STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 01/22/2026, with information obtained through 02/05/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and complaint investigation at Eickstaedt, a community-based residential facility (CBRF) located in Watertown, WI. As a result of the survey, 10 deficiencies were identified. Six deficiencies were repeat deficiencies from Statement of Deficiencies (SOD) ZBMH11, dated 09/12/2025. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. The complaint was substantiated. Census: 5	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's	N 169		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 169	Continued From page 1	N 169		

guardian, Guardian K, was notified immediately when there was an incident of unprecedented bleeding of his/her genital area, which resulted in a subsequent examination and investigation for sexual abuse.

Findings include:

On 01/22/2026, Surveyor reviewed a self-report submitted by the provider. The report, dated 01/06/2026 documented, "On 12/31/25, [Resident 1] was incontinent of a large amount of stool. As [Caregiver L] was cleaning [him/her] up [s/he] noticed a small amount of bright red blood on the wipes ...[Caregiver L] noticed a small trickle of blood comng [sic] from [Resident 1]'s [genital area] ...911 was activated and [Resident 1] was transported to the hospital. Per the [emergency department] notes, [Resident 1] sustained a small scratch [at his/her genital area] ..."

Attached to the self-report was a document titled, "Summation of the Investigation into Possible Caregiver Misconduct [Resident 1]." Within the document was the following, " ...[Program Manager I] did remind [Caregiver L] to call the guardian to advise the guardian that [Resident 1] was being sent out..."

A "Call for Service" log from the local police department documented the following blotter entry: "Patient from a group home - nonverbal [Resident 1] came in with [genital] bleeding, has an abrasion [at his/her genital area] / [unknown] if accidental while changing [him/her] or abuse." The log detailed a couple of evaluation steps taken by clinical staff from the emergency department where Resident 1 was taken and indicated that adult protective services (APS) was notified of the incident. The report also contained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 169	Continued From page 2	N 169		

the following details at their respectively logged dates/times:

- 12/31/2025 (6:41 p.m.): "[Resident 1] is developmentally disabled, non-ambulatory, and non-verbal. [S/he] has use of [his/her] upper extremities but legs are contracted and have limited mobility."

- 01/02/2026 (5:50 p.m.): "[Resident 1]'s [family member]/guardian, [Guardian K], called as [s/he] was not advised by [numerical identifier] of [his/her] admission. [Guardian K] was updated regarding the info that I had gathered ..." (Of note, this was approximately 2 days after Resident 1's emergency department admission.)

On 01/30/2026, Surveyor reviewed an incident report from the provider for the above incident. The incident report, dated 12/31/2025, documented details corroborating the above incident involving Resident 1. The author of the report, [Caregiver L], documented that s/he notified "the nurse and house lead" of the incident. There was no evidence that Caregiver L notified Guardian K.

On 02/03/2026, at approximately 1:28 p.m., Surveyor interviewed Guardian K. Guardian K reported that no one from the provider informed him/her of Resident 1's vaginal bleeding or having been taken to the emergency department as a result. Guardian K reported s/he didn't become aware of the incident until approximately 2 days later when s/he received a phone call from one of the provider's staff inquiring about a possible knee injury experienced by Resident 1. Guardian K reported during that phone call the staff member mentioned Resident 1's emergency department admission on 12/31/2025 and asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 169	Continued From page 3 if s/he had been aware of that. Guardian K reported that s/he replied to the staff member s/he was not aware of it. Guardian K stated that s/he was "very upset about that." Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the CBRF and its operation complied with all laws governing it. Findings include: On 01/22/2026, with information obtained through 02/05/2/2026, Surveyor conducted a verification visit for Statement of Deficiency (SOD) ZBMH11, dated 09/12/2025. Ten citations of noncompliance were identified, 6 of which were repeat citations, as identified below: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0196 DHS 83.13(2)(a) Licensee Ensures Facility Complies with Laws N0277 DHS 83.25 Continuing Education	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 196	Continued From page 4 N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication This requirement is being cited for the second time. See Statement of Deficiency (SOD) ZBMH11, dated 09/12/2025. N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes This requirement is being cited for the second time. See Statement of Deficiency (SOD) ZBMH11, dated 09/12/2025. 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) ZBMH11, dated 09/12/2025. N0415 DHS 83.37(2)(d) Documentation of Medication Administration This requirement is being cited for the second time. See Statement of Deficiency (SOD) ZBMH11, dated 09/12/2025. 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) ZBMH11, dated 09/12/2025. N0431 DHS 83.38(1)(g) Health Monitoring This requirement is being cited for the second time. See Statement of Deficiency (SOD) ZBMH11, dated 09/12/2025. N0448 DHS 83.41(2)(a) Nutrition: Diet On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) G.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 196	Continued From page 5 Coordinator G reported understanding of the deficiencies identified and denied having additional questions or concerns. Cross Reference: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0196 DHS 83.13(2)(a) Licensee Ensures Facility Complies with Laws N0277 DHS 83.25 Continuing Education N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN N0431 DHS 83.38(1)(g) Health Monitoring N0448 DHS 83.41(2)(a) Nutrition: Diet	N 196		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 277	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Caregiver M received at least 15 hours per calendar year of continuing education in the required topics beginning with the first full calendar year of employment Findings include: The provider is licensed to serve up to 6 individuals within the client groups of physically disabled, developmentally disturbed, emotionally disturbed/mental illness, and traumatic brain injury. On 01/22/2026, Surveyor reviewed records for all the provider's 5 residents, which identified the following diagnoses: - Resident 1: Spastic quadriplegia, tetrahydrobiopterin synthesis defect, obsessive compulsive disorder, anxiety disorder, and "intellectual disability" - Resident 2: Cerebral palsy and hemiplegia/hemiparesis - Resident 3: "Profound developmental disability," Cri-du-chat syndrome, blindness, and major depressive disorder - Resident 4: "Developmental disability" and scoliosis - Resident 6: Cerebral palsy, spastic quadriplegia, anxiety disorder, and depression On 01/22/2026, Surveyor reviewed the 2025	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 277	Continued From page 7 training record for Caregiver M, who was hired on 04/01/2021. The record identified training that was completed between 01/01/2025 - 12/31/2025. The record identified that 2.7 hours of training were completed by Caregiver M in that timeframe in the subject areas of the Health Insurance Portability and Accountability Act (HIPAA), medication management and administration, working with individuals with alcohol use disorder, and working with individuals with substance use disorder. At approximately 3:05 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) G. Coordinator G confirmed there was no other training record for Caregiver M. Coordinator G acknowledged Surveyor's concern that Caregiver M missed approximately 12 out of 15 hours of continuing education in 2025 and did not complete training in all the required topic areas. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 277		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 8	{N 352}		

interview, the provider did not ensure that 5 of 5 residents reviewed received all their prescribed medications in the dosages and at intervals prescribed by their practitioners.

Resident 1's zinc, lorazepam, and polyethylene glycol were not administered as prescribed on 3 occasions, 1 occasion, and 1 occasion, respectively.

Resident 2's clonazepam, calcium + vitamin D, and famotidine were not administered as prescribed on 1 occasion, 2 occasions, and 2 occasions, respectively.

Resident 3's alprazolam was not administered as prescribed to him/her on 3 occasions. On the evening of 01/13/2026, s/he was administered a clonazepam tablet prescribed to Resident 2. When administered as prescribed, 1 container of Resident 3's polyethylene glycol would last 30 days. On 01/22/2026, Surveyor observed that staff were still administering Resident 3's polyethylene glycol powder from a container that was annotated as opened on 12/22/2025 - 1 month prior to the survey - and was still approximately 25% full. Of 31 potential administrations from 12/23/2025 (the day after the container was marked as opened) through 01/22/2026, staff signed off as having administered each daily dose. Resident 3 was prescribed bisacodyl 10 mg suppositories for daily administration unless s/he experienced loose stools. Thirty suppositories were most recently dispensed on 01/06/2026. From 01/07/2026 through 01/22/2026 (16 administrations), staff signed off on administering each daily suppository, which was inconsistent with only 11 suppositories missing from the baggie in which the pharmacy dispensed his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 9	{N 352}		

suppositories. Resident 3's medical records identified historic concerns with constipation.

Resident 4's calcium + vitamin D tablets were not administered as prescribed to him/her on 01/11/2026. Resident 4 was prescribed bisacodyl 10 mg suppositories for administration every other day unless s/he experienced a bowel movement. Fourteen suppositories were most recently dispensed on 01/15/2026. From 01/16/2026 through 01/22/2026 (3 administrations per his/her medication administration record (MAR)), staff signed off on each potential administration, which was inconsistent with only 1 suppository missing from the baggie in which the pharmacy dispensed his/her suppositories.

Resident 6's cetirizine and acetaminophen were not administered as prescribed on 2 occasions and 1 occasion, respectively.

This is a repeat deficiency. See Statement of Deficiencies (SOD) ZBMH11, dated 09/12/2025.

