STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018569	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERCREST	503 CLOVERCREST CT WATERTOWN, WI 53094

(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 11/11/2025, with information obtained through 11/14/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Clovercrest, a community-based residential facility (CBRF) located in Watertown, WI. As a result of the survey, 12 deficiencies were identified. Eight of the deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025, and SOD 1BXT11, dated 10/28/2022. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 4	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written report was sent to the Department within 3 working days after Resident 2 experienced a fall that resulted in a laceration of his/her lower lip that required suture placement.	N 165		

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

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N 165	Continued From page 1 Findings include: On 11/11/2025, while touring the environment at approximately 10:30 a.m., Surveyor observed a dry erase calendar on the wall, which identified the following for 11/10/2025: "[Resident 2 initials] ...After Hospital Visit." At approximately 10:55 a.m., Surveyor interviewed Caregiver C about the calendar entry. Caregiver C reported that Resident 2 had been taken to the hospital's emergency department after a fall s/he experienced. Caregiver C reported Resident 2 had experienced 2 falls within days of each other and while s/he could recall the details of each fall, s/he could not recall which fall occurred on which day. Caregiver C reported that in one fall, Resident 2 tripped over a chair and fell. Caregiver C reported that for the other fall Resident 2 fell as part of his/her known behaviors of falling to the ground when s/he did not like being redirected by Caregiver C. Resident 2 reported recalling that with the fall that ended up in Resident 2 going to the emergency department, there was "blood everywhere" but Caregiver C couldn't tell from where Resident 2 was bleeding. Caregiver C reported that emergency medical services were contacted and Resident 2 was taken to the emergency department where s/he received 4 stitches to his/her lower mouth area. On 11/11/2025, Surveyor reviewed the records from Resident 2's emergency department admission. A "Patient Visit Information" document, dated 11/01/2025, identified that Resident 2 was seen in the emergency department due to an accidental fall and laceration of his/her lower lip. Within the document was the following: "The sutures in	N 165		

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N 165	Continued From page 2 [his/her] lip with [sic] usually dissolved [sic] in some cases they do not and will have to be removed." On 11/12/2025, Surveyor reviewed Department records for the provider. There was no evidence of a report having been received by the Department of the above incident. On 11/12/2025, at approximately 1:54 p.m., Surveyor requested from Coordinator of Administrative Services (Coordinator) A via e-mail any evidence of the provider having notified the Department of Resident 2's fall from 11/01/2025. On 11/13/2025, at approximately 1:12 p.m., Surveyor received an e-mail response from Coordinator A in which s/he confirmed that a report was not submitted to the Department for the above incident.	N 165		
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 record review and interview, the provider did not ensure that the CBRF and its operation complied with all laws governing it. Findings include: On 11/11/2025, with information obtained through 11/14/2025, Surveyor conducted a verification visit for Statement of Deficiency (SOD) Z88P11,	N 196		

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N 196	Continued From page 3 dated 08/15/2025. Twelve citations of noncompliance were identified, 8 of which were repeat citations, as identified below: N0205 DHS 83.14(2)(j) Not Permit a Condition of Substantial Risk This requirement is being cited for the second time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. N0388 DHS 83.35(3)(c) Implement, Follow the Individual Service Plan This requirement is being cited for the second time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs This requirement is being cited for the second time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medications This requirement is being cited for the third time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025, and SOD 1BXT11, dated 10/28/2022. N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN This requirement is being cited for the second time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. N0427 DHS 83.38(1)(c) Leisure Time Activities This requirement is being cited for the second time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025.	N 196		

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N 196	Continued From page 4 N0499 DHS 83.45(3) Toxic Substances This requirement is being cited for the third time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025, and SOD 1BXT11 dated 10/28/2022. N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways This requirement is being cited for the second time. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A. Coordinator A reported understanding of the deficiencies identified. When asked about how the deficiencies from the last SOD were addressed, Coordinator A reported there was a meeting in which staff discussed correction of the deficiencies and had made a plan to correct them. Cross Reference: N0205 DHS 83.14(2)(j) Not Permit a Condition of Substantial Risk N0388 DHS 83.35(3)(c) Implement, Follow the Individual Service Plan N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medications N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN N0427 DHS 83.38(1)(c) Leisure Time Activities N0499 DHS 83.45(3) Toxic Substances N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 196		

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{N 205}	Continued From page 5	{N 205}		
{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 record review and interview, the licensee permitted the existence of a condition which created a substantial risk to Resident 1's health and welfare. Resident 1, who was known to steal food, have a history of choking and aspirating food, and still be at risk for both choking and aspirating food, was able to access and ingest a meatball off another resident's plate that was left in the kitchen sink by staff. Resident 1 began choking on the meatball which warranted emergency medical services and subsequent emergency department admission. While in the emergency department, Resident 1 required supplemental oxygen from an initial flow at 5 liters per minute in order to address his/her diagnosed acute hypoxic respiratory failure and maintain an oxygen saturation level within normal limits. This is a repeat deficiency. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. Findings include: On 11/11/2025, at approximately 11:29 a.m., Surveyor observed Caregiver C prepare lunch in the kitchen for residents. During this, on 3 separate occasions, Resident 1 entered the	{N 205}		

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{N 205}	Continued From page 6	{N 205}		

kitchen and approached Caregiver C. Caregiver C redirected Resident 1 away from the kitchen each time. At 11:42 a.m., Surveyor observed Resident 1 eating lunch at the dining table. The foods on Resident 1's plate appeared to each be of a pureed texture.

At approximately 4:00 p.m., Surveyor observed Caregiver F begin to prepare dinner in the kitchen for residents. On 3 different occasions between 4:00 p.m. - 4:52 p.m. while Caregiver F was preparing dinner, Resident 1 was observed to approach the food being prepared - the first 2 of which, at approximately 4:15 p.m. and 4:33 p.m., while food was cooking in a pot on the stove. On both of those occasions, Caregiver F was observed redirecting Resident 1 - the first of which s/he physically blocked Resident 1 from the stove and told him/her to, "Get away!" On the third occasion, at approximately 4:44 p.m., food was observed on dinner plates on the kitchen counter to the right of the sink. Caregiver F was near the kitchen sink with his/her back to the plates. Resident 1, who had previously approached Surveyor in the kitchen, walked next to the stove and approached the plated food, unseen by Caregiver F. Resident 1 then stuck his/her hands in one of the plates of food when s/he was then seen by Caregiver F, who redirected him/her away.

On 11/12/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including severe intellectual disability and impulse control disorder. Resident 1's individual support plan (ISP), dated 09/11/2025, and behavior support plan (BSP) documented the following about his/her feeding needs and related behaviors:

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{N 205}	Continued From page 7	{N 205}		

- "I am a high choking hazard and staff must make sure that I eat my food slowly and take drinks in between bites ..."

- "I receive a Dysphagia [sic] Level 2: Mechanically altered diet with ground or pureed meats. All foods must be moist and soft textured and in pieces no large [sic] than ¼ inch. If [Resident 1] is having difficulty chewing and swallowing, food may be pureed. Meats should be ground or minced no larger than one-quarter-inch pieces ...Staff need to sit with me and make sure that I eat slowly, chew my food, and swallow. I have a high aspiration and choking risk! I am to get no solid foods like grapes ...I do not assist with food prep because of my tendency to try and take food."

- A separate section of the ISP documented that Resident 1 had a history of choking with the following detailed: "On 01/15/25 [Resident 1] took a peer's hot dog and started eating it and choked. Staff performed the Heimlich Maneuver and cleared [his/her] airway. [S/he] was taken to the [emergency room] via ambulance. [S/he] did return home. The next day staff noticed [s/he] was not [him/herself] so [Resident 1] was sent back up to the [emergency room] and [s/he] was diagnosed with aspiration pneumonia. This did resolve. [Resident 1] has had multiple aspiration choking episodes in the past. Please refer to [his/her] current diet to help prevent these episodes from occurring."

- A "kitchen safety" section identified that Resident 1 "enjoy[ed] helping staff prep meals, but must be monitored at all times."

- Resident 1's BSP identified "Food Stealing" as a behavior with the following detailed: "[S/he] has

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{N 205}	Continued From page 8	{N 205}		

the tendency to food steal during meal prep times. When [Resident 1] steals food, [s/he] will often swallow it without chewing, which puts [him/her] at risk for choking. Please follow the guidelines below to help prevent [Resident 1] from food stealing." The antecedent for this behavior was documented as, "Food left unattended on the counter."

Resident 1's medical records included a hospital report from his/her admission to the emergency department during the evening of 10/18/2025 into 10/19/2205. The report identified that Resident 1 presented "from [his/her] group home with an aspiration episode. [S/he] had taken a meatball off of some analysis [sic] plate and put it in [his/her] mouth very fast and subsequently had a choking episode. [S/he] was admitted with acute hypoxia requiring 4 L nasal cannula. [S/he] was given Zosyn in the emergency department with rapid improvement in symptoms. [S/he] did have a fever shortly after admission at about 4:00 a.m. However, [s/he] has been afebrile since that time ...Plan a 5 day course of oral Augmentin." The report diagnosed Resident 1 as having "acute hypoxic respiratory failure suspect secondary to aspiration pneumonitis." The report documented that upon an assessment shortly after Resident 1's admission s/he had a pulse oximetry reading of 89% even with supplemental oxygen delivered via nasal cannula at a flow of 5 liters per minute. A later assessment identified that Resident 1 weaned to a flow of 4 liters per minute of supplemental oxygen in order to maintain oxygen saturation levels above 92%.

