk and an elopement risk.

On 03/12/2025, staff observation notes reviewed documented Resident 2 had made it out the door on the 200 wing, and was outside without a coat on 02/07/2025. On 02/09/2025 staff documented they were notified by another resident that Resident 2 was outside his/her window.

Surveyor reviewed Resident 2's incident reports and did not locate any incidents related to Resident 2's elopement.

The outdoor temperatures recorded on 02/09/2025 in the vicinity of the provider included a high temperature of 18 degrees Fahrenheit, with a low temperature of -8 degrees Fahrenheit.

The Department was not notified of Resident 2's elopement that occurred on 02/09/2025.

On 03/12/2025, at approximately 1:15 PM, Surveyor interviewed Caregiver D. Caregiver D stated a resident saw Resident 2 outside of his/her window and informed staff of his/her observation. Caregiver D stated Resident 2 likely eloped through the exit door near the kitchen. Caregiver D stated that exit was the only exit

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N 205	Continued From page 18 without an alarm on it. Caregiver D stated the door had not had an alarm on it since s/he had been working there. Caregiver D stated Resident 2 was outside and was wearing socks, shoes, a t-shirt and pants.	N 205		
N 352	83.32(3)(h) Rights of Residents: Receive medication 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident received all medications as prescribed. Resident 1 did not receive his/her scheduled Nystatin Powder as ordered by his/her provider for a skin infection. Resident 1 was seen in the Emergency Room (ER) on 02/25/2025 and was diagnosed with a Urinary Tract Infection (UTI.) Resident 1 received a prescription order for an antibiotic, dated 02/25/2025, that was not administered until 02/28/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023 and ZTUE12, dated 11/09/2023. Findings include:	N 352		

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N 352	Continued From page 19 On 02/25/2025, the department received a complaint regarding the provider's monitoring of residents' changes in condition. On 03/12/2025, at approximately 9:45 AM, Surveyors interviewed Administrator A. Administrator A stated Adult Protective Services (APS) visited the facility and became involved in Resident 1's care planning. Surveyors requested Resident 1's individual service plan (ISP), original medication orders, and medication administration records (MAR.) Resident 1 was admitted on 08/26/2024 with multiple diagnoses, including toxic encephalopathy due to methanol, partial complex seizure disorder without epilepsy, and heart failure. S/he had a corporate guardian. Resident 1's ISP indicated s/he required assistance from staff with managing and administering medications. At approximately 1:45 PM, Surveyors interviewed Licensee B. Licensee B stated Resident 1 had a UTI the week before s/he was discharged from the provider. Licensee B stated Resident 1 tested positive for a UTI around 02/25/2025, and tested negative on or around 03/04/2025. At 2:32 PM, Surveyors received an email from Licensee B with original medication orders for Resident 1 that included the following: Amoxicillin-Clavulanate (Augmentin) 875-125 MG Tablet. Take 1 tablet by mouth 2 times daily for 7 days for UTI. Start date: 02/25/2025; End date: 03/04/2025. Nystatin (Nystop) 100,000 Unit/Gram Powder. Apply to skin 4 times daily for a skin infection due	N 352		

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N 352	Continued From page 20 to the fungus Candida. Start date: 02/25/2025; End date: none indicated. Resident 1's February 2025 MAR did not include an order for Nystatin Powder. There was no indication the powder was administered by staff to address Resident 1's skin infection. The MAR showed an order for the Augmentin antibiotic that was signed as administered on 02/28/2025. It was entered in the MAR as needed with no time of administration identified. It appeared to be given once on 02/28/2025. Resident 1's March 2025 MAR did not include an order for Nystatin Powder. There was no indication the powder was administered by staff to address Resident 1's skin infection. The MAR showed an order for Augmentin to be administered 2 times daily at 8:00 AM and 8:00 PM. It was not signed as administered on 03/01/2025 at 8:00 AM. It was signed as administered at the following times between 03/01/2025 and 03/05/2025: 8:00 AM: 03/02/2025, 03/03/2025, 03/04/2025, 03/05/2025; 8:00 PM: 03/01/2025, 03/02/2025, 03/03/2025, 03/04/2025. On 03/17/2025, at approximately 1:30 PM, Surveyor contacted Resident 1's pharmacy by phone. Surveyor interviewed Pharmacy Representative (PR) C. PR C stated they received Resident 1's Augmentin order and Nystatin order on 02/25/2025. PR C stated the orders were received later in the day and were delivered to the provider on 02/26/2025. PR C stated the Nystatin was originally out of stock in the size that was ordered but s/he believed it was filled and delivered the following day. PR C stated the provider was billed for it and they did not receive any calls indicating it was not received.	N 352		