Findings include:

Example 1 - Resident 1's zinc, lorazepam, and polyethylene glycol administrations

On 01/30/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including spastic quadriplegia, tetrahydrobiopterin synthesis defect, intellectual disability, and anxiety disorder. Resident 1's record identified that staff managed and administered his/her medications. Resident 1's prescriptions included the following:

- Zinc 50 mg tablets with instructions to, "Take 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 10 tablet by mouth or via g-tube 3 times weekly on Mon/Wed/Fri in the morning for supplement." - Lorazepam 1 mg tablets with instructions to, "Take 1 tablet per g-tube twice daily for agitation." - Polyethylene glycol 3350 powder with instructions to, "Dissolve 8.5 gm (half capful) in 150 mL fluid and give my mouth or per g-tube once in the evening every other day for constipation." In reviewing Resident 1's MARs from 12/09/2025 - 01/22/2026, Surveyor observed the following: - Zinc tablet administered 12/25/2025 (a Thursday), 12/27/2025 (a Saturday), and 12/30/2025 (a Tuesday) which was not consistent with the prescription instructions to administer Mondays, Wednesdays, and Fridays. - Polyethylene glycol powder documented as "skipped" on 01/04/2026 due to, "none in facility." Surveyor noted this administration would have been due as it was skipped the day prior (01/03/2026) and the day after (01/05/2026) in accordance with the prescription instructions. On 01/30/2026, Surveyor reviewed an incident report dated 01/03/2026 which documented that the overnight (NOC) shift staff on 01/02/2026 "noticed that [Resident 1] didn't receive [his/her] 8 pm Lorazepam." The report indicated that the provider's nurse was made aware of the incident. In reviewing the MAR for that day, Surveyor observed that Resident 1's 8:00 p.m. lorazepam dose had been signed as administered. Example 2 - Resident 2's clonazepam, calcium + vitamin D, and famotidine	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 11 On 01/22/2026, at approximately 2:05 p.m., Surveyor reviewed medications for Resident 2 with Licensed Practical Nurse (LPN) F. LPN F confirmed that the provider's system was for staff to punch out tablets/capsules from the numerical bubble pack that corresponded with the date of administration (e.g. the tablets for bubble pack "12" would be punched out and administered on 01/12/2026). Surveyor observed medication cards for evening calcium + vitamin D tablets and evening famotidine tablets, both with prescription labels identifying they were prescribed to Resident 2. In observing the medication cards, Surveyor observed the calcium + vitamin D tablets as well as famotidine tablets, in their respective cards, for bubble pack numbers 10 and 11 were still in their packs. LPN F confirmed Surveyor's observation. After looking through the provider's records on his/her laptop, LPN F reported s/he found incident reports for the above occasions. On 01/30/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/07/2024 with diagnoses including cerebral palsy and seizure disorder. Resident 2's record identified that staff managed and administered his/her medications. Resident 2's prescriptions included the following: - Clonazepam 1 mg tablets with instructions to, "Take 1 tablet by mouth three times daily at 8AM, 2PM, 8PM for epilepsy." - Calcium 600 + Vitamin D 400 tablets with instructions to, "Take 1 tablet by mouth twice daily in the morning & in the evening ..." - Famotidine 20 mg tablets with instructions to,	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 12 "Take 1 tablet by mouth twice daily in the morning & in the evening for [gastroesophageal reflux disease (GERD)]." In reviewing Resident 2's MARs from 12/09/2025 - 01/22/2026, Surveyor observed the following: - Clonazepam tablet documented as "skipped" for its 8:00 p.m. administration due to, "could not find med." - Calcium + vitamin D tablet documented as administered on the evenings of 01/10/2026 and 01/11/2026 (inconsistent with the tablets being in the card as observed by Surveyor and LPN F on 01/22/2026). - Famotidine tablet documented as administered on the evenings of 01/10/2026 and 01/11/2026 (inconsistent with the tablets being in the card as observed by Surveyor and LPN F on 01/22/2026). On 01/30/2026, Surveyor reviewed incident reports provided by Coordinator of Administrative Services (Coordinator) G. Four reports detailed the above missed famotidine and calcium + vitamin D administrations - one report per medication per day of missed administration. All reports were dated 01/13/2026 and documented that the errors were discovered on 01/13/2026 as well. All reports documented that the evening (PM) shift staff that day noticed the tablets still in their pouches but signed off as administered in Resident 2's MAR. The reports all indicated that the provider's nurse was made aware of the incidents. Example 3 - Resident 3's polyethylene glycol, bisacodyl suppositories, alprazolam, and the administration of Resident 2's clonazepam to	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 13 him/her On 01/22/2026, at approximately 10:30 a.m., Surveyor interviewed Lead Caregiver A regarding Resident 3. Lead Caregiver A reported that in the past Resident 3 experienced blockage of his/her bowels, as revealed from an x-ray. Lead Caregiver A reported that after this, Resident 3 was prescribed suppositories that were to be administered daily. At approximately 2:05 p.m., Surveyor reviewed medications for Resident 3 with LPN F. Surveyor observed a container of polyethylene glycol prescribed to Resident 3. The prescription label contained instructions to, "Mix 17 grams (Fill cap to line) in 4-8 oz liquid, stir well and drink once daily for constipation." A handwritten annotation in black marker indicated that the container was opened by staff for use on 12/22/2025. The manufacturer's label on the container indicated that the label contained 30-once daily doses of powder. Surveyor noted that even if the container's first dose wasn't pulled until 12/23/2025, the 30th dose would have been administered 01/21/2026 (day prior to the survey) if it had been administered daily as prescribed since 12/23/2025. Surveyor observed that the container appeared to be approximately 25% full. LPN F reported that s/he believed there had been some instances in which Resident 3's polyethylene glycol had been held due to medical provider directives. While observing Resident 3's polyethylene glycol container, Surveyor and LPN F together reviewed Resident 3's MARs from 12/09/2025 - 01/22/2026. Resident 3's MARs documented his/her daily polyethylene glycol administration time as 8:00 a.m. From 12/23/2025, the day after	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 14	{N 352}		

the container was documented as opened, through 01/22/2026 (approximately 31 administrations), staff signed off on daily administration of Resident 3's polyethylene glycol. LPN F reported s/he conducted audits on the medications on an approximate monthly basis. LPN F reported s/he last checked Resident 3's polyethylene glycol on 01/06/2026 and marked on the container approximately how full it was. Surveyor observed the handwritten mark and date on the container annotated by LPN F. LPN F reported s/he understood Surveyor's concern that Resident 3's polyethylene glycol container should have been empty if staff were administering it as they documented they had.

In reviewing the medications with LPN F, Surveyor also observed a baggie of suppositories prescribed to Resident 3. The pharmacy label on the baggie documented that the baggie contained 30 bisacodyl 10 mg suppositories with instructions to, "Unwrap and insert 1 suppository rectally once daily for constipation (Hold for loose stool)." The label indicated that the suppositories were dispensed on 01/06/2026. Surveyor observed 19 suppositories remaining in the baggie, indicating that 11 had been used.

While observing Resident 3's suppositories, Surveyor and LPN F together reviewed Resident 3's MARs from 12/01/2025 - 01/22/2026. Resident 3's MARs documented his/her daily suppository administration time as 8:00 a.m. From 12/01/2025 - 01/22/2026 (morning of the survey), staff signed off on daily administration of Resident 3's suppositories. Surveyor noted that even if the first suppository from the baggie wasn't used until 01/07/2026, the day after being dispensed, 16 suppositories should have been used if they were being administered as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 15 documented, which was inconsistent with only 11 missing from the baggie. While discussing this concern with LPN F, Caregiver C entered the area and took part in the interview. Caregiver C reported s/he believed some of the suppositories were more recently dispensed and had just been put by staff in the old baggie dated 01/06/2026. On 01/29/2026, at approximately 11:47 a.m., Surveyor interviewed Director of Operations O from the pharmacy that dispensed medications for each of the provider's residents. Director of Operations O confirmed that Resident 3's suppositories were most recently dispensed on 01/06/2026 and that none were dispensed since that date. On 01/30/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/21/2021 with diagnoses including cri-du-chat syndrome, profound developmental disability, and major depressive disorder. Resident 3's record identified that staff managed and administered his/her medications. Resident 3's prescriptions included the following additional medications: - Alprazolam 1.0 mg tablets with instructions to, "Take 1 tablet by mouth twice daily at noon and 8PM for anxiety." - Alprazolam 0.5 mg tablets with instructions to, "Take 1 tablet by mouth every morning for anxiety." In reviewing Resident 3's MARs from 12/09/2025 - 01/22/2026, Surveyor observed the following:	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 16 - The 12/31/2025 8:00 p.m. dose of alprazolam was documented as "skipped" due to "could not find med." - The 01/14/2026 12:00 p.m. dose of alprazolam was documented as "skipped" due to "held" with no other notes documented. Surveyor reviewed an incident report dated 01/13/2026 (8:06 p.m.) which detailed an incident in which Caregiver C documented mistakenly administering Resident 3 a clonazepam tablet prescribed to Resident 2. Another incident report dated 01/18/2026, documented that, "[Lead Caregiver A] noticed that [Resident 3]'s 8 AM alprazolam wasn't given to [him/her]." In reviewing the MAR entry for that administration, Surveyor observed that his/her 8:00 a.m. alprazolam was documented as administered. At approximately 10:08 a.m., Surveyor e-mailed Coordinator G and asked if there were any specific doctor's orders or other notes specifying for Resident 3's alprazolam to have been held around 01/14/2026. At approximately 2:03 p.m., Surveyor received a response from Coordinator G, who reported s/he was able to find a note regarding Resident 3's alprazolam. Surveyor reviewed the attached note, dated 01/13/2026, which documented, "[Resident 3] was given [Resident 2]'s clonazepam 1 mg tablet by mistake. Writer [Registered Nurse (RN) H] notified. The on-call physician ...was contacted. [S/he] gave a verbal order to hold [Resident 3]'s 8 Pm alprazolam [due to] duplicative therapy. Guardian was notified." Surveyor noted the holding of Resident 3's	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 17 alprazolam on 01/13/2026 due to the medication administration error from the note was corroborated on his/her MAR entry for that administration, however, nothing in the note documented information about the holding of his/her 12:00 p.m. alprazolam dose the next day (01/14/2026). On 02/03/2026, Surveyor reviewed medical records for Resident 3, which detailed the following historical concerns related to constipation s/he previously experienced: - Visit on 11/19/2025: Resident 3's medical provider identified a concern of "abdominal discomfort" for him/her with the historical context of, "Abdominal x-ray obtained today shows ...moderate stool volume in the left colon and rectum, improved compared to the prior imaging on 09/29/25." - Visit on 12/10/2025: " ...Has not had a bowel movement yet today but per xray [sic] report from yesterday constipation is improved ..." Resident 3's medical provider identified one of Resident 3's medical concerns as "chronic constipation" with the note, "Constipation is improved - continue with current stool softeners/suppository regimen ..." On 02/03/2026, at approximately 11:48 a.m., Surveyor interviewed Medical Assistant P from Resident 3's medical provider's office. Medical Assistant P reported that the office received a call from the provider's staff on 01/14/2026 looking for a refill prescription of Resident 3's alprazolam. Surveyor noted that this was the date Resident 3's 12:00 p.m. alprazolam was documented as skipped.	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 18 Example 4 - Resident 4's calcium + vitamin D and bisacodyl suppositories On 01/22/2026, at approximately 2:05 p.m., Surveyor reviewed medications for Resident 4 with LPN F. LPN F confirmed that the provider's system was for staff to punch out tablets/capsules from the numerical bubble pack that corresponded with the date of administration (e.g. the tablets for bubble pack "12" would be punched out and administered on 01/12/2026). Surveyor observed a medication card for evening calcium + vitamin D tablets with a prescription label identifying it was prescribed to Resident 4. In observing the medication card, Surveyor observed that the calcium + vitamin D tablets for bubble pack number 11 were still in the pack. LPN F confirmed Surveyor's observation. After looking through the provider's records on his/her laptop, LPN F reported s/he found an incident report correlated with the occasion. In reviewing the medications with LPN F, Surveyor also observed a baggie of suppositories prescribed to Resident 4. The pharmacy label on the baggie documented that the baggie contained 14 bisacodyl 10 mg suppositories with instructions to, "Insert 1 suppository rectally every other day at noon for constipation (Hold if has bowel movement)." The label indicated that the suppositories were dispensed on 01/15/2026. Surveyor observed 13 suppositories remaining in the baggie, indicating that 1 had been used. While observing Resident 4's suppositories, Surveyor and LPN F together reviewed Resident 4's MARs from 12/01/2025 - 01/22/2026. From 12/01/2025 - 01/22/2026 (morning of the survey), staff signed off on each prescribed administration of Resident 4's suppositories, including an	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 19	{N 352}		