According to the National Institutes of Health (NIH), hypoxia occurs when "oxygen is insufficient at the tissue level..." Severe hypoxia "can result in tachycardia [increased heart rate] to

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{N 205}	Continued From page 9 provide sufficient oxygen to the tissues," and compromised oxygenation can cause organ function to deteriorate. A resting oxygen saturation of less than 95% is considered abnormal. (Source: NIH: National Library of Medicine, Hypoxia, March 4, 2024, https://www.ncbi.nlm.nih.gov/books/NBK482316/#:~:text=Hypoxia%20is%20a%20state%20in,in%20the%20blood%20(hypoxemia) (retrieval date - November 24, 2025). Surveyor reviewed an incident report that corroborated the above episode. The report, dated 10/18/2025 (6:45 p.m.) detailed, "[Resident 1] got into food that was not [his/hers] that was in the sink to be thrown out. It was a meatball. Staff got [him/her] to spit some out but [s/he] swallowed the rest. [S/he] started to choke and then aspirate so staff called nurse and 911. [S/he] had lots of phlegm. [S/he] was taken to hospital lights and sirens and staff called [his/her] [family]." On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A. Coordinator A acknowledged Surveyor's concern that staff did not safeguard food from Resident 1 outside of his/her feeding restrictions despite known behaviors of food stealing and his/her high choking and aspiration risk. Coordinator A denied having any questions regarding Surveyor's concern. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 205}		

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{N 388}	Continued From page 10	{N 388}		
{N 388}	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that the individual service plans (ISPs) were followed as written for 4 of 4 residents reviewed. The ISP for Resident 3, who was known to be incontinent and at risk for falls, was not followed with regards to his/her safety checks, toileting supervision, and toileting schedule. The ISP for Resident 4, who required total assistance from staff to conduct incontinence cares and manage his/her gastrostomy tube (g-tube), was not followed with regards to his/her g-tube administrations/flushing and toileting schedules. The ISP for Resident 1, who was known to be incontinent at times and require toileting reminders, was not followed with regards to his/her toileting schedule. The ISP for Resident 2, who was known to be incontinent, was not followed with regards to his/her toileting schedule. This is a repeat deficiency. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. Findings include: Examples 1 and 2 - Resident 3's safety checks and toileting supervision	{N 388}		

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{N 388}	Continued From page 11 On 11/11/2025, at approximately 8:55 a.m., Surveyor entered the home to conduct a survey and began observing Caregiver C conduct caregiving tasks. Surveyor observed that the door to Resident 3's room was closed. At approximately 9:01 a.m., Caregiver C confirmed that Resident 3 was in his/her room listening to music. At approximately 11:17 a.m., Surveyor observed Caregiver C open Resident 3's door and check on him/her for the first time since Surveyor came onsite (approximately 2.25 hours). At approximately 11:55 a.m., Resident 3 propelled him/herself in his/her wheelchair from his/her room to the dining area. At approximately 12:05 p.m., Surveyor observe Caregiver C go with Resident 3 into the central bathroom. Shortly after this, Caregiver C left the bathroom and closed the door (with Resident 3 still inside). Caregiver C was then observed engaging in other work tasks. At approximately 12:17 p.m. (approximately 10 minutes later), Caregiver C was observed checking on Resident 3. Afterwards, both Caregiver C and Resident 3 came out of the bathroom. On 11/11/2025, Surveyor reviewed Resident 3's ISP, dated 09/11/2025. Resident 3 was documented as being developmentally disabled and non-verbal. Resident 3's ISP documented that s/he required 24-hour supervision and total assistance for cares and was not able to make his/her needs known. Resident 3 was also documented as being at risk for falls. Under the "Toileting" section, the ISP documented, "Do not leave me alone in the bathroom as I am a risk for falls." Under the "Ambulation/Transfers" section, the ISP documented, "Check on [Resident 3] at least every 30 minutes during awake hours."	{N 388}		

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{N 388}	Continued From page 12 Surveyor noted that from his/her observations that day, Resident 3 had been left alone in the bathroom (contrary to his/her ISP directive) and staff missed approximately 4 safety checks that would have been due during Surveyor's morning observations. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concerns. Coordinator A acknowledged Surveyor's concern and said nothing further. Example 3 - Resident 4's g-tube schedule not followed on 2 of 4 observed occasions On 11/11/2025, at approximately 9:00 a.m., Surveyor observed a "Feeding and Flushing Schedule for [Resident 4]" document posted on the dry erase board in the home's kitchen/dining area (Photo 8). The schedule was documented as created by Resident 4's managed care organization (MCO) team. The schedule outlined the times at which and the specific step-by-step process of which staff were to utilize to conduct various g-tube tasks - including medication administration, flushing, and feeding. A summary of the schedule included the following tasks: - "8 AM" - Medication administration with 3 separate 120-mL water flushes - "9 AM" - Feeding with 120 mL water flushes before and after the feeding - "11 AM" - Prune juice with 120 mL water flushes before and after - "1 PM" - Feeding with 120 mL water flushes before and after the feeding	{N 388}		

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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 388}	Continued From page 13 - "3 PM" - 400 mL water flush The schedule documented that Resident 4 was to have water flushes totaling 1960 mL as broken down within the flushing schedule (which included 2 additional flushes after 3:00 p.m.). During the survey, Surveyor observed the morning feeding/flushes, which took place at approximately 9:17 a.m., and the afternoon feeding/flushes, which took place at approximately 1:00 p.m. (both as scheduled and both done by Caregiver C, the sole employee working at the home during the first shift). Surveyor did not observe any prune juice administration or water flushes occur between those times. At approximately 2:00 p.m., Caregiver C left the home due to it being the end of his/her shift. Other than 2 administrations described above, Surveyor did not observe any other flushes conducted by him/her. (Of note, Resident 4 sat in his/her wheelchair in front of the living room television of the provider's home from the time Caregiver C brought him/her out of his/her room at approximately 10:44 a.m. Resident 4 was in direct view of Surveyor from then through the remainder of the survey that day.) On 11/11/2025, at approximately 2:21 p.m., Surveyor reviewed Resident 4's medication administration record (MAR), where staff appeared to document Resident 4's g-tube medication and supplement administration. The MAR contained a line for Resident 4's prune juice at 11:00 a.m. with the directive for staff to administer 120 mL daily but hold for loose stools. The entry for that day's administration was blank with no other annotations (Photo 12).	{N 388}		

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	0018569	A. BUILDING: _____ B. WING _____	R 11/14/2025

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{N 388}	Continued From page 14 At approximately 4:55 p.m., Surveyor also observed a shift report, where staff appeared to document daily fluid intakes, toileting, and food intake for each of the home's 4 residents. While observing the report, Surveyor interviewed Caregiver F, the sole second shift staff, to clarify the report. Under the "Void/[Bowel Movement (BM)]" section of the report for that day, Surveyor observed annotations including "Inc" with different numbers of lines and "BM-med." Caregiver F confirmed that "Inc" was abbreviated for incontinence episodes and that the number of lines indicated how many incontinent episodes the resident experienced. Caregiver F confirmed that "BM" was abbreviated for "bowel movement" and that staff wrote "BM" along with size to indicate when a resident experienced a bowel movement. No bowel movement was documented as having occurred for Resident 4. In the shift report, Resident 4's g-tube schedule was documented with each timed task sectioned in its own box. Caregiver C's initials were handwritten within the 8:00 a.m. task box, the 9:00 a.m. task box, and the 11:00 a.m. task box (Photo 9). Caregiver F confirmed that staff initialed off on tasks to show they were completed. Surveyor noted that Caregiver C's initials indicating that the 11:00 a.m. prune juice administration and flushes were completed directly conflicted with his/her observations of Caregiver C's tasks. Surveyor observed Caregiver F, who was the sole second shift employee from the time s/he started work, at approximately 1:57 p.m., until Surveyor left at approximately 5:30 p.m. During that period, Surveyor did not observe Caregiver F conduct any flushes for Resident 4, despite one being due at 3:00 p.m.	{N 388}		

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{N 388}	Continued From page 15 On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A acknowledged Surveyor's concern and said nothing further. Example 4 - Resident 1's toileting schedule On 11/11/2025, Surveyor entered the home at approximately 8:55 a.m. to conduct a survey. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area, and kitchen. Caregiver C was observed on shift and confirmed s/he was the only employee working at the home. From the time Surveyor was onsite, from approximately 8:55 a.m. - 1:12 p.m., and then 1:12 p.m. - 5:30 p.m., Surveyor was in view and hearing range of the caregivers on shift - Caregiver C, who was onsite from the survey start until approximately 2:00 p.m., and Caregiver F, who was on site from approximately 1:57 p.m. until Surveyor left. Surveyor observed the following 2 personal cares take place for Resident 1: - Approximately 12:29 p.m. - 12:34 p.m. - Caregiver C assisted Resident 1 in the central bathroom - Approximately 1:57 p.m. - 2:00 p.m. - Caregiver F assisted Resident 1 in the central bathroom On 11/11/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including severe intellectual disability and seizure disorder. Resident 1 was documented as being non-verbal	{N 388}		

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{N 388}	Continued From page 16 but able to communicate some needs with yes/no questions, some words, and sign language. Resident 1's ISP, dated 09/11/2025, documented that s/he required 24-hour supervision and total assistance for cares. In another section of the ISP, Resident 1 was documented as being not able to make his/her needs known. Under the "Toileting" section of Resident 1's ISP, the following was documented: - "I know the sign language for "toilet" and will sometimes say "potty" when I need to use the restroom" - "Staff need to remind me to use the restroom every 2 hours ...I wear a pull up brief 24/7 due to incontinence ...If staff are consistent in reminding me to use the restroom it helps me to stay continent ..." Of the potential 2 opportunities for toileting between 8:55 a.m. - 12:29 p.m. and 2:00 p.m. - 5:30 p.m., Surveyor did not observe staff remind Resident 1 to use the restroom. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A acknowledged Surveyor's concern and said nothing further. Example 5 - Resident 2's toileting schedule On 11/11/2025, Surveyor entered the home at approximately 8:55 a.m. to conduct a survey. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area, and kitchen. Caregiver C was observed on shift and confirmed s/he was the only employee working at the home.	{N 388}		