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N 352	Continued From page 21 On 03/27/2025 at 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 returned to the provider the same day as his/her ER admission. Administrator A stated Resident 1 would have gotten his/her first dose of Augmentin from the provider the next day. When asked if Administrator A could account for the Augmentin on 02/26/2025 and 02/27/2025, Administrator A stated s/he would have to look. Administrator A stated it looked like Resident 1 did not receive his/her dose until the evening of 03/01/2025. Administrator A later stated the Augmentin was ordered on 02/28/2025 at 8:15 PM, and was given on 02/28/2025. Administrator A stated the latest the Augmentin should have been given was the day after Resident 1's ER visit. Administrator A did not have information regarding the Nystatin order. On 04/09/2025, at approximately 2:00 PM, Surveyor interviewed Licensee B. Surveyor shared concerns regarding the timely administration of Resident 1's antibiotic and orders not appearing on the MAR. Licensee B stated s/he had to go "toe to toe" with the medication passers in the past. Licensee B stated additional staff training would help ensure medication passers are following the correct procedures. The provider did not ensure Resident 1 received all prescribed medications as ordered. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 352		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env	N 356		

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N 356	Continued From page 22 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents had the least restrictive conditions necessary when all residents were confined to their rooms after the provider identified several residents were exhibiting signs of illness. Findings include: On 03/12/2025, at approximately 11:30 AM, Surveyor reviewed Resident 2's records. Resident 2 was admitted on 09/13/2024 with multiple diagnoses, including vascular dementia and insomnia. A staff observation note for Resident 2, dated 02/12/2025, read, in part, "...Has been pretty compliant this shift in telling [him/her] to go back to [his/her] room several times due to entire building being under quarantine..." On 03/17/2025, at 1:17 PM, Surveyors received an email from the local police department with records pertaining to emergency contact visits with the provider. A police report, dated 02/17/2025, indicated police were dispatched for a welfare check of a resident. The report read, in part, "...they explained to me that a resident	N 356		

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N 356	Continued From page 23 [Resident 4] had made threats to throw [him/herself] out of [his/her] wheelchair on the the [sic] floor to harm [his/herself.] Staff explained that [Resident 4] is unhappy with the issue that residents are limited to their rooms due to the flu going around throughout the facility...[Resident 4] told me that [s/he] is upset with being 'stuck' in [his/her] room and would rather get the flu than not be able to visit with anyone in the building..." On 03/27/2025, at 3:46 PM, Surveyor emailed Health Officer (HO) J at the county health department to verify if any outbreaks were reported from the facility and if the county health department provided any directives to the facility such as confining residents to their rooms. At 3:50 PM, Surveyor interviewed Administrator A via phone. Administrator A stated the provider did a mini inspection and found several residents had colds. Administrator A stated the provider confined everyone to their rooms in order to ensure healthy residents did not get sick and the sick residents were contained. When asked if the county health department was notified of the illnesses and resident room restrictions, Administrator A stated, "Not that I know of." On 03/31/2025, at 9:33 AM, Surveyor received an email from HO J stating s/he was not aware of any outbreaks during February in the county and confirmed their records did not show a reported outbreak. HO J did not indicate the county health department directed the facility to confine residents to their rooms. On 04/09/2025, at approximately 2:00 PM, Surveyor interviewed Licensee B. Licensee B stated s/he did not have knowledge of an outbreak at the facility. Licensee B stated s/he	N 356		

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N 356	Continued From page 24 was told about a COVID lockdown by the previous administrator. Licensee B stated s/he was not aware of local county public health's involvement. Licensee B stated s/he was under the impression if COVID was in the building, the provider should have kept everyone away from everybody else.	N 356		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess 2 of 3 residents (Resident 1 and Resident 2) reviewed for residents' needs, abilities, and physical and mental condition before admitting the person to the facility. Findings include: The provider is licensed to care for up to 50 residents in the client groups developmentally disabled, terminally ill, physically disabled, advanced aged, and irreversible	N 381		

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dementia/Alzheimer's.

On 03/12/2025, at approximately 11:30 AM, Surveyors reviewed records for Resident 1, Resident 2, and Resident 3. The following was identified:

Resident 1 was admitted on 08/26/2024. There was no written documentation in Resident 1's record to indicate Resident 1 was assessed prior to admission to determine Resident 1's needs, abilities, and physical and mental condition.

Resident 2 was admitted on 09/30/2024. There was no written documentation in Resident 2's record to indicate Resident 2 was assessed prior to admission to determine Resident 2's needs, abilities, and physical and mental condition.

At approximately 1:45 PM, Surveyors interviewed Licensee B. When asked about Resident 1's pre-admission assessment, Licensee B stated Previous Administrator (PA) H completed it and s/he did not know where the assessment was. Surveyors requested all pre-admission assessment documentation for Resident 1 and Resident 2.

On 03/27/2025, at 3:50 PM, Surveyors interviewed Administrator A. When asked if Administrator A found any assessments, Administrator A stated s/he had observed a couple in the charts and the nurse just completed all of them. Surveyors made a second request to obtain pre-admission and ongoing assessment documentation.