additional administration on 12/31/2025, indicating 3 daily administrations from 12/30/2025 through 01/01/2026. Surveyor noted that even if the first suppository from the baggie wasn't used until 01/16/2026, the day after being dispensed, staff initialed off on the administration of 3 suppositories since then, including 01/17/2026, 01/19/2026, and 01/21/2026. Surveyor noted that this was inconsistent with only 1 suppository missing from the baggie.

Surveyor interviewed LPN F during the above encounter. LPN F reported s/he thought it was possible there was a similar issue as with Resident 3's suppositories - that staff received a new supply of suppositories but were putting them in an older, previously-dispensed baggie.

On 01/29/2026, at approximately 11:47 a.m., Surveyor interviewed Director of Operations O from the pharmacy that dispensed medications for each of the provider's residents. Director of Operations O confirmed that Resident 4's suppositories were most recently dispensed on 01/15/2026 and that none were dispensed since that date.

On 01/30/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 06/21/2021 with diagnoses including developmental disability. Resident 4's record identified that staff managed and administered his/her medications. Resident 4's prescriptions included the following:

- Calcium + Vitamin D3 250-125 mg tablets with instructions to, "Take 2 tablets by mouth 3 times daily for supplement."

In reviewing Resident 4's MARs from 12/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 20 - 01/22/2026, Surveyor observed that his/her calcium + vitamin D was documented as administered on the evening of 01/11/2026. On 01/30/2026, Surveyor reviewed an incident report provided by Coordinator G. The report, dated 01/13/2026, documented that on that day staff noticed Resident 4's calcium + vitamin D tablets for the evening of 01/11/2026 were never popped out but that the MAR indicated they had been administered. Example 5 - Resident 6's acetaminophen and cetirizine On 01/22/2026, at approximately 2:05 p.m., Surveyor reviewed medications for Resident 6 with LPN F. LPN F confirmed that the provider's system was for staff to punch out tablets/capsules from the numerical bubble pack that corresponded with the date of administration (e.g. the tablets for bubble pack "12" would be punched out and administered on 01/12/2026). Surveyor observed a medication card for morning acetaminophen tablets with a prescription label identifying it was prescribed to Resident 6. In observing the medication card, Surveyor observed the acetaminophen tablets for bubble pack number 11 were still in their pack. LPN F confirmed Surveyor's observation. After looking through the provider's records on his/her laptop, LPN F reported s/he found an incident report for the above occasion. On 01/30/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 10/14/2025 with diagnoses including cerebral palsy, vitamin D deficiency, and mild intermittent asthma. Resident 6's record identified that staff managed and administered his/her medications.	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 21 Resident 6's prescriptions included the following: - Acetaminophen 500 mg tablets with instructions to, "Take 2 tablets (1000 mg) by mouth twice daily ..." - Cetirizine 10 mg tablets with instructions to, "Take 1 tablet by mouth once daily." In reviewing Resident 6's MARs from 12/09/2025 - 01/22/2026, Surveyor observed that his/her acetaminophen tablets were documented as administered on the evening of 01/11/2026, inconsistent with the tablets being in the card as observed by Surveyor and LPN F on 01/22/2026. On 01/30/2026, Surveyor reviewed incident reports provided by Coordinator G. One report, dated 01/12/2026, documented, "today while doing med check I noticed that 2 of [Resident 6]'s medications were not given to [him/her] on 1/11/26." The medications identified in the report included Resident 6's acetaminophen tablets and his/her cetirizine tablet. Surveyor reviewed Resident 6's MARs again, which identified his/her cetirizine tablet documented as administered on 01/11/2026. A second report, dated 12/11/2025, documented, "today while checking meds i [sic] noticed that [Resident 6]'s Certirizine [sic] Tab 10MG on the 10th was not given and the med was still in the card." Surveyor reviewed Resident 6's MARs again, which identified his/her cetirizine tablet documented as administered on 12/10/2025. Both reports identified that the medication errors had been "reported" but did not specify to whom. ADDITIONAL INTERVIEWS: On 01/22/2026, at approximately 10:30 a.m.,	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 352}	Continued From page 22 Surveyor interviewed Lead Caregiver A. Lead Caregiver A confirmed that s/he had made a couple of medication administration errors recently, which s/he reported was due to being exhausted from working several double shifts. On 02/05/2026, at approximately 2:00 p.m., Surveyor discussed medication administration concerns with Coordinator G. Coordinator G reported understanding of Surveyor's concerns and denied having any follow up questions or concerns. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 352}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 6's	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 389}	Continued From page 23	{N 389}		

individual service plan (ISP) was updated to reflect his/her emerging mental health concerns and needs.

This is a repeat deficiency. See Statement of Deficiencies (SOD) ZBMH11, dated 09/12/2025.

Findings include:

On 01/22/2026, at approximately 8:45 a.m., Surveyor interviewed Resident 6. Resident 6 reported that s/he experienced post-traumatic stress disorder (PTSD) symptoms and that s/he didn't feel some staff were supportive of his/her mental health needs. Resident 6 reported s/he believed some staff didn't appear to have a lot of training or awareness of PTSD.

At approximately 9:25 a.m., Surveyor interviewed Lead Caregiver A. Lead Caregiver A reported s/he thought Resident 6 had maybe been taken to the emergency department at the beginning of January for mental health concerns.

On 01/22/2026, Surveyor reviewed Resident 6's current ISP, dated 01/09/2026. The ISP identified that Resident 6 was his/her own legal representative. The ISP indicated that Resident 6 was diagnosed with anxiety disorder and depression. The ISP identified the following mentions of Resident 6's mental health condition/needs and related behaviors:

- "Person Outcome Goals: ...Get [his/her] mental health in order ..."

- "Positive Behavior Supports: No formal [behavior support plan] at this time ...[Resident 6] will be contacting [clinic] to get Psychiatric Services scheduled."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 389}	Continued From page 24 - "Meeting Summary ...Discussion was held regarding how important it is for [Resident 6] to establish a Psychiatrist to help [him/her] get [his/her] mental health stable ...On On [sic] 01/01/26 the police came to the home to do a wellness check on [Resident 6]. [S/he] did to [sic] the [hospital] on 01/02/26 for [his/her] mental health ..." There was no other information regarding his/her specific mental health concerns. On 01/30/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 10/14/2025. The following incident reports for Resident 6 detailed incidents surrounding his/her mental health condition and behaviors: - 12/11/2025 (6:45 a.m.): "Early this morning while doing rounds [overnight (NOC)] shift updated first shift about how [Resident 6] had a rough night and started crying during there [sic] shift. [Resident 6] over heard Noc shift giving first an [sic] update and began to get upset because [s/he] thought staff was talking bad about [him/her] ...After noc shift left [Resident 6] told me that [s/he] wasnt [sic] doing well and started to cry [s/he] stated that [s/he] was having a PTSD attack and that [s/he] was having thoughts about hurting [him/herself]. I than [sic] asked [him/her] if the situation from earlier triggered [him/her] and [s/he] stated yes. I than [sic] did some deep breathing exercises with [him/her] after that [s/he] began to calm down and stated that [s/he] was having negative thoughts so I did a DBT exercise with [him/her]. After that [s/he] said that [s/he] was feeling much better and was no longer having negative thoughts."	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 389}	Continued From page 25 - 12/13/2025 (6:57 a.m.): "[Resident 6] has been crying since I came in this morning. [S/he] says [s/he] keeps having flashbacks from last night. When staff was ignoring [him/her] and yelling at [him/her] ..." - 01/01/2026 (6:30 a.m.): "the police came today around 6:30am-7am to do a wellness check on [Resident 6] due to [him/her] calling human services more than once ...the police officer talked to [Resident 6] and then left shortly after." - 01/01/2026 (10:30 a.m.): "[Resident 6] went to [hospital] today for [his/her] mental health." - 01/01/2026 (12:00 p.m.): "[Resident 6] has been screaming and crying on and off all day today [s/he] stated the [sic] [s/he] wanted to go to [hospital] so they can evaluate [him/her] to be transformed [sic] to a psychiatric hospital in that area ...later on in the day around 12pm a [person] from human services called [Resident 6] and told [him/her] that [s/he] will try to see what [s/he] can do for [him/her] the [person] from human services than [sic] asked [Resident 6] to hand the phone to a staff member. while [sic] talking to the [person] from human service [Resident 6] began to scream at the top of [his/her] lungs ...after getting off the phone [Resident 6] stopped crying and said that i [sic] triggered [his/her] ptsd ..." - 01/19/2026 (8:05 a.m., authored by Program Manager I): "On 1/17 and 1/18 [Resident 6] contacted my personal cell phone to request a staff meeting due to issues with staff in the home. I did not answer these calls as [Resident 6] continues to contact me for behavioral health concerns and issues at the home outside of business hours and expects immediate answers ...My observation is that [Resident 6] continues to	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 389}	Continued From page 26	{N 389}		