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{N 388}	Continued From page 17 From the time Surveyor was onsite, from approximately 8:55 a.m. - 1:12 p.m., and then 1:12 p.m. - 5:30 p.m., Surveyor was in view and hearing range of the caregivers on shift - Caregiver C, who was onsite from the survey start until approximately 2:00 p.m., and Caregiver F, who was on site from approximately 1:57 p.m. until Surveyor left. Surveyor observed the following 2 personal cares take place for Resident 2: - Approximately 9:41 a.m. - 9:42 a.m. - Caregiver C assisted Resident 2 in the central bathroom - Approximately 2:39 p.m. - 2:42 p.m. - Caregiver F assisted Resident 2 in the central bathroom On 11/11/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/15/2024 with diagnoses including profound intellectual and developmental disability and autism. Resident 2 was documented as being non-verbal. Resident 2's ISP, dated 07/10/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 2 was documented as being incontinent. Under the "Toileting" section of Resident 2's ISP, the following was documented: "Freshened every 2 hours or more often as needed." Of the potential 3 opportunities for toileting between 9:42 a.m. - 2:39 p.m. and 2:42 p.m. - 5:30 p.m., Surveyor did not observe staff attempt to toilet Resident 2 or conduct incontinence cares. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator	{N 388}		

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{N 388}	Continued From page 18 Services (Coordinator) A regarding the above concern. Coordinator A acknowledged Surveyor's concern and said nothing further. Example 6 - Resident 3's toileting schedule On 11/11/2025, Surveyor entered the home at approximately 8:55 a.m. to conduct a survey. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area, and kitchen. Caregiver C was observed on shift and confirmed s/he was the only employee working at the home. From the time Surveyor was onsite, from approximately 8:55 a.m. - 1:12 p.m., and then 1:12 p.m. - 5:30 p.m., Surveyor was in view and hearing range of the caregivers on shift - Caregiver C, who was onsite from the survey start until approximately 2:00 p.m., and Caregiver F, who was on site from approximately 1:57 p.m. until Surveyor left. Surveyor observed 1 personal care take place for Resident 3, from approximately 12:05 p.m. - 12:17 p.m. when s/he was assisted in the bathroom by Caregiver C. On 11/11/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/21/2021 with diagnoses including profound intellectual disability. Resident 3 was documented as being non-verbal. Resident 3's ISP, dated 09/11/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 3 was documented as being incontinent. Under Resident 3's fall prevention information, Resident 3's ISP documented, "Staff assist me to use the restroom every two hours." Of the potential 3 opportunities for toileting	{N 388}		

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{N 388}	Continued From page 19 between 8:55 a.m. - 12:05 p.m. and 12:17 p.m. - 5:30 p.m., Surveyor did not observe staff attempt to toilet Resident 3 or conduct incontinence cares. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A acknowledged Surveyor's concern and said nothing further. Example 7 - Resident 4's toileting schedule On 11/11/2025, Surveyor entered the home at approximately 8:55 a.m. to conduct a survey. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area, and kitchen. Caregiver C was observed on shift and confirmed s/he was the only employee working at the home. From the time Surveyor was onsite, from approximately 8:55 a.m. - 1:12 p.m., and then 1:12 p.m. - 5:30 p.m., Surveyor was in view and hearing range of the caregivers on shift - Caregiver C, who was onsite from the survey start until approximately 2:00 p.m., and Caregiver F, who was on site from approximately 1:57 p.m. until Surveyor left. Surveyor observed the following 2 personal cares take place for Resident 2: - Approximately 9:09 a.m. - 9:15 a.m. - Caregiver C conducted incontinence cares for Resident 4 while s/he was in bed. - Approximately 10:35 a.m. - 10:44 a.m. - Caregiver C conducted incontinence cares for Resident 4 in his/her bed.	{N 388}		

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{N 388}	Continued From page 20 On 11/11/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including profound intellectual and developmental disability, seizure disorder, and spastic tetraplegia. Resident 4 was documented as being non-verbal. Resident 4's ISP, dated 05/14/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 4's ISP documented that s/he was incontinent and on a 2-hour toileting schedule. Of the potential 3 opportunities for toileting between 10:44 a.m. - 5:30 p.m., Surveyor did not observe staff attempt to conduct incontinence cares for Resident 4. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A acknowledged Surveyor's concern and said nothing further. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs	{N 388}		
{N 396}	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, record review, and	{N 396}		

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{N 396}	Continued From page 21 interview, the provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of residents. The provider's home was typically staffed with a 1:4 ratio (1 staff to 4 residents), with the caregiver on shift expected to prepare meals, conduct caregiving tasks, and conduct leisure activities three times daily. All 4 residents were documented to be intellectually and/or developmentally disabled, be non-verbal, require total assistance for cares, require 24/7 supervision, and not make their needs known. Resident 4 required a Hoyer lift to transfer and used a wheelchair for mobility that had to be propelled by staff. Resident 3 at times required staff assistance to transfer. Resident 4 had a gastrostomy tube (g-tube) for which s/he required staff to manage a schedule of flushing, feeds, and medication administration throughout the day. All 4 residents had a 2-hour toileting schedule, 3 of whom staff needed to physically assist. All 4 residents required staff to administer medications and prepare and serve food. Three of the 4 residents required specific preparation of their food in accordance with their specialty diets (not counting Resident 4's g-tube feedings). Two of the 4 residents (Resident 2 and Resident 3) were observed to require staff's total assistance to feed themselves. Resident 1 required direct staff supervision throughout his/her meals to cue for safe eating as s/he was a risk of choking and aspirating (and had experienced a recent choking and aspirating incident). One resident, Resident 3, required 30-minute checks and was documented as being at risk for falls. Two residents, Resident 1 and Resident 2, were at risk for exit-seeking or elopement. One resident, Resident 1, was known to have typical behaviors of physical aggression towards others, which	{N 396}		

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{N 396}	Continued From page 22 included putting others in headlocks or pulling their hair. On 11/11/2025, Surveyor observed the morning and evening shifts. Even with the single caregiver each shift engaged in tasks throughout the shift, Surveyor noted that activities (in accordance with the provider's schedule) did not take place and toileting schedules for 4 of 4 residents were not followed. Between the observed shifts, Surveyor observed 31 occurrences of Resident 1's behaviors towards others (including hair pulling, putting his/her arms around their necks, and/or attempting to physically approach them), 11 occurrences of exit seeking by Resident 2, and 5 occurrences of Resident 2 chewing on non-food items. For several of the above occasions, the caregiver on shift was engaged in other tasks and required Surveyor's direction to intervene. Review of Resident 1's behavior support plan (BSP) identified that engaging Resident 1 in structured activities and/or going for walks helped to mitigate his/her behaviors - participation in which by a single caregiving staff would be limited due to the abilities, supervision requirements, and care needs of the other residents. From the above observations of resident behaviors and care needs, corroborated by record review and staff interview, the ability of 1 caregiver to conduct a personal care task (e.g. toileting, bathing, dressing) to the level each resident required inherently limited his/her ability to supervise and intervene for the exit-seeking and physical behaviors of Resident 1 and Resident 2. Conversely, the need to supervise Resident 1 and Resident 2 to the level their behaviors were observed, reported, and/or documented inherently limited the ability of 1 caregiver to conduct personal cares in a private	{N 396}		

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{N 396}	Continued From page 23 and dignified manner for the remaining residents. This is a repeat deficiency. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. Findings include: The provider is licensed to serve up to 6 nonambulatory residents within the client groups of traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, and alcohol/drug dependent. On 11/11/2025, Surveyor conducted a verification visit. From the time Surveyor was on site, from approximately 8:55 a.m. - 1:12 p.m., and 1:19 p.m. - 5:30 p.m., Caregiver C was on site as the sole caregiver working from the survey start until approximately 2:00 p.m. when s/he left. Caregiver F was on site from approximately 1:57 p.m. until Surveyor left at approximately 5:30 p.m. Besides the approximate 3 minutes of overlap between the 2 staff, the home was staffed with 1 caregiver per each of the 2 shifts Surveyor observed. During the time Surveyor was on site, the following took place, which demonstrated the tasks that each caregiver engaged in throughout his/her shift as well as the observed residents' needs and abilities: - From 9:09 a.m. - 9:20 a.m., Caregiver C engaged in personal care tasks for Resident 4, including changing him/her and administering his/her g-tube feeding. While conducting cares, Caregiver C left the door to Resident 4's room open, with both Resident 1 and Resident 2 in view. Caregiver C reported s/he wanted to give Resident 4 more dignity by privately changing him/her but s/he couldn't because s/he had to be able to keep an eye on Resident 1. Caregiver C	{N 396}		

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{N 396}	Continued From page 24 reported that s/he served as a direct 1:1 staff for Resident 1 when a second staff member was present but that s/he was unable to provide him/her 1:1 support when no second staff member was available. Surveyor noted that the cares for Resident 4 took approximately 11 minutes. - Throughout nearly the entire survey period, Resident 2 was observed wandering throughout the home. On 11 occasions, Surveyor observed exit-seeking behavior by him/her, including the following: 1) At approximately 9:46 a.m., Resident 2 opened the front door and then was redirected by Caregiver C. 2) At approximately 10:01 a.m., Resident 2 opened the front door and then was redirected by Caregiver C. 3) At approximately 10:10 a.m., Resident 2 opened the front door and then was redirected by Caregiver C. 4) At approximately 10:28 a.m., Resident 2 opened the front door and then was physically redirected by Caregiver C. 5) At approximately 11:14 a.m., Resident 2 opened the front door and was then physically redirected by Caregiver C. 6) At approximately 1:00 p.m., while Caregiver C was administering Resident 4's g-tube feeding, Resident 2 opened the door and walked outside. Coordinator of Administrator Services (Coordinator) A, who confirmed s/he was not a caregiver, did not complete caregiving tasks, and	{N 396}		

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{N 396}	Continued From page 25	{N 396}		

was only onsite to conduct the survey with Surveyor, observed the occurrence and went outside to redirect Resident 2 back in. Caregiver C observed what happened and stated, "I can't exactly stop what I'm doing so that's unfortunate."