At 6:08 PM, Surveyors received an email from Administrator A, including a document titled, "Admission Application," for Resident 2. The

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N 381	Continued From page 26 document was not dated and did not indicate who completed the assessment. As of 04/01/2025, at 10:00 AM, Surveyors had not received any additional pre-admission documentation.	N 381		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents were involved in developing the individual service plan (ISP) when the ISP was not signed by the resident or the resident's legal representative, as appropriate, acknowledging their involvement in, understanding of, and agreement with, the plan.	{N 387}		

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{N 387}	Continued From page 27 This is a repeat deficiency and is being cited for the fifth time. See Statement of Deficiency (SOD) XK2K12, dated 10/18/2024, SOD XK2K11, dated 06/11/2024, SOD ZTUE12, dated 11/09/2023, and SOD ZTUE11, dated 08/10/2023. Findings include: On 03/12/2025 at approximately 9:45 AM. Surveyor interviewed Administrator A. When asked for resident records, Administrator A provided Surveyor with information to access the provider's electronic records system where resident records were maintained. Surveyor requested any paper copies of ISPs that were not maintained in the electronic record. The provider's electronic records system included the following: Resident 1 had an admission date of 08/26/2024. The ISP was not signed and it was not clear when it was last updated. Resident 2 had an admission date of 09/30/2024. The ISP was not signed and it was not clear when it was last updated. As of 3:05 PM, Surveyor did not receive any physical ISPs from Administrator A. On 03/19/2025 at 2:30 PM, Power of Attorney (POA) I stated s/he signed with hospice but did not recall signing an ISP developed by the provider. POA I stated Previous Administrator (PA) H presented him/her a stack of papers, flipped through them, and told POA I to sign a bunch of stuff. The care plan was not reviewed. POA I stated the printer had run out of ink during the signing and s/he did not have a clear	{N 387}		

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{N 387}	Continued From page 28 understanding of all the documentation. POA I stated s/he met with the hospice agency to review Resident 2's care when they came to enroll Resident 2 and adjust Resident 2's medications. POA I stated s/he had meetings verbally with the nurse but never a full discussion regarding Resident 2's care plan. On 03/27/2025, at 3:50 PM, Surveyor interviewed Administrator A. When asked if Administrator A had found any signed ISPs, Administrator A stated s/he had not. Surveyor made a second request to obtain any signed and physical ISPs maintained by the provider. As of 03/31/2025, at 2:08 PM, the provider had not submitted any signed ISPs as requested.	{N 387}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the	N 389		

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N 389	Continued From page 29	N 389		

provider did not update the Individual Service Plan (ISP) when 3 of 3 residents (Resident 1, Resident 2 and Resident 3) had a change in condition.

Findings include:

The provider is licensed to care for up to 50 residents in the client groups developmentally disabled, terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's.

On 01/10/2025, 02/19/2025, 02/25/2025, and 03/06/2025, the department received complaints regarding resident care needs not being met.

Resident 1

On 03/12/2025 at approximately 9:45 AM, Surveyors interviewed Administrator A. Administrator A stated the provider was working with a staffing agency to "get up to state standards." Administrator A stated s/he was aware that some records needed to be updated. When asked about Resident 1, Administrator A stated Resident 1 was no longer residing with the provider. Administrator A stated that the night before Resident 1 moved, Resident 1 attacked a staff member. Administrator A stated Resident 1 was receiving 1:1 staffing that was provided by his/her managed care organization (MCO.) Resident 1 required "eyes on" supervision when s/he was awake and mobile. When asked about Resident 1's elopement risk, Administrator A stated the provider was not doing much to deter elopements. Surveyor requested signed ISPs for Resident 1, Resident 2 and Resident 3.

At approximately 11:30 AM, Surveyors reviewed

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N 389	Continued From page 30 Resident 1's record in the provider's electronic documentation system. Resident 1 was admitted on 08/26/2024 with multiple diagnoses, including toxic encephalopathy due to methanol, partial complex seizure disorder without epilepsy, and heart failure. Resident 1 was discharged on 03/05/2025. S/he had a corporate guardian. Staff observation notes, dated between August 2024 and March 2025, indicated Resident 1 had multiple successful elopements from the facility. Resident 1 required police intervention to return to the provider and demonstrated verbal and physical aggression towards staff on multiple occasions. Incident reports completed by the provider referenced aggressive behaviors on 03/02/2025 and 03/04/2025, and an elopement on 10/09/2024. At approximately 1:30 PM, Surveyor interviewed Caregiver D. When asked about interventions in place to support Resident 1, Caregiver D stated the provider implemented a door alarm, wander guard, an Apple watch, and a camera placed outside of his/her bedroom door. At approximately 1:45 PM, Surveyor interviewed Licensee B. Licensee B stated Resident 1 was authorized 1:1 supports through his/her MCO. Licensee B stated the provider received $20,000 a month to accommodate that. Licensee B stated Resident 1 had eyes on him/her all the time when Resident 1 was awake and 15-minute checks while sleeping. Licensee B stated Resident 1 had a history of being "very abusive," including sexual offenses and offenses against the elderly.	N 389		