have issues with staff and mental health concerns. I have spoken to all staff and addressed with them [Resident 6]'s mental health needs and the proper way to communicate with [him/her] ...If [s/he] has immediate mental health concerns [s/he] must let the staff know or contact the crisis help line."

- 01/18/2026 (5:40 a.m.): "while [sic] starting my shift I heard Noc shift tell [Resident 6] that [s/he] will be right back and will have to wait a minute. [Resident 6] began to start crying very loud, I asked [Resident 6] if [s/he] was ok [s/he] stated that [s/he] was having negative thoughts in [his/her] head I told [Resident 6] to take some deep breathes [sic] and that NOC shift will be back to tend to [him/her] in a few seconds ... [Resident 6] said ok and stopped crying."

On 01/30/2026, Surveyor reviewed shift report notes documented by staff, which detailed the following related to Resident 6's mental health concerns and behaviors:

- 12/11/2025: "Had a PTSD Attack [sic] today staff was able to calm [him/her] down."

- 12/16/2025: "Had a rough morning crying on and off today."

- 01/02/2026: "Left at 10:30 am to go to [hospital] for [his/her] mental health."

On 01/30/2026, Surveyor reviewed medical reports for Resident 6, which detailed the following related to his/her mental health concerns and behaviors:

- An "Encounter Note" from 12/04/2025 documented, "Recently hospitalized for suicidal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 389}	Continued From page 27	{N 389}		

ideations. doing [sic] okay now. Has follow up with [county] ..."

- "Patient Visit Summary" from 12/31/2025 documented that Resident 6 was seen that day in the emergency department due to PTSD

- A post-acute "Discharge Report" printed 01/06/2026 documented a psychiatry referral that was placed for Resident 6 which identified that s/he experienced chronic suicidal ideation.

- Hospital report dated 01/07/2026 documented that Resident 6 was admitted to the hospital on 1/3 "after presenting to an outside [emergency department] with auditory/visual hallucinations and suicidal ideations ..."

On 01/30/2026, at approximately 10:08 a.m., Surveyor requested from Coordinator of Administrative Services (Coordinator) G a behavior support plan (BSP), if any existed, for Resident 6. At approximately 2:03 p.m., Coordinator G confirmed Resident 6 did not have a BSP.

On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator G and discussed the concern that Resident 6's mental health-related behaviors and needs were not documented in his/her ISP. Coordinator G confirmed s/he was present at the ISP meeting for Resident 6 on 01/09/2026 and reported s/he didn't believe there was any conversation that took place about Resident 6's mental health needs other than his/her care team encouraging him/her to establish psychiatric care. Coordinator G reported that Caregiver C did a good job talking to Resident 6 when s/he was experiencing behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 389}	Continued From page 28 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 389}		
{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 record review, observation, and interview, the provider did not ensure that staff were provided in sufficient numbers on a 24-hour basis to meet the needs of the residents. The provider's home was typically staffed with a 1:5 ratio on afternoon/evening (PM) shifts, and on several days, morning (AM) shifts. Both AM and PM shifts required the caregiver on shift to prepare meals, conduct caregiving tasks to meet the identified needs below of residents, conduct leisure time activities, and on occasion, conduct cleaning tasks. Five of the provider's 5 residents, Resident 1, Resident 2, Resident 3, Resident 4, and Resident 6, were documented as requiring full or total assistance to complete personal care tasks and requiring 24/7 supervision. Four of the 5 residents, Resident 1, Resident 2, Resident 3, and Resident 4, had impaired verbal/communication abilities, with 2 of the 4 not being able to make their needs known and the remainder 2 of the 4 requiring assistance to make their needs known.	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 29 Four of the 5 residents, Resident 1, Resident 2, Resident 4, and Resident 6, required a mechanical lift for all transfers. Resident 1, Resident 2, occasionally Resident 3, and Resident 4 required staff assistance for mobility in their wheelchairs. Resident 1 and Resident 2 had gastrostomy tubes (g-tubes) for which they required staff to manage schedules of flushing, feeds, and medication administration throughout the day. All 5 residents were incontinent and required a regular schedule of generally 2-hour checks and changes to be completed by staff (except for Resident 2, who was documented as requiring incontinence checks every 3-4 hours). Resident 5 had a catheter for which s/he required staff to manage emptying of his/her bag. All 5 residents required staff to administer medications, which included ointments, powdered medications, and medications that had to be specifically prepared for g-tube administration for Resident 1 and Resident 2. Across each of the 5 residents, staff had to administer an aggregate of the following approximate number of medications at the corresponding approximate times: 7:00 a.m. (1 medication), 8:00 a.m. (64 medications), 12:00 p.m. (5 medications), 2:00 p.m. (1 medication), 4:00 p.m. (4 medications), 5:00 p.m. (4 medications), and 8:00 p.m. (37 medications). Besides relying on staff for the general preparation of each meal, all 5 residents required staff assistance in either the preparation of their therapeutic diets or with feeding for each meal - not counting the g-tube feedings for Resident 1 and Resident 2. Resident 1 required staff assistance to eat meals and for food to be	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 30	{N 396}		

prepared in bite-sized pieces, Resident 2 required food to be pureed with liquids thickened to a pudding consistency and was observed to require staff assistance to be fed, Resident 3 required foods to be pureed and to be directly fed by staff, Resident 4 required a chopped diet, and Resident 6 required staff assistance for feeding.

Resident 1 required staff to conduct range of motion (ROM) exercises with him/her every shift, Resident 2 required ROM exercises to be conducted twice daily, and Resident 2 required repositioning every 2-3 hours to prevent skin breakdown.

Regarding shower scheduling, both Resident 2 and Resident 6 were to receive showers during the PM shift on Tuesdays, Thursdays, and Saturdays; Resident 1 was to receive showers during the AM shift on Sundays, Tuesdays, and Thursdays; and Resident 4 was to receive showers during the AM shift on Mondays, Wednesdays, and Fridays.

Staff report identified concerns related to sufficient staffing as it related to resident care needs, including when staff were expected to work double shifts (a period of approximately 16 hours) which reportedly related to medication administration errors.

This is a repeat deficiency. See Statement of Deficiencies (SOD) ZBMH11, dated 09/12/2025.

Findings include:

On 01/22/2026, Surveyor conducted a complaint investigation into allegations of adequate staffing.

The provider is licensed to serve up to 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 31	{N 396}		

nonambulatory residents within the client groups of developmentally disabled, traumatic brain injury, physically disabled, and emotionally disturbed/mental illness.

On 01/22/2026, Surveyor conducted a survey at the provider's home and was onsite from approximately 8:33 a.m. - 4:00 p.m. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area and kitchen. From the common area, where Surveyor spent the entire survey period, Surveyor could observe the hallway that the bedrooms for Resident 1, Resident 3, and Resident 6 were off as well as the entrance to the hallway where the bedrooms for Resident 2 and Resident 4 were located. Upon arriving onsite, Surveyor observed 3 caregivers working - Lead Caregiver A, Caregiver C, and Caregiver N, who was in training. Surveyor observed Lead Caregiver A assisting in care tasks until approximately 11:30 a.m. when s/he left to transport and accompany Resident 1 to a medical appointment. Throughout the entire Survey period, staff were observed engaged in caregiving tasks, which included personal cares and medication administration, food preparation, and some cleaning tasks, including dishes after meals and laundry.