7) At approximately 1:05 p.m., while Caregiver C was rinsing Resident 4's syringe out of view from the front door, Resident 2 opened the front door. Caregiver C came to the door and redirected him/her away.

8) At approximately 1:20 p.m., Resident 2 opened the front door and tried to pull the door handle to the outer storm door before being physically redirected by Caregiver C.

9) At approximately 1:30 p.m., Resident 2 opened the front door and then was physically redirected by Caregiver C.

10) At approximately 2:05 p.m., Resident 2 opened the front door and then was redirected by Caregiver F.

11) At approximately 2:38 p.m., Resident 2 opened the front door and then was redirected by Caregiver F.

- On 5 occasions, Surveyor observed Resident 2 chewing on non-food items, including the following:

1) At approximately 10:55 a.m., Resident 2 entered the common area and was observed chewing on a blanket, which Caregiver C then pulled out of his/her mouth.

2) At approximately 11:57 a.m., Resident 2 was observed chewing on a sweatshirt.

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{N 396}	Continued From page 26 3) At approximately 12:15 p.m., Resident 2 was observed chewing on a sweatshirt. Surveyor observed him/her specifically stuffing part of the sweatshirt into his/her mouth and then pulling it back out, repeatedly. 4) At approximately 3:07 p.m., Resident 2 was observed chewing on a sweatshirt. At approximately 3:09 p.m., Caregiver F discovered Resident 2 and took the sweatshirt away. 5) At approximately 3:47 p.m., Resident 2 was observed chewing on a cloth incontinence pad and specifically stuffing the pad into his/her mouth. At this time, Caregiver F was redirecting Resident 1 away from Resident 3. At 3:53 p.m. (approximately 6 minutes later), Caregiver F discovered Resident 2 chewing on the pad and took it away. Of note in relation to Resident 2's behaviors, at approximately 12:40 p.m., Surveyor and Caregiver C observed Resident 2 start to walk down the one of the hallways where resident bedrooms were located. Caregiver C immediately directed him/her back to the common area. When asked by Surveyor why Resident 2 was supposed to be away from the bedrooms, Caregiver C replied that there were things for Resident 2 to get into and chew from the residents' rooms. However, Surveyor had observed earlier that morning, from approximately 9:22 a.m. - 9:29 a.m. (7 minutes) that Resident 2 laid in Resident 1's bed. This was not observed by Caregiver C, who was charting at the computer in the dining area and monitoring Resident 1. Resident 2 spontaneously got up and left the room him/herself at approximately 9:29 a.m.	{N 396}		

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{N 396}	Continued From page 27 - On 31 occasions, Surveyor observed Resident 1 demonstrate behaviors towards other residents including hair pulling, putting his/her arms around their necks, and/or attempting to physically approach them (see citation for Wis. Admin. Code § DHS 83.38(1)(i) (Behavior Management)). Of note, from these occasions, the following occurred demonstrating the limited ability of the sole caregiver on shift to intervene: 1) At approximately 10:38 a.m., Resident 1 hugged Resident 2 with his/her arms around Resident 2's neck. Coordinator of Administrator Services (Coordinator) A physically pulled Resident 1 off Resident 2. Coordinator A confirmed s/he was not a caregiver and had only been onsite to assist Surveyor with the survey. Caregiver C was in Resident 4's room conducting personal cares for him/her. 2) At approximately 11:09 a.m., Resident 1 began pulling Resident 4's hair before being redirected by Coordinator A. Caregiver C was observed assisting Resident 2 and did not initially see the incident. 3) At approximately 11:20 a.m., Resident 1 approached Resident 2 and held his/her head before being physically redirected by Coordinator A. 4) At approximately 1:00 p.m., Resident 1 approached Resident 3, who was seated in his/her wheelchair, and put his/her arms around Resident 3's head. Caregiver C, who was in the middle of conducting a g-tube feed for Resident 4 nearby, observed the incident and stated, "I can't exactly stop what I'm doing so that's unfortunate." Caregiver C verbally called out for Resident 1 to stop what s/he was doing. (As documented	{N 396}		

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above, as this occurred, Resident 2 walked out the front door, which warranted Coordinator A to redirect him/her back in the home.)

5) At approximately 2:05 p.m., while Caregiver F was attending to Resident 2, Coordinator A physically intervened to prevent Resident 1, who was attempting to approach Resident 3, from accessing him/her.

6) At approximately 2:34 p.m., Resident 1 approached Resident 4 and initially placed his/her arms around Resident 4's head. S/he then began pulling Resident 4's hair. Surveyor directed Coordinator A to the situation. Caregiver F was in the staff office out of view. One minute later, Resident 1 approached Resident 4 again and put his/her nose to Resident 4's hair. Coordinator A then redirected Resident 1.

7) At approximately 2:39 p.m., Resident 1 approached Resident 3 and began pulling his/her hair, which was not seen by Caregiver F who had been attending to Resident 2 near the bathroom.

8) At approximately 4:18 p.m., while Caregiver F was in the kitchen preparing dinner, Resident 1 approached Resident 3 and leaned in towards his/her head. After approximately 10 seconds, Resident 1 began pulling Resident 3's hair. Surveyor directed Caregiver F to the situation, who had not seen it.

9) At approximately 4:26 p.m., while Caregiver F was in the kitchen preparing dinner, Resident 1 approached Resident 4 and began pulling his/her hair. Surveyor directed Caregiver F to the situation, who had not seen it.

10) At approximately 4:40 p.m., Resident 1

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{N 396}	Continued From page 29	{N 396}		

approached and leaned in towards Resident 4. After a few seconds, Resident 1 began pulling Resident 4's hair. Surveyor directed Caregiver F, who was still preparing dinner in the kitchen, to the situation and Resident 1 began putting his/her arms around Resident 4's neck. Caregiver F redirected Resident 1.

11) At approximately 4:59 p.m., Resident 1 approached Resident 2, placed his/her arms around Resident 2's neck, and began pulling Resident 2's hair. Surveyor directed Caregiver F, who was still preparing dinner in the kitchen, to the situation.

12) At approximately 5:08 p.m., while Caregiver F was out of view at the medication closet preparing residents' evening medications, Resident 1 approached Resident 2, put his/her arms around Resident 2's head, and began pulling his/her hair. Surveyor directed Caregiver F to the situation.

On 11/11/2025, Surveyor reviewed individual service plans (ISPs) and behavior support plans (BSPs), as applicable, of the provider's 4 residents, which detailed the following:

- Resident 1's diagnoses included severe intellectual disability and impulse control disorder. Resident 1 was documented as being non-verbal but able to communicate some needs with yes/no questions, some words, and sign language. Resident 1's ISP, dated 09/11/2025, documented that s/he required 24-hour supervision and required total assistance for cares. In another section of the ISP, Resident 1 was documented as not able to make his/her needs known. Resident 1's ISP identified s/he was at high risk for choking and aspirating and that, " ...staff must

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make sure that I eat my food slowly and take drinks in between bites." The ISP documented that Resident 1 required moist and soft-textured food with pieces no larger than ¼ inch in size and nectar-thickened liquids. The ISP also noted, "Staff need to sit with me and make sure that I eat slowly, chew my food, and swallow." The ISP noted 2 past choking episodes from food in 2009 as well as a choking occurrence on 01/15/2025 in which Resident 1 "took a peer's hot dog and started eating it and choked." (Of note, medical records from 10/18/2025 identified another choking incident experienced by Resident 1 that evening when s/he took a meatball from the sink that was intended to be thrown out.) Resident 1's ISP also documented that Resident 1 "needs to be monitored to be sure of [his/her] whereabouts at all times. If left unattended, [s/he] will get curious and explore things on his/her own." The ISP noted that "most" of Resident 1's negative behaviors were when s/he was seeking attention and that, "if you keep me occupied, I am less likely to have these behaviors." The ISP also noted that Resident 1 liked to keep busy, "spend time with staff and peers," help with chores, and go for walks. Resident 1's ISP noted that s/he required a reminder from staff every 2 hours (during the day) to use the restroom. Resident 1's BSP, also dated 09/11/2025, identified known behaviors of aggression towards others, self-injurious behavior, food stealing, and wandering.

- Resident 2's diagnoses included profound intellectual and developmental disability and autism. Resident 2 was documented as being non-verbal. Resident 4's ISP, dated 07/10/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known.

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{N 396}	Continued From page 31 Resident 2 was documented to be at risk for elopements, falls, aspiration, and ingesting non-food items. Resident 2 was documented as requiring foods to be cut up in bite-sized pieces and supervision while eating "because [s/he] eats too fast and puts too much food in [his/her] mouth especially when [s/he] starts eating." Along with this, Resident 2 was documented as having a history of choking and requiring staff cuing to slow down and chew his/her food thoroughly throughout his/her meals. Resident 2's ISP identified that s/he had a history of wandering/elopement and documented, "I enjoy being outside and going for walks and will often go to the door. All of the doors in my home have a chime on them to alert staff that the door has been open." Resident 2's ISP noted that s/he was on a 2-hour toileting schedule. Resident 2's BSP, also dated 07/10/2025, identified known behaviors of dropping to the floor, pica, food stealing, and wandering. - Resident 3 was documented as being developmentally disabled and non-verbal. Resident 3's ISP, dated 09/11/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 3 was documented to be at risk for falls and aspiration. Resident 3 was documented as requiring "chopped" solids with his/her meals. Resident 3 was documented as having unsteady gait and balance and at times required staff assistance to pivot transfer and walk. Resident 3 was otherwise noted to utilize a wheelchair for ambulation. Resident 3's ISP identified that s/he enjoyed his/her personal space in his/her bedroom and privacy in the bathroom, though it was noted that staff were to not leave Resident 3 unattended in the bathroom due to his/her fall risk. The ISP	{N 396}		

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directed for staff to check on Resident 3 every 30 minutes during waking and sleeping hours. Resident 3's ISP noted that staff were to assist him/her to toilet every 2 hours. Resident 3's BSP, also dated 09/11/2025, identified known behaviors of self-injurious behavior and agitation.