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N 389	Continued From page 31 Resident 1's ISP did not include documentation for the increased frequency of elopements. It did not include strategies or interventions to manage elopements. It did not include information to reflect the implementation and use of alarms and tracking devices. Under a section titled, "Risk - Elopement," it stated Resident 1 was identified as an elopement risk. Under "Resident's Desired Outcomes," it read, "To have proper precautions and redirection techniques in place to prevent elopements." Under an "Elopement Prevention" section, it identified the resident's needs as, "Window Stopper to prevent elopement." It did not include any other strategies, interventions or safety checks. Under a section titled, "Risk - Wandering," it read, "Resident has been identified as a wandering risk, but has no previous occurrences of elopement." The ISP did not reflect orders to increase staffing supervision to 1:1 or when that was implemented. The ISP did not include any information regarding Resident 1's history of aggressive behaviors. It did not include strategies and interventions for staff to utilize to manage behaviors. The ISP did not include information regarding Resident 1's vitals and the frequency in which they should be taken. Under a "Toileting" section, it stated, "Independent." The section did not include information regarding Resident 1's history of urinary tract infections (UTI), or urinary retention. The ISP was not signed and it was not clear when it was last updated. On 04/09/2025 at approximately 2:15 PM, Surveyor interviewed Licensee B. Licensee B stated Resident 1's 1:1 supervision expectation was not added to Resident 1's ISP. Resident 2	N 389		

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N 389	Continued From page 32 Resident 2 was admitted on 09/30/2024 with multiple diagnoses, including vascular dementia and insomnia. Resident 2 had a power of attorney for healthcare (POAHC) and was discharged on 02/17/2025. On 03/12/2025 at approximately 1:30 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 2 was wearing 2 wander guards at the time of his/her elopement on 02/09/2025. Caregiver D stated Resident 2 wore a wander guard on his/her wrist and ankle. Staff observation notes for Resident 2, dated between October of 2024 and February 2025, included the following entries: 10/02/2024 at 5:45 PM: "...Exited the building times 3 today. Wanderguard [sic] placed on wrist. Very difficult to redirect to come back in ..." 10/06/2024 at 1:00 AM: "Resident would not settle down and went into other residents [sic] rooms waking them up and making them upset [sic] staff tried to redirect each time and got him/her back to [his/her] room with a lot [sic] of yelling ..." 10/06/2024 at 5:45 PM: "Resident got out the front door today ..." 10/09/2024 at 3:45 AM: "Resident has been in other residents [sic] rooms all night ..." 10/16/2024 at 6:45 AM: " ...[S/he] is wreaking havoc on the 400 wing. [His/her] things are in everyones [sic] room [sic] [s/he] is taking other peoples [sic] stuff to [his/her] room or to different parts of the building." 10/17/2024 at 5:00 AM: "Resident was last seen at 4 am and at 415 am [sic] staff couldn't fine [sic] [him/her...] Staff called management [sic] who advised to call POA (Power of Attorney) and 911	N 389		

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while continuing to search. Staff found [him/her] in anther [sic] resident's bed..."
10/19/2024 at 9:15 PM: "very [sic] combative today while trying to get [him/her] dressed for an appointment [sic.] [S/he] was hitting and pushing ...Later in the evening [s/he] took [his/her] pants and brief off and went into another residents [sic] room and used the bathroom while the resident was in [his/her] room [sic.] The [sic] resident was very upset that [Resident 2] was in [his/her] room with no bottoms on ..."
10/20/2024 at 4:30 PM: "Resident exited the building times 2 today through the end door on 400 hall. Extremely difficult to get [him/her] back inside ..."
10/31/2024 at 1:30 PM: "Resident walked into the kitchen today and was standing by the stove. Luckily kitchen staff were in the kitchen and noticed [him/her] before something happened ..."
01/04/2025 at 5:45 PM: "Resident went out of the building 3 times today. Was brought back in immediately ..."
01/05/2025 at 5:45 PM: "when [sic] trying to change out [his/her] old patch and place the new one [s/he] elbowed staff in the throat ..."
01/10/2025 at 3:30 PM: "Resident was aggressive towards staff ..."
01/17/2025 at 5:15 AM: " ...[S/he] has been very aggressive throughout the night with hitting [sic] kicking [sic] and pinching staff ..."
01/19/2025 at 4:45 AM: " ...[Resident 2] came out of [his/her] room with no pants on and then went into the dinning [sic] room and took off [his/her] brief ..."
01/26/2025 at 12:45 AM: "Resident has came [sic] out of room multiple times with out [sic] pants and a brief on [sic] did [sic] come out at one point without a top on [sic] also resident has poop all over 400 wing hallway and all over [his/her] room ..."