At approximately 8:42 a.m., Surveyor observed a staff schedule for January 2026 posted in the common area. The schedule documented daily shifts generally broken down as 6:00 a.m. - 2:00 p.m. (AM / first shift), 2:00 p.m. - 10:00 p.m. (PM / second shift), and 10:00 p.m. - 6:00 a.m. (NOC / overnight shift). Surveyor observed from the schedule that approximately half the AM shifts documented 2 staff working, while the other half documented 1 staff working. Surveyor also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 32 observed that most PM shifts documented 1 staff member working. At approximately 8:45 a.m., Surveyor interviewed Resident 6. Resident 6 reported having concerns with adequate staffing at the home and stated, "Sometimes there's only one [staff member] and that's a lot for one person." Resident 6 also stated, "When there's one [staff member] you have to wait to get tended to." Resident 6 reported there was an occasion where s/he had a holiday celebration/party with his/her family at the home and there was only 1 staff member working. Resident 6 reported that during this party s/he could tell s/he experienced an episode of incontinence and had asked the staff member to be changed at approximately 2:30 p.m. Resident 6 reported s/he had to wait until 5:30 p.m. before the staff member finally got to him/her. Resident 6 reported s/he believed there "definitely" needs to be 2 staff members working at the home. Resident 6 reported that on occasions where only 1 staff member worked s/he could see signs that they appeared stressed and that they could sometimes be "short" with him/her. Resident 6 reported s/he typically had to wait to have incontinence cares done when there was only 1 staff member working. At approximately 9:25 a.m., Surveyor interviewed Lead Caregiver A regarding an overview of resident needs. Lead Caregiver A reported that each of the provider's 5 residents required total assistance for all cares and that 4 of the 5 residents required staff assistance for all transfers. Lead Caregiver A reported that all 5 residents were non-ambulatory. Lead Caregiver A also reported that all 5 residents were incontinent of both bowel and bladder and required staff to change briefs for them. Lead Caregiver A	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 33	{N 396}		

reported that Resident 2 had a g-tube for which s/he was administered g-tube feedings, but that s/he had also recently begun showing an interest in consuming food orally, which s/he was cleared by his/her medical provider to do. Lead Caregiver A reported that as a result, Resident 2 was offered oral meals consistent with his/her therapeutic diet of pureed foods and pudding-thickened liquids, as well as provided g-tube feedings. Lead Caregiver A reported that Resident 1, Resident 4, and Resident 6 required their foods to be chopped. Lead Caregiver A reported that Resident 3 required his/her foods to be pureed.

While interviewing Lead Caregiver A, Surveyor observed Caregiver N feeding Resident 2 breakfast.

At approximately 10:30 a.m., Surveyor interviewed Lead Caregiver A again. When asked if one staff member per AM and PM shifts were enough to meet the care needs of residents, Lead Caregiver A replied, "No." Lead Caregiver A reported that the residents, who were all incontinent, did not get changed as often. Lead Caregiver A reported that Resident 1 was supposed to be changed every 2 hours but really s/he needed to be changed more often than that due to the frequency and amount of water used for his/her g-tube flushes. Lead Caregiver A reported that it would be better if Resident 1 was checked for incontinence approximately every hour but that it would be difficult to do that. Lead Caregiver A confirmed that the caregivers working were responsible for conducting daily leisure activities (outside of when occasional outside personnel came to conduct an activity), meal preparation, medication administration, personal cares, and some cleaning tasks. Lead Caregiver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 34 A reported that it was "sometimes" difficult to maintain the shower schedule with one staff member on shift and that s/he has had to re-schedule resident showers due to timing limitations. Lead Caregiver A reported that due to limited staffing s/he has had to work multiple days of double shifts (2 8-hour shifts, or 16 hours total) and reported s/he had been working a lot of double shifts since 01/05/2026. Lead Caregiver A reported s/he was exhausted due to this schedule and had made a couple of medication administration errors recently out of exhaustion. Lead Caregiver A reported s/he was working a double shift that day. Lead Caregiver A became teary during the interview and reported that it was difficult to do all the resident care tasks with only 1 person working. Lead Caregiver A reported s/he believed more than 1 person per shift needed to be regularly staffed at the home in order to meet resident care needs and that s/he had discussed this with Program Manager I. Lead Caregiver A reported s/he believed the provider was trying to staff with 2 staff members for AM and PM shifts, but that the staff who had been recently hired already left employment. At approximately 11:00 a.m., a staff member who identified him/herself as an art therapist arrived onsite and began conducting a leisure art activity with residents. At approximately 1:15 p.m., Surveyor interviewed Caregiver C. Caregiver C reported s/he thought the home "should be [staffed with] 2 people." Caregiver C reported that it was hard to get resident care needs met with only 1 staff member working and that s/he felt 2 staff were needed to meet resident care needs. Caregiver C reported that management had expressed intentions to staff the home with 2 staff per AM and PM shifts.	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 35 On 01/22/2026, Surveyor reviewed individual service plans (ISPs) and medication administration records (MARs) for each of the provider's 5 residents. Besides documenting that all residents required 24/7 supervision, the following was also documented: - Resident 1 (ISP dated 09/08/2025): Diagnosed with intellectual disability, tetrahydrobiopterin synthesis defect, spastic quadriplegia, and urinary incontinence. Resident 1 needed assistance to make his/her needs known and was able to vocalize some key phrases as well as answer yes/no questions "sometimes." Resident 1 required total assistance for cares. Resident 1 required staff to conduct ROM exercises with him/her every shift, 2-hour incontinence checks/cares, and baths or showers 3 days per week. Resident 1 was documented as being physically resistive to personal cares. Resident 1 required a Hoyer lift for all transfers and used a wheelchair for ambulation. Resident 1 required staff to administer medications to him/her at 7:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.; and for the medication to be either crushed and administered via his/her g-tube along with 800 mL water flushes for each administration, or, specifically for his/her 12:00 p.m. medications, administered orally with applesauce, pudding, or yogurt. Resident 1 required food to be offered to him/her for breakfast, lunch, and dinner, with food served in bite-sized pieces and for staff to assist him/her with eating. Resident 1 required staff to prepare and administer g-tube feedings at 3:00 p.m. and "after dinner." To meet Resident 1's hydration needs, staff were to ensure s/he consumed 500 mL of water with each meal as well as 300 mL each between breakfast, lunch, and supper. Any water not drank was to be	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 36	{N 396}		

administered by staff via Resident 1's g-tube in the evenings. Resident 1 was identified as having a history of falls and behaviors of pulling him/herself out of bed when s/he was experiencing a manic episode. Resident 1 had a behavior support plan (BSP) which identified known behaviors of self-injurious behaviors, physical aggression, and manic episodes. Resident 1's MARs identified the following medication administration schedule that staff were to follow: 22 medications at 8:00 a.m., 1 medication at 12:00 p.m., 3 medications at 4:00 p.m., and 12 medications at 8:00 p.m. Two of these involved ointments/creams that staff applied.

- Resident 2 (ISP dated 12/05/2025): Diagnosed with intellectual and developmental disability, cerebral palsy, and hemiplegia/hemiparesis. Resident 2 was not able to make his/her needs known and relied on body language and facial expressions for communication. Resident 2 required total assistance for all cares. Resident 2 required staff to conduct ROM exercises with him/her during personal cares twice daily, reposition him/her every 2-3 hours to prevent skin-breakdown, conduct incontinence checks/cares every 3-4 hours, and conduct baths or showers 3 days per week on the PM shifts. Resident 2 required a mechanical lift for all transfers and a manual wheelchair for all mobility that s/he could "sometimes" self-propel. Resident 2 required staff to administer medications to him/her at 8:00 a.m., 2:00 p.m., 5:00 p.m., and 8:00 p.m. which were either offered orally crushed or administered via his/her g-tube. Resident 2 was able to be offered meals but food had to be prepared as a pureed texture and liquids had to be thickened to a pudding-like consistency. Resident 2 required g-tube feedings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 37 which were administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. in addition to water flushes before and after each feeding. Resident 2's MARs identified the following medication administration schedule that staff were to follow: 8 medications at 8:00 a.m., 1 medication at 2:00 p.m., 2 medications at 5:00 p.m., and 4 medications at 8:00 p.m. - Resident 3 (ISP dated 08/07/2025): Diagnosed with profound developmental disability, blindness, cri-du-chat syndrome, hearing loss, and bilateral hip dysplasia. Resident 3 required assistance to make his/her needs known, with making noises or faces to express him/herself or speak "some" words. Resident 3 required total assistance for all cares. Resident 3 required staff to conduct incontinence cares/checks every 2 hours, assist fully with bathing, and guide him/her at times for ambulation and transfers. Resident 3 required staff to crush his/her medications, and administer them at 8:00 a.m., 12:00 p.m., and 8:00 p.m. in a food medium. Resident 3 required his/her foods to be pureed and for staff to feed him/her during all meals. Staff also had to provide Resident 3 a nutritional supplement drink 3 times each day. Resident 3 was identified to have self-injurious behaviors that included pulling hair and biting his/her hands/arms. Resident 3's MARs identified the following medication administration schedule that staff were to follow: 11 medications at 8:00 a.m., 2 medications at approximately 12:00 p.m., 1 medication at 5:30 p.m., and 6 medications at 8:00 p.m. One of these included a daily suppository and 2 included ointments/creams that staff applied. - Resident 4 (ISP dated 10/21/2025): Diagnosed with developmental disability and scoliosis. Resident 4 was not able to make his/her needs	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 38 known and could not communicate using words. Resident 4 was identified as having "limited hearing." Resident 4 required total assistance for all cares. Resident 4 required staff to conduct incontinence checks/cares every 2 hours. Resident 4 required a Hoyer lift for all transfers and a wheelchair for mobility. Resident 4 required staff to administer his/her medications at 7:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. with a food medium. Resident 4 required his/her foods to be chopped. Under the "Things That are Important to Me" heading within his/her ISP, one of the identified items was, "1:1 time with staff and going for walks." Resident 4's MARs identified the following medication administration schedule that staff were to follow: 1 medication at 7:00 a.m., 10 medications at 8:00 a.m., 2 medications at 12:00 p.m., 1 medication at 4:00 p.m., and 3 medications at 8:00 p.m. One of these included an ointment/cream that staff applied, and one was a suppository that was administered every-other-day. - Resident 6 (ISP dated 01/09/2026): Diagnosed with intellectual and developmental disability, cerebral palsy, epilepsy, spastic quadriplegia, and anxiety disorder. Resident 6 required total assistance for all cares. Resident 6 required staff to conduct incontinence checks/cares, manage his/her catheter, and conduct showers for him/her 3 days per week during the PM shifts. Resident 6 required a mechanical lift for all transfers. Resident 6 required staff to administer his/her medications at 8:00 a.m., 5:00 p.m., and 8:00 p.m. with a food medium. Resident 6 required staff assistance for feeding, including to spear food with his/her utensils. Resident 6's MARs identified the following medication administration schedule that staff were to follow: 13 medications at 8:00 a.m., 1 medication at 5:00 p.m., and 12	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 39	{N 396}		

medications at 8:00 p.m. One of these included an ointment/cream that staff applied.