- Resident 4's diagnoses included profound intellectual and developmental disability and spastic tetraplegia. Resident 4 was documented as being non-verbal. Resident 4's ISP, dated 05/14/2025, documented that s/he required total assistance for cares, which included for set up and administration of g-tube feedings and flushes. The ISP directed for a specific schedule of medication administration, flushes, and feedings that staff were to follow that involved 7 different times g-tube tasks were supposed to be conducted. Resident 4's ISP also documented that s/he utilized a wheelchair that s/he was unable to self-propel for mobility. Resident 4's ISP documented that s/he required 24-hour supervision and was not able to make his/her needs known. Resident 4's ISP noted that s/he was on a 2-hour toileting schedule.

Despite the Caregiver C and Caregiver F during their respective shifts observed by Surveyor to have been engaged in work tasks throughout their entire shift - including attending to residents, cares, charting, meal preparation, laundry, medication administration, and dishes - Surveyor observed cares missed in accordance with each of the 4 residents' individual service plan (ISP), including:

- Safety checks every 30 minutes for Resident 3 between approximately 8:55 a.m. - 11:17 a.m.

- Two of 4 g-tube administrations/flushes for

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{N 396}	Continued From page 33 Resident 4 (11:00 a.m. and 3:00 p.m.) - Two due opportunities to offer toileting/remind Resident 1 to toilet between 8:55 a.m. - 12:29 p.m. and 2:00 p.m. - 5:30 p.m. - Three due opportunities for toileting/incontinence cares for Resident 2 between 9:42 a.m. - 2:39 p.m. and 2:42 p.m. - 5:30 p.m. - Three due opportunities for toileting/incontinence cares for Resident 3 between 8:55 a.m. - 12:05 p.m. and 12:17 p.m. - 5:30 p.m. - Three due opportunities for toileting/incontinence cares for Resident 4 between 10:44 a.m. - 5:30 p.m. At approximately 9:00 a.m., Surveyor observed a staff schedule for November posted. The schedule identified several shifts that staff worked alone (Photo 10). At approximately 9:00 a.m., Surveyor observed a shower schedule posted on the dry erase board in the kitchen area, which identified the following (Photo 11): - Resident 1: Daily showers during the morning (AM) shift - Resident 2: Showers Tuesday, Thursday, and Saturday during the AM shift - Resident 3: Showers Monday, Wednesday, and Friday during the overnight (NOC) shift - Resident 4: Showers Monday, Wednesday, and	{N 396}		

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{N 396}	Continued From page 34 Friday during the afternoon/evening (PM) shift At approximately 9:05 a.m., Surveyor interviewed Caregiver C about staffing. When asked if 1 staff member per shift seemed to be enough in order to meet residents' needs, Caregiver C replied, "It depends on the staff." At approximately 2:46 p.m., Surveyor interviewed Caregiver F about staffing. Caregiver F reported that there were "rough days" with trying to meet all the residents' care needs. When asked to clarify, Caregiver F reported that rough days were days when Resident 1 was demonstrating his/her aggressive behaviors towards others and when Resident 2 wandered into others' rooms to grab clothing to chew. Caregiver F reported that when a second staff member worked then one staff was solely dedicated to serving as a 1:1 direct support staff for Resident 1. Caregiver F reported that it was his/her understanding that management was looking to have 2 staff on the morning (AM) shifts as well as the evening (PM) shifts. Caregiver F reported that s/he believed an additional staff member had been hired but that management was still looking to hire another. At approximately 3:31 p.m., Surveyor interviewed Caregiver F again. Caregiver F reported that none of the residents attended day programming. Caregiver F reported that staff had been looking into this for Resident 1 but that s/he would require a direct 1:1 staff member in order to attend. On 11/12/2025, Surveyor reviewed the staff schedule for October and November 2025 and identified that the majority of days had 1 employee staffed to work first or second shifts (during typical wake hours for residents when most of the above cares would be conducted),	{N 396}		

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{N 396}	Continued From page 35 including the following: - 10/06/2025 (first and second shifts) - 10/07/2025 (second shift) - 10/08/2025 (second shift) - 10/09/2025 (second shift) - 10/10/2025 (second shift) - 10/11/2025 (first and second shifts) - 10/12/2025 (first and second shifts) - 10/13/2025 (second shift) - 10/14/2025 (first and second shifts) - 10/15/2025 (first and second shifts) - 10/16/2025 (first and second shifts) - 10/17/2025 (first and second shifts) - 10/18/2025 (first and second shifts) - 10/19/2025 (first and second shifts) - 10/20/2025 (first and second shifts) - 10/21/2025 (first and second shifts) - 10/22/2025 (first and second shifts) - 10/23/2025 (second shift) - 10/24/2025 (first and second shifts) - 10/25/2025 (first and second shifts) - 10/26/2025 (first and second shifts) - 10/27/2025 (partial first shift, partial second shift) - 10/28/2025 (second shift) - 10/29/2025 (second shifts) - 10/30/2025 (first and second shifts) - 10/31/2025 (first and second shifts) - 11/01/2025 (first and second shifts) - 11/02/2025 (first and second shifts) - 11/03/2025 (first and second shifts) - 11/04/2025 (first and second shifts) - 11/05/2025 (second shift) - 11/06/2025 (first and second shifts) - 11/07/2025 (first and second shifts) - 11/08/2025 (first and second shifts) - 11/09/2025 (first and second shifts) - 11/10/2025 (first and second shifts)	{N 396}		

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{N 396}	Continued From page 36 Although the 11/11/2025 schedule showed 2 staff working the AM shift and the PM shift as open, from Surveyor's observation there was 1 staff member each on the AM and PM shifts. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator A about staffing concerns. Coordinator A acknowledged Surveyor's observation of the instances s/he intervened during resident behaviors in place of caregivers. Coordinator A reported s/he understood Surveyor's concerns. Coordinator A reported that the provider's intention was to have a second staff member for both AM and PM shifts, but s/he wasn't sure what was preventing the provider from being able to staff this way. Coordinator A replied s/he believed management was looking at the second staff member to be a direct 1:1 support for Resident 1 "for sure" on the AM shift. When asked about the PM shift, Coordinator A replied s/he wasn't sure if a second staff member on PMs would assist with resident cares in general or also be a direct 1:1 support for Resident 1. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0388 DHS 83.35(3)(c) Implement, Follow the Individual Service Plan N0433 DHS 83.38(1)(i) Behavior Management Y3234 DHS 50.09(1)(e) Treatment	{N 396}		
{N 407}	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a	{N 407}		

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{N 407}	Continued From page 37 pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that residents were reassessed by a pharmacist, practitioner, or registered nurse at least quarterly for the desired responses and possible side effects of scheduled psychotropic medications they were prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025, and SOD 1BXT11, dated 10/28/2022. Findings include: On 11/11/2025, at approximately 9:48 a.m., Surveyor requested from Coordinator of Administrative Services (Coordinator) A the most recent scheduled psychotropic medication reviews completed for the home's 4 residents as applicable. On 11/11/2025, Surveyor reviewed medication administration records (MARs) for the home's 4 residents from 09/01/2025 - 11/11/2025. Throughout this period, Surveyor noted the following psychotropic medications prescribed on a scheduled basis to Resident 1, Resident 2, and Resident 3:	{N 407}		

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{N 407}	Continued From page 38 - Resident 1 - lithium carbonate 300 mg tablets (1 tablet twice daily since 07/02/2025), mirtazapine 7.5 mg tablets (1 tablet 3x/day since 03/31/2025), olanzapine 10 mg tablets (1/2 tablet 2x/day since 01/07/2025, then updated on 10/17/2025 to 1 tablet twice daily), sertraline 100 mg tablets (since 07/02/2025), and clonazepam 1 mg tablets (since 08/13/2025). - Resident 2 - mirtazapine 30 mg tablets (2 tablets daily since 07/28/2025), paroxetine 40 mg tablets (1 tablet daily since 06/24/2025), and risperidone 1 mg tablets (initially 1.5 tablets 2x/day since 06/24/2025, then updated on 11/04/2025 to 1 tablet 2x/day) - Resident 3 - citalopram 40 mg tablets (1 tablet daily since 12/10/2024), and mirtazapine 7.5 mg tablets (1 tablet daily since 03/26/2025) At approximately 12:29 p.m., Coordinator A reported that s/he could see that the most recent scheduled psychotropic medication reviews were conducted in June 2025 by Licensed Practical Nurse (LPN) K. Surveyor noted that this was prior to the previous survey which identified a citation for quarterly psychotropic medication reviews (SOD Z88P11, dated 08/11/2025 and issued on 08/21/2025). Coordinator A then e-mailed Surveyor the reviews which correlated his/her report. Coordinator A reported s/he was waiting to see if s/he received any other reviews. At approximately 2:39 p.m., Surveyor asked Coordinator A about the status of the reviews. Coordinator A confirmed s/he had not received anything else. Upon leaving from the survey at that time, Coordinator A reported s/he would send any additional reviews that s/he received. Nothing further was received.	{N 407}		

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{N 407}	Continued From page 39 On 11/12/2025, at approximately 9:39 a.m., Surveyor e-mailed Coordinator A to confirm if s/he received any additional psychotropic medication reviews and gave a deadline of 12:00 p.m. for any additional records. Nothing further was received. On 11/12/2025, at approximately 12:37 p.m., Surveyor interviewed Coordinator A. Coordinator A confirmed s/he had no more recent scheduled psychotropic medication reviews to send Surveyor. On 11/12/2025, Surveyor reviewed behavior support plans (BSPs) for Resident 1, Resident 2, and Resident 3, which detailed the following behaviors: - Resident 1 (BSP dated 09/11/2025) - aggression ("pinching, kicking, hair pulling, putting others in headlocks, etc."), self-injurious behaviors (poking him/herself, banging his/her head on others' heads, biting his/her arm), food stealing, and wandering - Resident 2 (BSP dated 07/10/2025) - dropping to the floor, pica (the ingesting of non-food items), food stealing, and wandering - Resident 3 (BSP dated 09/11/2025) - history of self-injurious behavior (slapping him/herself, hit his/her groin, and biting his/her hand) and agitation Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 407}		