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N 389	Continued From page 34 02/05/2025 at 11:15 AM: "On 1-4-25 [Resident 2] was in another residents [sic] room going through [his/her] pills. The other resident called staff to get [him/her] out of [his/her] room. Staff did not see if [s/he] took any." 02/09/2025 at 3:30 AM: "Resident has been in and out of residents[sic] rooms all night and when staff was redirecting [him/her] resident pulled staffs [sic] hair [sic] punched staff in the face [sic] and was throwing stuff at staff [sic] and scratched staff on the face and chest along with kicking staff in the legs and has gotten outside multiple times and screamed when staff was trying to get [him/her] back inside." Staff observation notes, dated between January 2025 and February 2025, indicated Resident 2 had successfully exited the facility on multiple occasions. Resident 2 would frequently wander and enter the rooms of other residents. Resident 2 demonstrated physical and verbal aggression towards staff. Resident 2 had disrobed in public spaces and required frequent staff intervention. Resident 2's January 2025 Medication Administration Record (MAR) indicated Lorazepam 2mg/nl, as needed for anxiety, agitation, or restlessness, was signed as administered 19 times. Resident 2's Olanzapine 5mg, as needed for agitation and aggression, was administered 0 times. Resident 2's February 2025 MAR indicated Lorazepam 2mg/nl, as needed for anxiety, agitation, or restlessness, was signed as administered 8 times. Resident 2's Olanzapine 5mg, as needed for agitation and aggression, was administered 0 times. Resident 2's ISP included a section titled, "Risk -	N 389		

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Wandering." Under that section, it read, "Resident has been identified as a wandering risk, but has no previous occurrences of elopement." Under a section titled, "Risk - Elopement," it stated Resident 2 was identified as an elopement risk. It did not include any precautions or redirection techniques to limit elopements. It did not indicate that Resident 2 had eloped from the facility. It did not indicate that Resident 2 was to wear wander guards to prevent elopements. The ISP did not include any sections related to Resident 2's behaviors relating to verbal and physical aggression towards others, the entering of resident's rooms or the habit of disrobing in public spaces. The ISP did not include a detailed description of the behaviors which indicate the need for administration of the PRN psychotropic medications or when to administer them. The ISP was not signed and it was not clear when it was last updated.

On 03/27/2025, at 3:50 PM, Surveyor interviewed Administrator A and requested all assessments and the facility's behavior management policy. Administrator A stated all policies needed to be updated. Administrator A stated the provider did not have a policy and procedure that was specific to the provider, and they followed the policies the state followed.

On 03/28/2025, at approximately 3:08 PM, Surveyor sent an email to Administrator A indicating the wrong resident record was received. Surveyor requested Resident 2's records again.

On 03/30/2025, at 6:10 AM, Surveyor received an email from Administrator A indicating s/he sent the remainder of documentation s/he had for Resident 2. A signed ISP for Resident 2 was not

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N 389	Continued From page 36 located. Resident 3 Resident 3 was admitted on 04/05/2024 with multiple diagnoses, including Parkinson's disease, depression, and a history of falls. Resident 3 was his/her own legal decision maker. On 03/12/2025, at approximately 12:05 PM, Surveyors interviewed Resident 3. Resident 3 originally stated s/he was not a smoker. Resident 3 stated s/he preferred other substances and would go outside to the smoking area. Resident 3 stated the provider did not allow him/her to smoke in his/her room. Resident 3 stated s/he used to store his/her vape pens in the bottom drawer of his/her dresser. Resident 3 stated the provider knew about it and was agreeable to it as long as Resident 3 smoked outside. At approximately 1:30 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 3 was a smoker and had approximately 12 vape pens in his/her possession upon admission. Caregiver D stated Resident 3, and Licensee B discussed the smoking policy, and Resident 3 was allowed to have the vape pens and to smoke outside in the designated area. Caregiver D stated s/he believed the vape pens contained CBD. Caregiver D stated s/he was not aware of how Resident 3 purchased the CBD when Resident 3 would run out of it. Staff observation notes, dated between November 2024 and March 2025, indicated Resident 3 had a history of smoking in his/her room. Resident 3 had multiple falls including a fall that required an emergency room visit.	N 389		

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N 389	Continued From page 37 Resident 3's ISP did not contain any information about Resident 3's fall risk or fall management procedures. It did not include information about Resident 3's smoking habits and use of vape pens. It did not indicate how his/her CBD was obtained and how it was stored. The ISP was not signed and it was not clear when it was last updated. On 03/27/2025, at 3:50 PM, Surveyor interviewed Administrator A. When asked if Administrator A was able to find any signed ISP's for the residents discussed above, Administrator A stated s/he had not. When asked if there were any ISPs outside of the provider's electronic system, Administrator A stated none s/he was aware of. Administrator A stated the provider's nurse just updated all of the care plans and they would be sending them out for signatures.	N 389		
N 431	83.38(1)(g) Health monitoring. 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 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	N 431		