On 01/22/2026, Surveyor reviewed the staff schedule from 12/09/2025 - 01/22/2026 and identified the following dates on which 1 staff member was staffed to work AM or PM shift (during typical wake hours for residents when the above cares would be conducted:

- AM shifts on 12/11/2025, 12/13/2025, 12/15/2025, 12/20/2025, 12/21/2025, 12/25/2025, 12/28/2025, 01/01/2026, 01/02/2026, 01/04/2026, 01/07/2026, 01/08/2026, 01/10/2026 through 01/14/2026, 01/17/2026 through 01/19/2026, and 01/21/2026

- PM shifts on 12/13/2025, 12/19/2025 through 12/21/2025, 12/23/2025 through 12/30/2025, 12/31/2025 (partial shift), and 01/01/2026, through 01/21/2026

(Of note, SOD ZBMH11, where N0396 83.36(1)(a) Adequate Staff to Meet Resident Needs was last cited, involved similar staffing patterns with 4 of the same current residents present that had similar care needs now as then - Resident 1, Resident 2, Resident 3, and Resident 4. Since that survey, on 09/12/2025, the provider admitted Resident 6, who required full assistance with all cares, including transfers with a mechanical lift, feeding, and catheter bag emptying.)

At approximately 3:05 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) G. Coordinator G acknowledged Surveyor's concern that there continued to be inadequate staffing to meet resident needs since the last survey. Coordinator G reported that s/he was aware management was trying to hire for 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 396}	Continued From page 40 staff per AM and PM shift but that it hadn't yet worked out. On 01/30/2026, Surveyor reviewed an incident report dated 01/13/2026, which detailed a medication administration error made by Caregiver C. The report, also authored by Caregiver C, detailed that Caregiver C had accidentally administered Resident 2's clonazepam tablet to Resident 3. The report documented, " ...I told [Registered Nurse (RN) H] that I was extremely tired since i [sic] ended up having to work a unexpected double due to nobody being able to relive [sic] me at 2pm and that I must have gotten the medications mixed up due to being tired." On 02/05/2026, Surveyor reviewed a resident shower schedule provided by Coordinator G. The schedule identified that both Resident 1 and Resident 4 were to receive baths/showers 3 days weekly during the AM shifts. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 396}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 415}	Continued From page 41 resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that for Resident 1, Resident 2, Resident 4, and Resident 6, who were each administered as needed (PRN) medication from 12/09/2025 - 01/22/2026, staff documented the need for the PRN medication administration and the residents' responses. This is a repeat deficiency. See Statement of Deficiencies (SOD) ZBMH11, dated 09/12/2025. Findings include: On 01/22/2026, Surveyor reviewed medication administration records (MARs) from 12/09/2025 - 01/22/2026 for each of the provider's 5 residents, provided by Lead Caregiver A. Surveyor observed PRN medications that were documented as administered to Resident 1, Resident 2, Resident 4, and Resident 6. Example 1 - Resident 1 Resident 1's MARs identified the following PRN medications, their instructions, and administrations: - Lorazepam 2 mg tablets: "Take 1/2 tablet (1 mg) by mouth every 2 hours as needed for mania ..." Two separate administrations of PRN lorazepam were documented as administered on 12/07/2025 with no other information.	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 415}	Continued From page 42 - Acetaminophen 325 mg tablets: "Take 2 tablets (650 mg) by mouth or per g-tube every 4 hours as needed for pain / temp >38.6C ..." Four administrations of PRN acetaminophen were documented - 01/06/2026, 01/08/2026, 01/09/2026, and 01/10/2026 - with no other information. Example 2 - Resident 2 Resident 2's MARs identified the following PRN medications, their instructions, and administrations: - Acetaminophen 325 mg tablets: "Take 1-2 tablets by mouth every 4-6 hours as needed for pain or fever ..." One administration of PRN acetaminophen was documented on 12/19/2025 with no other information. Example 3 - Resident 4 Resident 4's MARs identified the following PRN medications, their instructions, and administrations: - Acetaminophen 500 mg tablets: "Take 2 tablets (1000 mg) by mouth every 6 hours as needed for pain ..." One administration of PRN acetaminophen was documented each on 01/13/2026 and 01/17/2026 with no other information. Example 4 - Resident 6 Resident 6's MARs identified the following PRN medications, their instructions, and administrations: - Acetaminophen 325 mg tablets: "Take 2 tablets	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 415}	Continued From page 43 (650 mg) by mouth every 4 hours as needed for pain / fever." Two administrations of PRN acetaminophen were documented - on 12/19/2025 and 01/10/2026 - with no other information. - Ibuprofen 400 mg tablets: "Take 1 tablet by mouth every 6 hours as needed for pain or fever." Thirty-five administrations of PRN ibuprofen were documented - on 12/10/2025, 12/11/2025, 12/14/2025, 2 on 12/16/2025, 12/19/2025, 2 on 12/20/2025, 2 on 12/22/2025, 2 on 12/24/2025, 2 on 12/26/2025, 12/27/2025, 2 on 12/28/2025, 2 on 12/29/2025, 12/30/2025, 2 on 12/31/2025, 01/06/2026, 2 on 01/07/2026, 01/08/2026, 2 on 01/10/2026, 01/12/2026, 01/15/2026, 01/16/2026, 01/18/2026, 2 on 01/17/2026, and 01/20/2026. No other information was documented. - Phenazopyridine 100 mg oral tablets: "Take one tablet by mouth every 8 hours as needed for bladder discomfort ..." Two separate administrations of PRN phenazopyridine were documented on 12/26/2025 with no other information. ADDITIONAL INFORMATION: On 01/22/2026, at approximately 11:50 a.m., Licensed Practical Nurse (LPN) F arrived onsite to assist with the survey. Surveyor reported that the MARs provided did not indicate any additional annotations about medication administration details. After looking on his/her laptop, LPN F reported that s/he and care staff who were logged in were able to hover their cursors over administrations to view additional notes. LPN F confirmed Surveyor's observation that this information did not appear in printed MARs provided to Surveyor. LPN F reported additional	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 415}	Continued From page 44	{N 415}		

information would have to be requested from the provider's electronic record system to figure out how to provide the additional MAR details to Surveyor.

On 01/30/2026, Surveyor reviewed exported MARs for the same date range provided by LPN F on an Excel spreadsheet. The spreadsheet contained columns for comments and follow up information to be documented. Surveyor observed the following for each of the above identified administrations:

- Resident 1 - No additional information was documented regarding the need for 6 total administrations of his/her PRN lorazepam or acetaminophen. Five of the 6 total administration entries contained no information regarding Resident 1's response to his/her PRN acetaminophen or lorazepam administrations

- Resident 2 - No additional information was documented regarding his/her PRN acetaminophen entry.

- Resident 4 - No additional information was documented regarding his/her PRN acetaminophen entries.

- Resident 6 - From the 39 total administration entries of his/her PRN acetaminophen, ibuprofen, and phenazopyridine, there was no information regarding Resident 6's response to any of the administrations. Thirty-seven of the 39 entries did not document a reason for the administration of Resident 6's PRN acetaminophen, ibuprofen, and phenazopyridine (the only 2 administration entries that documented reasons for administration were for his/her second ibuprofen administration on 12/16/2025 and his/her second phenazopyridine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 415}	Continued From page 45 administration on 12/26/2025). On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) G. Coordinator G reported understanding of Surveyor's medication administration documentation concerns and denied having any follow up questions or concerns. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 415}		
{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 Caregiver L, Caregiver Q, Caregiver R, Caregiver S, and Former Caregiver T, who all worked shifts alone in which they administered medications to residents rectally and/or stomally, were delegated by a registered nurse (RN) to administer such medications. This is a repeat deficiency. See Statement of Deficiencies (SOD) ZBMH11, dated 09/12/2025.	{N 416}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 416}	Continued From page 46 Findings include: On 01/22/2026, at approximately 10:07 a.m., Surveyor interviewed Lead Caregiver A. Lead Caregiver A reported that the medications for Resident 1 and Resident 2 were sometimes administered through their g-tubes and sometimes orally crushed depending on if they were eating well. On 01/22/2026, Surveyor reviewed December 2025 and January 2026 medication administration records (MARs) for each of the provider's 5 residents, which identified their prescriptions. Surveyor observed the following: - The prescription instructions for Resident 1's 5-HTP 50 mg tablets (8:00 a.m. and 8:00 p.m.), betaine HCl capsules (8:00 a.m. and 8:00 p.m.), carbidopa/levodopa 25-100mg tablets (8:00 a.m., 12:00 p.m., and 8:00 p.m.), carbamazepine 100 mg chew tablets (8:00 a.m.), CO Q-10 100 mg capsules (8:00 a.m.), cranberry 250 mg capsules (8:00 a.m.), DHA 100 mg capsules (8:00 a.m. and 8:00 p.m.), gamma-aminobutyric acid 100 mg capsules (8:00 a.m.), hydroxyzine 25 mg tablets (8:00 p.m.), lorazepam 1 mg tablets (8:00 a.m. and 8:00 p.m.), and omeprazole 40 mg capsules (8:00 a.m.) contained directions that they were to be administered via his/her gastrostomy tube (g-tube). - The prescription instructions for Resident 2's valproic acid 250mg/5mL oral solution (8:00 a.m. and 8:00 p.m.) contained instructions to be taken via his/her g-tube. - Resident 3 was prescribed bisacodyl 10 mg suppositories with instructions for daily administration, except for when experiencing	{N 416}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 416}	Continued From page 47	{N 416}		

loose stools. Resident 3's MARs showed that these were administered at approximately 8:00 a.m. daily.