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{N 416}	Continued From page 40	{N 416}		
{N 416}	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 8 of 8 staff reviewed were delegated by a registered nurse to administer medications via stomal or rectal administration. This is a repeat deficiency. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. Findings include: On 11/11/2025, at approximately 9:01 a.m., Surveyor interviewed Caregiver C. Caregiver C confirmed s/he already administered Resident 4's medications, which were administered via his/her gastrostomy tube (g-tube). On 11/11/2025, Surveyor reviewed the staff schedules from 10/06/2025 - 11/11/2025. From the schedules, Surveyor identified the following staff who worked at least 1 shift alone in the home: Caregiver B, Caregiver C, Caregiver F, Caregiver J, Caregiver O, Caregiver P, Caregiver Q, and Caregiver R. At approximately 9:48 a.m., Surveyor requested from Coordinator of Administrator Services	{N 416}		

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{N 416}	Continued From page 41 (Coordinator) A the current nursing delegations for Caregiver B, Caregiver C, Caregiver F, Caregiver J, Caregiver O, Caregiver P, Caregiver Q, and Caregiver R. On 11/11/2025, Surveyor reviewed medication administration records (MARs) for each of the home's 4 residents from 10/06/2025 - 11/11/2025 and identified the following prescribed medications: - Bisacodyl 10 mg suppositories prescribed to Resident 3 (active as of 09/15/2023) with the instructions, "Insert 1 suppository rectally once daily as needed for constipation." - Enema prescribed to Resident 3 (active as of 03/28/2025) with the instructions, "Insert 1 enema rectally once as needed for constipation (no stool in 4 days)." - Diazepam 10 mg gel (active as of 08/06/2025) prescribed to Resident 4 with the instructions, "Insert 10mg rectally once for 1 dose for seizures." - Bisacodyl 10 mg suppositories (active as of 09/20/2023) prescribed to Resident 4 with the instructions, "Insert 1 suppository rectally as needed if no bowel movement in 24 hours." In reviewing Resident 4's prescriptions, Resident 4's scheduled medications included daily levothyroxine tablets and flaxseed oil capsules, Multi-Vite liquid, and senna liquid as well as twice daily clobazam tablets, docusate liquid, and levetiracetam solution. The orders for all these medications specified that they were to be administered via g-tube.	{N 416}		

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{N 416}	Continued From page 42 From the records provided by Coordinator A shortly after Surveyor's request, Surveyor observed a series of documents, each of which were titled "Medication Administration Evaluation Form" and completed for 4 different employees. The form outlined general medication administration procedures as separately numbered tasks and identified "trials" in which an evaluator checked off that the employee being evaluated successfully demonstrated that procedure. The procedures included tasks like verifying the prescription label, offering water, initialing the medication administration record (MAR), and ensuring secure medication storage. Two of the tasks specifically referenced oral medications (" ...Encouraged the individual to put medication directly in mouth from cup," and "Staff watched for the person to swallow the medication ..."). Evaluators were identified on the forms as either Caregiver C, Caregiver F, Licensed Practical Nurse (LPN) K, or Registered Nurse (RN) L. There was no mention of medications administered rectally or via g-tube. There was no evidence that the staff being evaluated were specifically delegated by a registered nurse to administer medications stomally or rectally. Surveyor observed that evaluations were shown as being completed for Caregiver C and Caregiver F on the same days, and at approximately 11:00 a.m., interviewed Caregiver C about the process. Caregiver C confirmed that s/he and Caregiver F evaluated each other on the same days and that LPN K "might have been" present. Caregiver C confirmed that s/he had not been evaluated by RN L at any point as part of the process. When asked if RN L had conducted any sort of training specifically with staff for nursing delegations, Caregiver C reported that LPN K had, but not RN L.	{N 416}		

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{N 416}	Continued From page 43 There were no other records provided. At approximately 2:39 p.m., Surveyor interviewed Coordinator A about the status of the nursing delegation records request. Coordinator A confirmed s/he had not received anything else. Upon leaving from the survey at that time, Coordinator A reported s/he would send any additional reviews that s/he received. Nothing further was received. At approximately 2:46 p.m., Surveyor interviewed Caregiver F about the evaluation forms. Caregiver F reported that s/he and Caregiver C had evaluated each other and LPN K was also present during their evaluations. Caregiver F confirmed that s/he had not been evaluated by RN L at any point as part of the process. On 11/12/2025, at approximately 9:39 a.m., Surveyor e-mailed Coordinator A to confirm if s/he had any additional evidence of nursing delegations and gave a deadline of 12:00 p.m. for any additional records. Nothing further was received. On 11/12/2025, at approximately 12:37 p.m., Surveyor interviewed Coordinator A. Coordinator A confirmed s/he had no additional nursing delegation records to send Surveyor. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 416}		
{N 427}	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents	{N 427}		

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{N 427}	Continued From page 44 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a daily activity program was provided to residents to meet their interests and capabilities, or that an activity schedule reflecting the activities conducted was posted. This is a repeat deficiency. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. Findings include: On 11/11/2025, at approximately 8:59 a.m., Surveyor observed an activity schedule posted on the wall (Photo 7). The schedule was titled "[Licensee company] CBRF/AFH Group Home Monthly Activity Calendar." The schedule identified a separate activity that was to take place each morning, afternoon, and evening for every day of the week. A note on the bottom documented, "Activity times may vary depending on your group home and clients [sic] needs. Morning Activity Time: 9:45am-10:45am.	{N 427}		

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{N 427}	Continued From page 45 Afternoon Activity Time: 1pm-2pm. Evening Activity Time: 6pm-7pm." The activities listed to take place that day were as follows: "Art (Coloring)" (morning), "Bingo & Prizes (CM Lead, In person/zoom)" (afternoon)", and "Guided Meditation (YouTube Guided)" (evening). From approximately 8:55 a.m. - 1:12 p.m., and 1:19 p.m. - 5:30 p.m., while Surveyor was on site, Surveyor did not observe any activities from the schedule taking place. From approximately 9:41 a.m. - 9:53 a.m., Surveyor observed Coordinator of Administrative Services (Coordinator) A and Caregiver C intermittently assist Resident 1 engage in a puzzle. At times throughout the Survey, Caregiver C attempted to direct Resident 1 to activity items by means of redirecting him/her from approaching and physically contacting other residents. These items included a light-up globe, a vase with sand and plastic dinosaurs, and a magazine. Starting at approximately 12:17 p.m. throughout the afternoon, music played throughout the common areas, where Resident 3 was. Caregiver C reported that Resident 3 enjoyed listening to music. At approximately 10:44 a.m., Resident 4 was brought by Caregiver C to the living area in front of the television after s/he was assisted with getting ready for the day. From 10:44 a.m. until Surveyor left at approximately 5:30 p.m., Resident 4's position was unchanged. From approximately 11:30 a.m. - 12:42 p.m., the television was playing nothing and the screen was black. During the survey, Surveyor attempted to interact with each of the provider's 4 residents, none of whom demonstrated the ability to communicate with Surveyor. On 11/11/2025, Surveyor reviewed the current	{N 427}		

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{N 427}	Continued From page 46 individual service plans (ISPs) for all 4 residents of the home. All four - Resident 1, Resident 2, Resident 3, and Resident 4, were identified as being non-verbal. Resident 1's ISP, dated 09/11/2025, identified the following activities that s/he liked: spending time with staff/peers, helping with chores, walks, swimming, shopping, music, playing the piano, looking at picture books, music therapy, and riding his/her electric bike. Resident 2's ISP, dated 07/10/2025, identified the following activities that s/he liked: going outside and walking around, listening to music, going on van rides, observing group activities, and music therapy. Resident 3's ISP, dated 09/11/2025, identified the following activities s/he liked: listening to music, lounging in a comfortable chair or his/her couch, eating out, van rides, walks, and sporting events. Resident 4's ISP, dated 05/14/2025, identified the following activities that s/he liked: observing others, sitting in the screened porch, listening to music, holding rattles, going for walks and rides, observing activities taking place, music therapy, and bird watching. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A acknowledged Surveyor's concern and said nothing further. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 427}		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 433		

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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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure services were provided to manage the behaviors of Resident 1 which were harmful to others.

Findings include:

On 11/11/2025, Surveyor conducted a survey and was onsite from approximately 8:55 a.m. - 1:12 p.m., and 1:19 p.m. - 5:30 p.m. While onsite, Surveyor observed the following with regards to Resident 1:

- At approximately 8:57 a.m., Resident 1 approached Resident 2, who was sitting at the table, and put him/her in a headlock. Caregiver C redirected Resident 1. Throughout the survey, Resident 2 was observed to be non-verbal and did not demonstrate an ability to protect him/herself from Resident 1.

- At approximately 10:19 a.m., Caregiver C was observed with Resident 1 sitting at the dining table. Resident 1 grabbed onto Caregiver C's hair, and Caregiver C successfully requested him/her to let go.

- At approximately 10:33 a.m., Resident 1 approached and hugged Resident 2. Caregiver C

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redirected Resident 1.

- At approximately 10:38 a.m., Resident 1 hugged Resident 2 with his/her arms around Resident 2's neck. Coordinator of Administrator Services (Coordinator) A physically pulled Resident 1 off Resident 2. Coordinator A confirmed s/he was not a caregiver and had only been onsite to assist Surveyor with the survey. Caregiver C was in Resident 4's room conducting personal cares for him/her.

- At approximately 11:09 a.m., Resident 1 began pulling Resident 4's hair before being redirected by Coordinator A. Caregiver C was observed assisting Resident 2 and did not initially see the incident. Throughout the survey, Resident 4 was observed to utilize a wheelchair for mobility that s/he relied on staff to propel, was non-verbal, and did not demonstrate an ability to protect him/herself from Resident 1.