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N 431	Continued From page 38 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's health was monitored, and changes documented in his/her record. Resident 1 experienced persistent urinary tract infections (UTIs) between January 2025 and March 2025. His/her record did not reflect monitoring for signs and symptoms of a UTI and did not include documentation of treatment effectiveness. Resident 1 was prescribed a Nystatin Powder for a skin infection on 02/25/2025. His/her record did not include skin concerns or documentation to indicate a skin infection was present. Resident 1's physician order sheet, dated 02/01/2025, indicated vitals were to be taken daily at 12:00 PM, with an initial start date of 09/25/2024. Vitals were not consistently	N 431		

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N 431	Continued From page 39 monitored and documented by staff. This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. Findings include: On 02/25/2025, the department received a complaint regarding the provider's monitoring of a change in condition. On 03/12/2025, at approximately 9:45, Surveyors interviewed Administrator A. Administrator A stated Adult Protective Services (APS) was involved in Resident 1's care planning after concerns related to Resident 1's care were reported. APS provided a document of instructions for the provider to implement. At approximately 11:30 AM, Surveyors reviewed Resident 1's record via the provider's electronic documentation system. Resident 1 was admitted on 08/26/2024 with multiple diagnoses, including toxic encephalopathy due to methanol, partial complex seizure disorder without epilepsy and heart failure. Resident 1 was discharged on 03/05/2025. S/he had a corporate guardian. Example 1 - UTI Monitoring On 03/12/2025, at approximately 1:30 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 had a couple of UTIs after his/her catheter was removed. Caregiver D stated Resident 1 would pull out his/her catheter and deflate the balloon on his/her own. Caregiver D stated s/he believed the persistent UTIs were related to the catheter removal. Caregiver D	N 431		

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N 431	Continued From page 40 stated s/he suspected Resident 1 did not fully recover from the UTI s/he had in early February 2025. At 2:32 PM, Surveyors received an email from Licensee B with original medication orders for Resident 1 that included the following: Amoxicillin-Clavulanate (Augmentin) 875-125 MG Tablet. Take 1 tablet by mouth 2 times daily for 7 days for UTI. Start date: 02/25/2025; End date: 03/04/2025. Resident 1's January 2025 MAR included the following: Bactrim DS 800-160 MG. Take 1 tablet by mouth 2 times per day for 7 days. The medication was signed as administered between 01/14/2025 and 01/16/2025. There were no notations to indicate how Resident 1 was responding to the medication. Macrobid 100 MG. Take 1 capsule by mouth in the morning and 1 capsulate at bedtime for 10 days. The medication was signed as administered between 01/16/2025 and 01/26/2025. There were no notations to indicate how Resident 1 was responding to the medication. Resident 1's February 2025 MAR included the following: Ciprofloxacin 500 MG. Take 1 tablet by mouth twice daily for 10 days. The medication was signed as administered between 02/03/2025 and 02/13/2025. There were no notations to indicate how Resident 1 was responding to the medication.	N 431		

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N 431	Continued From page 41 Amox-Clav 875-125 MG Tablet. Take 1 tablet by mouth 2 times daily for 7 days for UTI. The medication was ordered as needed with no identified times for administration. The medication was signed as administered one time on 02/28/2025. Resident 1's March 2025 MAR included the following: Amox-Clab 875-125 MG Tablet. Take 1 tablet by mouth 2 times daily for 7 days for UTI. The medication was scheduled at 8:00 AM and 8:00 PM. There were no notations to indicate how Resident 1 was responding to the medication. On 03/03/2025, a notation stated, "hold for pink urine," under a section for an Apaxiban medication. On 03/04/2025, a notation stated, "pink urine," under the Apaxiban medication. Resident 1's observation notes dated between December 2024 and March 2025 included the following: 02/27/2025: "Resident had a concern about having blood in [his/her] urine. I told [him/her] to use the bathroom but not to flush. There was a little bit of blood when [s/he] was urinating. Notifying nurse/[Licensee B.] [S/he] was given antibiotic this morning for [his/her] UTI." 03/05/2025 at 1:00 PM: "Resident went to the ER this morning per APS (Adult Protective Services) request as they said [his/her] vitals are showing a possible UTI. [S/he] came back from the ER no new orders, there is a chance [s/he] could be put back on a catheter ..."	N 431		