- Resident 4 was prescribed bisacodyl 10 mg suppositories with instructions for administration every other day, except for when experiencing a bowel movement. Resident 4's MARs showed that these were administered at approximately 12:00 p.m. for each administration.

On 01/22/2026, Surveyor reviewed the staff schedules for December 2025 and January 2026. Surveyor observed that worked shifts were generally broken down as occurring 6:00 a.m. - 2:00 p.m. (first shift), 2:00 p.m. - 10:00 p.m. (second shift), and 10:00 p.m. - 6:00 a.m. (overnight (NOC) shift). Surveyor observed the following:

- Caregiver L worked alone on 12/21/2025 (second shift), 12/25/2025 (first shift), 01/02/2026 (second shift), 01/03/2026 (second shift), and 01/12/2026 (second shift).

- Caregiver Q worked alone 12/22/2025 (second shift), 12/27/2025 (second shift), 12/28/2025 (second shift), 01/01/2026 (second shift), and 01/04/2026 (first and second shifts).

- Caregiver R worked alone on 12/31/2025 from 6:00 p.m. - 6:00 a.m.

- Caregiver S worked alone on 12/30/2025 (second shift)

- Former Caregiver T worked alone on 12/23/2025 from 4:30 p.m. - 10:00 p.m.

In reviewing the resident MARs for the above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 416}	Continued From page 48 shifts and staff, Surveyor observed that Caregiver L, Caregiver Q, Caregiver R, Caregiver S, and Caregiver T signed off on having administered medications during their shifts, including the applicable medications above. At approximately 11:53 a.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) G and requested the RN delegations for each of the above staff. Coordinator G reported there were no delegations for Caregiver L, Caregiver Q, Caregiver R, Caregiver S, and Caregiver T. Coordinator G reported that Caregiver Q was supposed to be attending delegation training next week. Coordinator G reported s/he was aware of efforts made by management staff to try and get all the provider's staff delegated, including implementing a new procedure where staff would not be allowed to work in the home unless they had their applicable RN delegations. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 416}		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 49 Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of Resident 1 and Resident 3 was monitored. Staff were directed to follow a regimen of both g-tube water flushing and oral water intake for Resident 1 - the tracking of which was warranted due to the directive for any remaining water not consumed orally by him/her to be administered via his/her g-tube in addition to his/her existing flush amounts. Between 12/09/2025 - 01/21/2026, there was no evidence that staff followed Resident 1's g-tube flush regimen either fully or partially on 28 days. Within the same date range, there was no evidence that staff tracked Resident 1's oral water intake on 25 days. Of the days staff tracked Resident 1's oral water intake, Resident 1 was documented to consume less than his/her directed amount on 17 days. There was no evidence on these days that staff then accounted for this with additional g-tube water	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 50	{N 431}		

flushing. Resident 1 had a diagnosis of hypernatremia.

On 01/12/2026, staff documented the onset of a rash on Resident 1's buttocks that was concerning for ringworm. Starting on 01/13/2026 and through the survey period, staff administered an antifungal ointment that was prescribed by Resident 1's medical provider, but there was no evidence of any follow up monitoring done by staff of Resident 1's rash.

Staff were reported to have first noted a change in Resident 1's left knee on 01/01/2026 with an onset of swelling and observed pain behaviors. Four days later, on 01/05/2026, Resident 1 was taken to the emergency department for evaluation of his/her left knee, which was later diagnosed as having a fracture of his/her left medial tibial plateau. Emergency department clinical staff on 01/05/2026 observed "significant swelling" to Resident 1's left knee with bruising "in varying stages" at his/her knee that extended "down [his/her] leg and into [his/her] ankle." Staff also noted that Resident 1 demonstrated pain behaviors related to his/her left knee. However, between 01/01/2026 - 01/05/2026, there was no evidence of any monitoring or assessment completed by staff of Resident 1's knee after his/her change of condition was first observed.

Resident 3 had close monitoring by his/her medical provider from 11/19/2025 - 12/17/2025, with 4 visits having been conducted during this timeframe due to concerns Resident 3 was experiencing with intermittent vomiting episodes, abdominal gaseous distention, and chronic constipation. During the course of these visits, Resident 3's medical provider directed staff to provide Resident 3 with a clear liquid diet for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 51	{N 431}		

approximately 3 days and then grade his/her diet to bland foods. At the last follow up Resident 3 had within this series, on 12/17/2025, Resident 3 was documented to have not had any vomiting episodes since the initiation of the dietary changes, and his/her medical provider then directed for a continued graded progression back to his/her regular diet over the course of approximately 2-3 days. After this visit, the provider's notes for Resident 3 indicated that s/he had experienced 9 episodes of vomiting between 12/19/2025 - 01/18/2026 - 8 of which specifically occurred between 12/19/2025 - 01/03/2026 (a period of approximately 2 weeks). There was no evidence that staff followed up with Resident 3's medical provider during this timeframe to communicate the reemergence of his/her vomiting, which was consistent with the return to his/her regular diet - a concern for which Medical Assistant P, from Resident 3's medical provider's office, reported the medical provider would have "absolutely" wanted to see Resident 3. The information regarding Resident 3's condition as noted from his/her medical provider visit notes on 12/12/2025 and 12/17/2025 were not part of his/her record and were only obtained by staff from his/her medical provider's office upon request by Surveyor.

This is a repeat deficiency. See Statement of Deficiencies (SOD) ZBMH11, dated 09/12/2025.

Findings include:

Example 1 - Resident 1's hydration

On 01/22/2026, Surveyor conducted a survey at the home. Three caregivers, including Lead Caregiver A, Caregiver C, and Caregiver N were working first shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 52 On 01/22/2026, at approximately 9:10 a.m., Surveyor observed Resident 1 at the dining table. A water bottle was observed near him/her that appeared approximately half-full. There were no markings or indicators on the bottle to indicate the fluid amount. At approximately 10:12 a.m., Surveyor observed Resident 1 again. Resident 1's water bottle was still near him/her and it appeared approximately 1/3 full. At approximately 11:20 a.m., Resident 1 left the home to attend a medical appointment with Lead Caregiver A. On 01/22/2026, Surveyor reviewed Resident 1's partial record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including hypernatremia and intellectual disability. Resident 1 was documented as being "at times" verbal with yes/no responses and being able to verbalize "a few key phrases." Resident 1 was documented as having a legal guardian and needing total assistance for all cares. Within Resident 1's current individual service plan (ISP), dated 09/08/2025, under the "Diet' heading, the following was detailed: "[Resident 1] is to drink 1 extra 16oz. bottle of water added to [his/her] current amount." Surveyor noted that 16 fluid ounces equated to approximately 473 mL. Underneath that, the following information was documented: "To meet Hydration needs: [Resident 1] is to receive 4000 mL water via g tube daily to be given as indicated below:..." The schedule documented that at 7:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Resident 1 was to receive 800 mL water via	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 53 g-tube with his/her medication administration, to include 30 mL before/after medication administration. Underneath that, the following information was documented: "To meet Hydration needs: [Resident 1] is to receive: 2400 mL water by mouth daily to be given as indicated below ..." The schedule documented that Resident 1 was to receive 500 mL of water with each meal "if [Resident 1] chooses," and 300 mL of water on 3 separate occasions between breakfast and lunch, lunch and supper, and after supper. Underneath the schedules was the following: "If [Resident 1] is unable to consume all 2400 mL water orally staff should administer the remainder of the water via g tube in the evening ..." Surveyor noted that in accordance with the ISP, Resident 1's total directed oral water intake was approximately 2,873 mL - the 2,400 mL originally called for and the additional 16 oz, or approximately 473 mL, called for. Surveyor reviewed Resident 1's medication administration records (MARs) from 12/09/2025 - 01/22/2026 and observed entries for "water" that appeared to correlate with the g-tube flush schedule as outlined from his/her ISP. Surveyor observed that the entries only began on 01/07/2026 and documented the following: - 7:00 a.m.: 600 mL (all entries signed as "administered" by staff from 01/07/2026 - 01/22/2026) - 9:00 a.m.: 600 mL (all entries signed as "administered" by staff from 01/07/2026 - 01/22/2026) - 11:00 a.m.: 600 mL (entries signed as	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 54 "administered" by staff from 01/07/2026 - 01/21/2026) - 1:00 p.m.: 600 mL (entries signed as "administered" by staff from 01/07/2026 - 01/21/2026) - 3:00 p.m.: 600 mL (entries signed as "administered" by staff from 01/07/2026 - 01/21/2026) - 5:00 p.m.: 600 mL (entries signed as "administered" by staff from 01/07/2026 - 01/21/2026) - 7:00 p.m.: 600 mL (entries signed as "administered" by staff from 01/07/2026 - 01/21/2026) Surveyor observed that this accounted for 4,200 mL of water - closely correlating with the flush schedule from Resident 1's ISP. On 01/22/2026, Surveyor reviewed shift reports from 12/09/2025 - 01/21/2026, where staff appeared to complete daily notes on residents. Surveyor observed that an entry within the shift reports prompted staff to initial off on Resident 1's g-tube water flushes with the same schedule as documented in the MAR. Prior to 01/07/2026 (where staff began using the MAR), Surveyor observed from the shift reports the following 28 days in which Resident 1's g-tube flushes were either fully or partially unaccounted for by being left blank: 12/10/2025, through 12/15/2025, 12/16/2025 (3 of 7 flushes missing), 12/17/2025, 12/18/2025, 12/19/2025 (2 of 7 flushes missing), 12/20/2025, 12/21/2025 (3 of 7 flushes missing), 12/22/2025 (5 of 7 flushes missing), 12/23/2025 through 12/26/2025, 12/27/2025 (3 of 7 flushes missing), 12/28/2025 (5 of 7 flushes missing), 12/29/2025, 12/30/2025 (5 of 7 flushes missing), 12/31/2025 (3 of 7 flushes missing), 01/01/2026, 01/02/2026 (4 of 7 flushes missing), 01/03/2026	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 55 (4 of 7 flushes missing), 01/04/2026 through 01/06/2026. The shift report templates also included a section for staff to document Resident 1's fluid intake each day. From the shift reports, Surveyor observed the following oral water fluid intakes documented: - 12/09/2025: "12 oz water bottle" - 12/11/2025: 1,200 mL total - 12/15/2025: 3,360 mL total - 12/16/2025: 600 mL total - 12/18/2025: 600 mL total - 12/19/2025: 600 mL total - 12/20/2025: 2,400 cc total - 12/23/2025: 1,200 cc total - 12/29/2025: 600 cc was documented for breakfast and 1,200 cc of "water + juice" was documented for dinner. There was no clarification as to how much was water and how much was juice. - 01/02/2026: 1,200 cc total - 01/03/2026: 2,400 cc total - 01/05/2026: 1,800 cc total - 01/06/2026: 600 cc total - 01/07/2026: 800 cc total - 01/12/2026: 1,800 cc total - 01/15/2026: 950 cc total - 01/17/2026: 3,600 cc total - 01/18/2026: 2,400 cc total - 01/20/2026: 1,500 cc total For the above 17 days in which staff documented Resident 1 consuming less than 2,873 mL of water orally as directed by his/her ISP, there were no notes indicating whether additional water was administered to him/her via his/her g-tube to make up the difference, as also directed by his/her ISP.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 56 On the 25 remaining days within this range there were no oral water intake amounts recorded for Resident 1, including 12/10/2025, 12/12/2025 through 12/14/2025, 12/17/2025, 12/21/2025, 12/22/2025, 12/24/2025 through 12/28/2025, 12/30/2025 through 01/01/2026, 01/04/2026, 01/08/2026 through 01/11/2026, 01/13/2026, 01/14/2026, 01/16/2026, 01/19/2026, and 01/21/2026. On 02/03/2025, at approximately 3:29 p.m., Surveyor e-mailed Coordinator of Administrative Services (Coordinator) G to ask if the MARs and shift reports were where staff tracked Resident 1's fluid intake or if there was another system staff utilized to track his/her intake. At approximately 3:40 p.m., Coordinator G replied that s/he was informed by Lead Caregiver A that Resident 1's water flushes were tracked on the MAR and his/her fluid intake from meals and his/her water bottle were tracked on the daily report/shift report. On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator G. Coordinator G acknowledged Surveyor's concern regarding the lack of fluid intake monitoring documented by staff and denied having any additional questions or concerns. Example 2 - Resident 1's buttocks rash ongoing monitoring On 01/22/2026, Surveyor reviewed Resident 1's partial record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including hypernatremia and intellectual disability. Resident 1 was documented as being "at times" verbal with yes/no responses and being able to verbalize "a	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 57	{N 431}		