- At approximately 11:20 a.m., Resident 1 approached Resident 2 and held his/her head before being physically redirected by Coordinator A.

- At approximately 12:27 p.m., Resident 1 began pulling Coordinator A's hair. Coordinator A pulled his/her hair out of Resident 1's grasp.

- At approximately 1:00 p.m., Resident 1 approached Resident 3, who was seated in his/her wheelchair, and put his/her arms around Resident 3's head. Caregiver C, who was in the middle of conducting a gastrostomy tube (g-tube) feeding for Resident 4 nearby, observed the incident and stated, "I can't exactly stop what I'm doing so that's unfortunate." Caregiver C verbally called out for Resident 1 to stop what s/he was

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doing. Throughout the survey, Resident 3 was observed to be non-verbal.

- At approximately 1:41 p.m., Resident 1 began pulling Resident 4's hair. Caregiver C redirected him/her.

- At approximately 2:03 p.m., Resident 1 began approaching and reaching out towards Resident 2. Coordinator A redirected him/her. Two minutes later, at 2:05 p.m., while Caregiver F was attending to Resident 2, Coordinator A physically intervened to prevent Resident 1, who was attempting to approach Resident 3, from accessing him/her.

- At approximately 2:08 p.m., Resident 1 began pulling Resident 3's hair. Coordinator A initially attempted redirecting him/her, followed by Caregiver F.

- At approximately 2:18 p.m., Caregiver F physically blocked Resident 1 to prevent him/her from accessing Resident 3 as s/he was reaching towards him/her. Caregiver F was then observed trying to engage Resident 1 in looking at a book.

- At approximately 2:34 p.m., Resident 1 approached Resident 4 and initially placed his/her arms around Resident 4's head. S/he then began pulling Resident 4's hair. Surveyor directed Coordinator A to the situation. Caregiver F was in the staff office out of view. One minute later, Resident 1 approached Resident 4 again and put his/her nose to Resident 4's hair. Coordinator A then redirected Resident 1.

- At approximately 2:39 p.m., Resident 1 approached Resident 3 and began pulling his/her hair, which was not seen by Caregiver F who had

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been attending to Resident 2 near the bathroom.

- At approximately 2:46 p.m., Resident 1 began pulling on Caregiver F's hair while Surveyor was interviewing him/her. Caregiver F provided verbal cuing for Resident 1 to let go. Afterwards, Resident 1 approached Resident 4 and leaned in towards his/her head. Caregiver F then redirected Resident 1.

- At approximately 3:14 p.m., Resident 1 approached Resident 4. Caregiver F attempted to redirect him/her, but Resident 1 began pulling Resident 4's hair. Resident 1 was then physically moved by Caregiver F.

- At approximately 3:31 p.m., Caregiver F physically blocked Resident 1 from approaching Resident 3. Caregiver F reported to Surveyor that staff had been looking into day programming for Resident 1 but that s/he would require a 1:1 support to attend.

- At approximately 3:36 p.m., Resident 1 approached Resident 4. Caregiver F attempted to verbally redirect him/her, but Resident 1 began pulling Resident 4's hair. Caregiver F physically pulled Resident 1 off Resident 4 and moved him/her away.

- At approximately 3:47 p.m., Resident 1 approached Resident 3. Caregiver F gave a verbal warning to Resident 1. Resident 1 then put his/her hand on Resident 3's head. Caregiver F physically redirected Resident 1. Three minutes later, at 3:50 p.m., Caregiver F redirected Resident 1, who had been reaching out towards Resident 3, again.

- At approximately 4:05 p.m., Resident 1

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CLOVERCREST	503 CLOVERCREST CT WATERTOWN, WI 53094

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approached Resident 4 and leaned in towards him/her. Caregiver F didn't initially see the encounter due to preparing dinner in the kitchen. After a few seconds, Caregiver F saw Resident 1 and verbally redirected him/her.

- At approximately 4:07 p.m., Resident 1 approached Resident 3 and put his/her fingers in Resident 3's hair. Caregiver F physically redirected Resident 1 and reported that s/he had to turn the stove off and stop meal preparation in order to supervise Resident 1 (Surveyor observed Caregiver F turn the stove off as s/he reported this). Caregiver F stated, "I can't cook like this."

- At approximately 4:18 p.m., while Caregiver F was in the kitchen preparing dinner, Resident 1 approached Resident 3 and leaned in towards his/her head. After approximately 10 seconds, Resident 1 began pulling Resident 3's hair. Surveyor directed Caregiver F to the situation, who had not seen it.

- At approximately 4:26 p.m., while Caregiver F was in the kitchen preparing dinner, Resident 1 approached Resident 4 and began pulling his/her hair. Surveyor directed Caregiver F to the situation, who had not seen it.

- At approximately 4:29 p.m., Resident 1 approached Resident 3 before being redirected by Caregiver F.

- At approximately 4:33 p.m., Resident 1 was redirected by Caregiver F away from the stove, where food was cooking in a pot. One minute later, at 4:34 p.m., Resident 1 approached Resident 3 and began pulling his/her hair. Two minutes after that, at 4:36 p.m., Resident 1 was observed standing with his/her face

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approximately 3" away from Resident 3's face. This was not seen by Caregiver F, who was still cooking in the kitchen.

- At approximately 4:40 p.m., Resident 1 approached and leaned in towards Resident 4. After a few seconds, Resident 1 began pulling Resident 4's hair. Surveyor directed Caregiver F, who was still preparing dinner in the kitchen, to the situation, and Resident 1 began putting his/her arms around Resident 4's neck. Caregiver F redirected Resident 1.

- At approximately 4:44 p.m., while Caregiver F was attempting to redirect Resident 1 away from plated food, Resident 1 grabbed and pulled Caregiver F's glasses off. Resident 1 did not return the glasses initially with verbal cuing by Caregiver F. After a couple more moments of cuing, Resident 1 let go of the glasses. Resident 1 then approached Resident 3 and began leaning in towards him/her before being redirected by Caregiver F.

- At approximately 4:52 p.m., Resident 1 approached Resident 2, who was seated at the dining table, and began putting his/her arms around Resident 2's head. Caregiver F physically redirected Resident 1.

- At approximately 4:59 p.m., Resident 1 approached Resident 2, placed his/her arms around Resident 2's neck, and began pulling Resident 2's hair. Surveyor directed Caregiver F, who was still preparing dinner in the kitchen, to the situation.

- At approximately 5:08 p.m., while Caregiver F was out of view at the medication closet preparing residents' evening medications,

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Resident 1 approached Resident 2, put his/her arms around Resident 2's head, and began pulling his/her hair. Surveyor directed Caregiver F to the situation.

On 11/11/2025, at approximately 9:05 a.m., Surveyor interviewed Caregiver C regarding Resident 1's behaviors. Caregiver C reported that since Surveyor's last survey, Resident 1's behaviors of hair pulling and getting into others' personal spaces had persisted. Caregiver C reported noticing Resident 1 began a new behavior of kissing people on their chest.

On 11/11/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including severe intellectual disability and impulse control disorder. Resident 1's individual support plan (ISP), dated 09/11/2025, documented that Resident 1 required 24-hour supervision. The ISP documented that the provider was working with Resident 1's managed care organization to have a direct 1:1 staff for him/her, as well as the following regarding his/her behaviors:

- "Sometimes I invade people's personal space and need to be reminded to not get too close."

- "I may also need reminders to not touch/rub other's [sic] arms or lift up my shirt in front of others. Redirect as necessary."

- "Most of my negative behaviors are when I am seeking attention. If you keep me occupied, I am less likely to have these behaviors."

Resident 1's behavior support plan (BSP), also dated 09/11/2025, documented aggression as one of his/her "behaviors of concern," which was

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defined as, "Pinching, kicking, hair pulling, putting others in headlocks, etc." Approaches to manage included:

- "Whenever possible, attempt to structure [Resident 1]'s leisure time (i.e., dressing, personal care, folding clothes, making bed, taking out trash, etc.)."

- Specific directives for how staff should approach handshakes, walking, and playful interaction with Resident 1.

- "If [Resident 1] invades personal space (i.e., approaching closely), establish eye contact and firmly state, '[Resident 1], you're in (name)'s personal space. STEP BACK.' Redirect [Resident 1] to a more appropriate activity. If [Resident 1] cooperates, offer praise and redirect to an alternate activity. If [Resident 1] continues to invade the personal space of [his/her] peer, position yourself between [Resident 1] and the peer. If [Resident 1] does not back up, use a touch cue to show [him/her] where [s/he] should be. When [s/he] stays in that position, praise [him/her] and give [him/her] an opportunity to show [s/he] can do it on [his/her] own. If [s/he] moves too close again, repeat the training procedure."

- "Building rapport with [Resident 1] ...[Resident 1] will challenge new staff. It is important to be consistent. Build a rapport with [Resident 1] by engaging [him/her] in activities and providing 1:1 attention, such as including [him/her] with whatever you are doing (i.e. laundry, taking out the trash, m [sic], going on a walk, meaningful activities, etc.). [Resident 1] enjoys and understands humor."

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N 433	Continued From page 55 - "Redirect [his/her] hands if [s/he] attempts to pull your hair to something like a handshake, high five, or ask [him/her] where [his/her] hands belong (at [his/her] side or behind [his/her] back)." - "Throughout the day, staff will work with Resident 1 on various skills including room and self care, social skills, and self management (being able to entertain [him/herself] without harming/targeting others ...[Resident 1] benefits from structured activities such as helping with laundry, playing [his/her] keyboard, making [his/her] bed, or looking at books." - "Should [Resident 1] reach out for a peer's or staff hair do the following: Step between [Resident 1] and the individual, ask [him/her] where [his/her] hands should be (to [his/her] sides or behind back), give [him/her] little to no feedback, praise [him/her] when [his/her] hands are in the correct place, repeat as needed. If [Resident 1] engages in hair pulling or headlocks staff should FIRMLY ASK [RESIDENT 1] TO LET GO AND COUNT TO 3 '[Resident 1] Let Go, 1, 2, 3.'" - "If [Resident 1] continues to be aggressive, encourage [Resident 1] to go to a quiet area or encourage to move from [Resident 1]'s area ...Explain to [Resident 1] that people do not like to interact with [him/her] when [s/he] is aggressive ...Encourage [Resident 1] to calm down so that [s/he] can rejoin the group when [s/he] is interacting in a socially appropriate manner." Of note, Surveyor reviewed Resident 1's previous BSPs, dated 09/11/2024 (1 year prior to the one described above), and 03/13/2025 (approximately 6 months prior to the one described above. The only difference in the information documented	N 433		

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from the BSP dated 09/11/2024 and 03/13/2025 and the current one, dated 09/11/2025, was the line: "If [Resident 1] engages in hair pulling or headlocks staff should FIRMLY ASK [RESIDENT 1] TO LET GO AND COUNT TO 3 '[Resident 1] Let Go, 1, 2, 3.'"