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N 431	Continued From page 42 Resident 1's Individual Service Plan (ISP) did not include information regarding his/her persistent UTIs. It did not include information regarding signs and symptoms to monitor for or interventions to support treatment of UTI. Example 2 - Skin Integrity Resident 1's ISP included a section titled, "Bathing - Partial Assistance." It indicated Resident 1 required partial assistance from staff to complete bathing tasks and to maintain good personal hygiene. Resident 1's "Assessment" tab was explored in the provider's electronic record. There was no evidence of any skin assessments completed. Resident 1's staff observation notes dated between December 2024 and March 2025 did not include any concerns related to skin integrity. At 2:32 PM, Surveyors received an email from Licensee B with original medication orders for Resident 1 that included the following: Nystatin (Nystop) 100,000 Unit/Gram Powder. Apply to skin 4 times daily for a skin infection due to the fungus Candida. Start date: 02/25/2055; End date: none indicated. Resident 1's February 2025 and March 2025 MARs did not include an order for Nystatin Powder. On 03/27/2025, at 3:50 PM, Surveyor interviewed Administrator A. Surveyor stated skin assessments were not located in the electronic record and requested any paper copies of skin	N 431		

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N 431	Continued From page 43 assessments completed. When asked how skin assessments were completed, Administrator A stated the bath aide did one during each resident bath or shower. At approximately 8:40 PM, Surveyor received an email from Administrator A including skin assessments completed for Resident 1. Skin assessments were completed on the following dates: 02/07/2025 - Comments: Self. No Concerns. 02/13/2025 - Comments: Self. No Concerns. 02/20/2025 - Comments: Self. No Concerns. 02/26/2025 - Comments: Self. No Concerns. 03/04/2025 - Comments: Self. No Concerns. Resident 1 was diagnosed with a fungal skin infection on 02/25/2025 during an ER visit. The skin assessments completed prior to the skin infection diagnosis do not reflect any skin concerns. The skin assessments after the diagnosis do not reflect any changes in the skin infection or indicate if the prescribed Nystatin was being used to treat the condition. Example 3 - Vitals Resident 1's "Physician Order Sheet," with active orders as of 01/01/2025, did not include orders for daily vitals to be taken. The physician orders with active orders as of 02/01/2025 and 03/01/2025, included instructions for vitals to be taken daily at 12:00 PM, with an initial start date of 09/25/2024. The APS instructions, titled, "Instructions for [Resident 1] (2/26/2025)" read, in part, "Every AM (morning): Perform vitals as soon as [s/he] is awake along with charting the time [s/he] wakes	N 431		

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N 431	Continued From page 44	N 431		

up. It appeared staff started taking vitals on 02/26/2025.

Resident 1's January 2025, February 2025, and March 2025 medication administration record (MAR) included a vitals section at the bottom of the record that was blank.

Resident 1's "Service Plan Task" document included the following instructions: "Vitals - daily. Instructions: Take daily vitals. Status: Resident requires monthly vitals to be taken. Scheduled dates: 02/01/2025-No End Date." "Weight - monthly. Instructions: check weight monthly. Status: Resident requires a daily weight to be taken. Scheduled dates: 11/04/2024 - No End Date." The Service Plan Task document included conflicting direction as to the frequency that vitals needed to be taken. The direction was inconsistent with the physician order sheets.

Resident 1's Individual Service Plan (ISP) did not include information regarding vitals and the frequency they should be checked and documented.

Resident 1's scheduled care history in the provider's electronic record indicated vitals were to be taken daily. There was evidence that vitals were taken daily after the APS instructions were provided. Prior to the APS instructions, vitals were not documented daily as ordered.

On 03/21/2025, at 3:45 PM, Surveyor interviewed Guardian F via phone. Guardian F stated s/he was Resident 1's guardian and had assumed that role sometime in November of 2024. Guardian F stated the provider did not notify him/her of Resident 1's UTIs. Guardian F stated APS discharged Resident 1 citing immediate care and

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N 431	Continued From page 45 safety concerns. Guardian F stated the provider did not discharge Resident 1. On 04/09/2025, at approximately 2:00 PM, Surveyor interviewed Licensee B. Surveyor shared the above concerns with Licensee B. Licensee B stated Resident 1 did not have any skin issues until s/he had the UTI. Licensee B stated there may have been an issue with the original assessment and how that played out. Licensee B stated Resident 1 was private and would tell staff if s/he had any issues or concerns. Licensee B stated Resident 1 would ask staff to "take a look" if s/he had concerns. Licensee B stated that was why there was not a whole lot of record about Resident 1. Cross Reference N0352 DHS 88.32(3)(h) Rights of Residents: Receive Medication	N 431		
N 446	83.41(1)(b) Equipment. Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all equipment was stored in a clean manner and in good repair. Findings include: On 03/12/2025, at approximately 12:40 PM,	N 446		