On 11/11/2025, Surveyor reviewed Department records for the provider, including Statement of Deficiency (SOD) Z88P11, dated 08/15/2025. Within that, a citation was reviewed for Wis. Admin. Code § DHS 83.14(2)(j) (Not Permit a Condition of Substantial Risk). That citation identified observed concerns at that time with several observed instances of Resident 1 pulling the hair of other residents and staff (some of which were unseen by the sole caregiver working) and placing Resident 2 in a chokehold-type position.

On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding Resident 1's behaviors. When asked what staff were doing differently since the last survey to manage Resident 1's behaviors, Coordinator A replied that staff were told by the provider's executive team to document instances of Resident 1's behaviors, which would be done typically via incident reports. Coordinator A reported s/he was not sure if this directive was documented in Resident 1's BSP or ISP but confirmed that this was an expectation of staff because then the executive team would be able to communicate the frequency of Resident 1's behaviors to his/her managed care organization team. Surveyor requested any incident reports completed by Caregiver F for second shift on 11/11/2025 (when several instances of Resident 1's aggressive behaviors had been observed). Coordinator A reported s/he

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N 433	Continued From page 57 wasn't sure if any had been filled out. Coordinator A confirmed the concern with lack of documentation and reported that if management saw no reports being filled out that they might not recognize the extent of Resident 1's behaviors. Of note, no further records were received. Cross Reference: N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs	N 433		
{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 that cleaning compounds were stored in a secure area. This is a repeat deficiency. See Statement of Deficiency (SOD) Z88P11, dated 08/15/2025, and SOD 1BXT11 dated 10/28/2022. Findings include: The provider is licensed to serve up to 6 nonambulatory residents within the client groups of traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, and alcohol/drug dependent. On 11/11/2025, at approximately 10:00 a.m., Surveyor toured the home. In the central bathroom (closest to the common areas), at	{N 499}		

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approximately 10:04 a.m., Surveyor observed a cabinet next to the sink. The cabinet's 2 doors were outfitted with strap locks, but neither lock was in the secured position to prevent the cabinets' contents from being accessed (Photo 1). Surveyor opened the door of the upper cabinet and observed 3 different cleaning compounds (Photos 2 and 3), which included:

- 1 bottle of Comet disinfecting-sanitizing bathroom cleaner
- 1 bottle of Sparkle Glass Cleaner
- 1 bottle of LA's Totally Awesome Window Clean glass and surface cleaner

At approximately 2:15 p.m., Surveyor observed the bathroom again. The cabinet and its unsecured strap locks were unchanged from Surveyor's earlier observation (Photo 4).

Between the times of Surveyor's 2 observations, Resident 2 was observed wandering throughout the home, at times out of view of Surveyor and Caregiver C, who was working nearly the entire time as the sole caregiver between 10:00 a.m. - 2:15 p.m. and at times engaged in other tasks, including conducting cares for the other residents (Resident 1, Resident 3, and Resident 4) and preparing meals. At approximately 10:43 a.m., Surveyor observed Resident 2, while wandering, attempt to open the doors of cabinets in the dining area, which were outfitted with the same strap locks as those in the bathroom. Afterwards, Resident 2 wandered into the central bathroom unsupervised. Approximately 20 seconds later, Caregiver C discovered Resident 2 and physically redirected him/her from the central bathroom. At approximately 1:32 a.m., while doing a medication audit with Caregiver C, Surveyor requested hand sanitizer. Caregiver C provided

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hand sanitizer and reported that it used to be stored on the kitchen counter, but staff had to store it more securely due to Resident 2's risk and behaviors of ingesting non-food items.

On 11/11/2025, Surveyor reviewed the current individual service plan (ISP) for Resident 2, dated 07/10/2025. Resident 2's ISP indicated that s/he was at "risk to ingest non-food items." Under a section detailing restrictions for Resident 2, the following was documented: "Cleaning supplies are stored in a locked cabinet. Staff will work with me on skill and safety related to cleaning products in my home." Under a section detailing risks for Resident 2, the following was documented: " ...[S/he] also has a history of putting inedible items in [his/her] mouth (leaves, socks, crumbs on the floor, anything that resembles food, etc.)."

On 11/11/2025, Surveyor reviewed the current ISP for Resident 1, dated 09/11/2025. Under a section detailing risks for Resident 1, the following was documented: " ...Staff ensure that they [cleaning supplies] are stored safely. Cleaning supplies are locked in [his/her] home."

On 11/11/2025, Surveyor reviewed the ISP for Resident 3, dated 09/11/2025. Under a section detailing restrictions for Resident 3, the following was documented: "Cleaning supplies are stored in a locked cabinet. Staff will work with me on skill and safety related to cleaning products in my home."

On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A confirmed that toxic substances were supposed to be secured by

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{N 499}	Continued From page 60 staff. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 499}		
{N 637}	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 of 2 exits provided unobstructed travel to the outside. This is a repeat deficiency. See Statement of	{N 637}		

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{N 637}	Continued From page 61 Deficiency (SOD) Z88P11, dated 08/15/2025. Findings include: The provider is licensed to serve up to 6 nonambulatory residents within the client groups of traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, and alcohol/drug dependent. On 11/11/2025, at approximately 1:08 p.m., Surveyor observed the home's exits, which included the front door and a door that led from the living area to the enclosed patio. From the enclosed patio, a storm door led to an outdoor patio. The storm door was entirely blocked by 2 chairs placed side-by-side in front of it (Photo 5). At approximately 1:23 p.m., Surveyor observed the home's exit diagram (Photo 6). The diagram identified both the front door and side door (from the enclosed patio) as the home's exits identified for evacuation. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A reported that when Surveyor had been out for a few minutes during the survey that s/he walked around the home and saw the chairs blocking one of the exit doors. Coordinator A reported s/he spoke with Caregiver C about it, who reported to him/her that s/he didn't know what to do with the extra chairs. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 637}		

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Y3234	Continued From page 62	Y3234		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that Resident 4 was treated with full recognition of his/her dignity by Caregiver C when Caregiver C conducted incontinence cares and gastrostomy tube (g-tube) administrations for him/her in direct view of both Resident 1 and Resident 2, who were also different genders than Resident 4. Findings include: On 11/11/2025, at approximately 9:09 a.m., Surveyor began observing Caregiver C conduct caregiving tasks. Caregiver C reported s/he was going to conduct incontinence cares for Resident 4, get him/her dressed, and start his/her g-tube feeding. Caregiver C left the door open to	Y3234		

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Resident 4's room while s/he began conducting cares for him/her. Resident 4 remained laying in his/her bed during the encounter. Resident 1 entered Resident 4's room on 2 separate occasions while Caregiver C was engaged in incontinence cares for Resident 4. Caregiver C reported that s/he wanted to give Resident 4 dignity in changing him/her privately, but s/he was not able to because s/he had to keep an eye on Resident 1 due to his/her behaviors. Resident 1 was then observed to enter Resident 4's room a third time while Caregiver C was still conducting incontinence cares. Caregiver C redirected him/her away from Resident 4 twice. While Caregiver C was conducting incontinence cares for Resident 4, Resident 2 was also observed to wander back and forth in the hallway outside Resident 4's room (with the door still open). At one point, Surveyor observed Caregiver C, who had disposable gloves on, physically guide Resident 1 by his/her arm to redirect him/her away from Resident 4's bed area before returning to conduct Resident 4's incontinence cares. Resident 1 was observed on 2 more occasions entering Resident 4's room while incontinence cares were still being conducted, and after the second occasion, remained in Resident 4's room watching Caregiver C finish dressing Resident 4. Resident 1 remained in Resident 4's room while Caregiver C set up and administered Resident 4's g-tube flushes and morning feeding, at times watching the process. As part of this, Resident 4's shirt was up to just above his/her stomach in order to expose his/her g-tube stoma.

At approximately 9:48 a.m., Caregiver C reported to Surveyor that Resident 4's g-tube feeding was done and that s/he was going to conduct a post-feeding water flush. While observing Caregiver C flush Resident 4's g-tube (which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018569	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERCREST	503 CLOVERCREST CT WATERTOWN, WI 53094

(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
Y3234	Continued From page 64 again exposed his/her abdomen and stomach area), Resident 1 stood next to Caregiver C at Resident 4's bedside. At approximately 10:35 a.m., Surveyor observed Caregiver C go into Resident 4's room again. Caregiver C reported s/he was going to check to see if Resident 4 needed to be changed and get him/her up for the day. While beginning to check Resident 4 (who was still laying in his/her bed from earlier that morning), Resident 1 entered Resident 4's room and stood alongside Caregiver C watching cares being started. Caregiver C then physically redirected Resident 1 out of the room. On 11/14/2025, at approximately 3:00 p.m., Surveyor interviewed Coordinator of Administrator Services (Coordinator) A regarding the above concern. Coordinator A acknowledged Surveyor's concern and agreed with Surveyor that it seemed difficult for staff to manage maintaining adequate supervision of Resident 1 while also allowing personal cares to be conduct in privacy. Cross Reference: N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs	Y3234		