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N 446	Continued From page 46 Surveyors toured the provider's kitchen. Surveyors identified the following concerns: -A sign posted on the freezer door that read, "Please close tightly!" -The door handle on the freezer was not adhered to the freezer and did not latch without forcefully closing it. -The inside of the freezer had ice blocks scattered throughout the space, including a chunk of ice on the freezer floor, presenting as a trip hazard. There were several frozen icicles forming and descending from the freezer ceiling. At approximately 12:45 PM, Surveyors interviewed Cook D. Cook D stated the freezer's door handle had been broken for months. When asked if there was a maintenance request to address the door handle, Cook D stated there was probably a report at the nurse's station. At approximately 1:55 PM, Surveyors interviewed Licensee B. Licensee B stated the freezer door had a bad seal and the inside of the freezer should be defrosted monthly. Licensee B did not have a schedule or system to track how often that task was being completed. Licensee B stated the handle of the freezer needed to get tightened. On 04/09/2025, at approximately 3:00 PM, Surveyor interviewed Licensee B. Licensee B stated the provider obtained 4 new refrigerators and repaired the door latch on the freezer. Licensee B stated they were in the process of figuring out what to do with the freezer.	N 446		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the	N 452		

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N 452	Continued From page 47 CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary conditions for the prevention of food borne illnesses. The temperature of the refrigerator was not at or below 40 degrees Fahrenheit. Refrigerated and frozen foods were not labeled and dated consistently. This had the potential to affect 27 of 27 residents residing in the facility. Findings include: The provider is licensed to care for up to 50 residents in the client groups developmentally disabled, terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 03/12/2025, at approximately 12:40 PM,	N 452		

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N 452	Continued From page 48 Surveyors toured the provider's kitchen. Surveyors identified the following concerns: -The freezer had an open bag of chicken patties that had visible frost around the opening of the bag. The bag was not sealed properly. There were additional bags of food that were not dated or labeled. -The walk-in refrigerator thermometer read 50 degrees Fahrenheit. -The walk-in refrigerator contained multiple food products and leftovers that were outdated, including: packaged potato salad that had a handwritten note stating, "opened 2/13" with a use by date blacked out with permanent marker with a new date written that was not legible. A crockpot was observed on the shelf, not fully covered and open to air with aluminum foil that read, "super good pork roast. EAT ME," and had a date of "3-4" written on it. A bag of cubed meat was thawing on the top rack of a cart, not dated or labeled. A bag of chicken (not labeled or dated) was thawing below the cubed meat, and a beef pot roast was thawing below the bag of chicken. -The pantry contained multiple food products that were past the "best by" or "use by" date on the packaging. -A separate refrigerator contained cartons of prune juice with "Best if Used By" dates in April 2024. According to the Wisconsin Food Code, the Federal Department of Agriculture's Food Code, and ServSafe standards, date marking is necessary to indicate when food must be consumed or discarded. These standards indicate refrigerated, ready to eat (RTE), potentially hazardous food (PHF), and time/temperature controlled for safety (TCS) foods that are removed from manufacturer packaging and/or prepared for consumption must	N 452		

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N 452	Continued From page 49 be date-marked and discarded within 7 days. Refrigerated, RTE, PHF, and TCS foods prepared and packaged in a food processing plant shall also be date-marked when opened in the facility (date not to exceed 7 days). (Servsafe Coursebook, 7th Ed., 2017, p. 5-23) At approximately 2:45 PM, Surveyors re-toured the kitchen with Licensee B. The walk-in refrigerator thermometer continued to read 50 degrees Fahrenheit. Surveyors shared concerns related to food safety and food borne illness. Licensee B stated s/he would ensure the refrigerator was serviced to address the temperature concerns. On 04/09/2025, at approximately 3:00 PM, Surveyor interviewed Licensee B. Licensee B stated the provider obtained 4 new refrigerators. Licensee B indicated the new equipment should address the food safety concerns moving forward.	N 452		
N 496	83.45(1)(e) Electrical, mechanical, water supply Systems. The CBRF shall maintain all electrical, mechanical, water supply, plumbing, fire protection and sewage disposal systems in a safe and functioning condition. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure electrical systems were in a safe and functioning condition when the heating element located in the wall of the shower room was activated and produced flames and black smoke. Findings include:	N 496		

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N 496	Continued From page 50 On 03/04/2025, the Department received a complaint regarding a fire in the facility. On 03/12/2025 at approximately 1:05 PM, Surveyor interviewed Caregiver L and asked if s/he had any knowledge of a fire. Caregiver L stated there was a fire when the heater in the shower room was turned on and started smoking. Caregiver L stated that the wires started smoking and may have been turned on by a "wandering" resident. Caregiver L led Surveyor to the shower room where the heater was located. The heater was an in-wall unit and was located on the same wall as the walk-in shower. On 03/12/2025 at approximately 1:15 PM, Surveyor interviewed Licensee B regarding the incident. Licensee B confirmed there was black smoke and stated, "I know an electrical element should not be close to a water source. I thought it was off. I took it out, disabled it and the wires were capped." Licensee B further stated the incident was contained to the shower room and no alarms went off. Licensee B stated s/he did not take any further action in response to the incident.	N 496		