few key phrases." Resident 1 was documented as having a legal guardian and needing total assistance for all cares.

On 01/30/2026, Surveyor reviewed an incident report for Resident 1, dated 01/12/2026. The report documented, "today [sic] while changing [Resident 1] this morning I saw on [his/her] right butt cheek a red circle like a ring shape. Half of the circle looked red and inflamed. I called the nurse ([Licensed Practical Nurse (LPN) F]) and notified [Resident 1's guardian]." The report also documented, "Corrective Actions Taken: washed the area with warm water and soap. Called the nurse and [Resident 1's guardian] and wrote a report," and, "Plan of Future Corrective Actions: continue to document and report and notify [Resident 1's guardian] and nurse."

There were no other reports in Resident 1's record regarding the rash.

On 01/30/2026, Surveyor reviewed daily shift report notes, where staff documented notes on residents. There were no notes regarding the rash on Resident 1's buttocks.

On 02/03/2025, at approximately 3:31 p.m., Surveyor interviewed LPN F about the above incident. LPN F reported recalling that the rash had been a concern for possible ringworm. LPN F reported s/he had reviewed the incident report about the issue and would e-mail Surveyor his/her notes about the rash.

On 02/03/2025, Surveyor reviewed the note sent by LPN F, which documented the following: "1/12/26 11am [Caregiver C] notified writer regarding circular mark on [Resident 1]'s 'butt cheek.' With concerns of it being ringworm, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 58	{N 431}		

nurse recommended that [Caregiver C] contact [Guardian K] who makes all of [his/her] medical appointments. [S/he] is scheduling an appointment to [follow up] with [his/her] [primary care provider]. 1/13/26 [Guardian K] reports that, '[Resident 1]'s [primary care provider] has sent in a script for cream and [s/he] does not need to see them for an appointment today.' Ketoconazole 2% Topical Cream [twice daily]. [Follow up] with [primary care provider] 4/14/26."

From reviewing Resident 1's January 2026 medication administration record (MAR), Surveyor observed an entry for ketoconazole cream that began on 01/13/2026, corroborating LPN F's note above. Staff documenting administering the ointment twice daily from 01/13/2026 through the survey period.

On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator G. Coordinator G acknowledged Surveyor's concern regarding the lack of follow up monitoring documented by staff of Resident 1's rash and denied having additional questions or concerns.

Example 3 - Resident 1's bruising and subsequent left medial tibial plateau fracture

On 01/22/2026, Surveyor reviewed a self-report within the Department's records for the provider. The report, dated 01/06/2026, detailed a course of events and follow up that took place on 12/31/2025 upon Resident 1 having been discovered by staff to experience an onset of vaginal bleeding. Resident 1 was evaluated in the emergency department and returned home that same day. The report then documented, "On 1/1/25 [sic] while care staff was changing the client's clothes bruising was noted on [his/her]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 59 bilateral arms and [his/her] left knee was red and swollen. On 1/5/26 [his/her] knee remained swollen and [Resident 1] was transported to the hospital and an x-ray identified a possible left tibial plateau fracture ...[Resident 1] returned with a splint on [his/her] knee. Staff will schedule a follow-up appointment with an orthopedic physician. [Resident 1] does not seem to have significant pain and has [as needed (PRN)] acetaminophen for pain ..." A document, titled, "Summation of the Investigation into Possible Caregiver Misconduct [Resident 1]" was attached to the report. The report detailed the following: 1. "The next day, 1/1/26, [Caregiver C] a caregiver, worked and when [s/he] was changing [Resident 1]'s pants, [s/he] noticed that [Resident 1]'s left knee was swollen and red and seemed painful to [Resident 1]. When [Caregiver Q] came on duty [s/he] showed [him/her] [Resident 1]'s red swollen knee. On 1/2/26 [s/he] documented bilateral bruises on [Resident 1]'s arms and the red swollen knee. For event date [s/he] mistakenly entered 1/2/26 when the actual discovery occurred 1/1/26. [Resident 1]'s knee continued to remain swollen so [Resident 1] was transported to the hospital on 1/5/26 for an x-ray of [his/her] knee. The x-ray disclosed a probable left knee tibial plateau fracture ...' 2. A statement dated 01/05/2026 from Caregiver Q, which documented, " ...[Caregiver C] showed me [Resident 1]s [sic] knee and informed that [s/he] came back from the hospital injured and suspected maybe it happened while [emergency medical services] was transferring [him/her] ..." The only other information s/he documented in his/her statement was about his/her coordination	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 60 with Caregiver C to fill out an incident report. 3. Statements dated 01/06/2026 from Caregiver C, which documented, "On January first while changing [Resident 1] i [sic] notice [sic] swelling on [his/her] knee I showed 2nd shift i [sic] than [sic] stated that id [sic] do a [sic] incident report when I come in the next day on the 2nd since I had to leave. While writing the report on the 2nd I accidentally put that i [sic] discovered the swelling on the 2nd and not the 1st ...On the January first I had no problems or issues with [his/her] transfers." 4. Notes from an admission Resident 1 had to the emergency department on 01/05/2026. The notes documented that Resident 1 arrived at approximately 2:34 p.m. that day with a complaint of left knee pain/injury. The triage registered nurse's note documented, "Caregiver stated [s/he] just got back from vacation today and noticed [patient (pt)] had bruising and swelling to [his/her] left knee. Caregiver stated as far as [s/he] knows pt has had no injuries to that area. Pt has significant swelling to [his/her] left knee with bruising to [his/her] knee and bruising down [his/her] leg and into [his/her] ankle. Bruises are in varying stages. Pt does wince when touching [his/her] left knee." The admission summary documented, " ...per caregiver patient can not verbalize pain scales. And patient does not communicate well ..." Diagnostic imaging revealed an "impaction of the medial tibial plateau" of Resident 1's left knee. Resident 1's knee was placed in a splint and it was recommended s/he follow up with an orthopedic specialist for further evaluation. On 01/22/2026, Surveyor reviewed shift reports from 12/09/2025 -01/22/2026, where staff	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 61	{N 431}		

appeared to document notes on residents. Between 12/31/2025 - 01/05/2026, there were no notes documented regarding Resident 1's left knee.

On 01/22/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including spastic quadriplegia and intellectual disability. Resident 1 was documented as being "at times" verbal with yes/no responses and being able to verbalize "a few key phrases." Resident 1 was documented as having a legal guardian and needing total assistance for all cares.

On 01/22/2026, at approximately 2:00 p.m., Surveyor requested from Coordinator G all medical visit notes, emergency department visit notes, and incident reports for Resident 1 since 12/09/2025.

On 01/30/2026, Surveyor reviewed the provided reports. An incident report, dated 01/02/2026 and authored by Caregiver C, detailed, "while changing [Resident 1] i [sic] saw that [s/he] seemed to be in discomfort every time i [sic] tried to roll [him/her] i [sic] than [sic] changed [his/her] pants and [s/he] started reaching at [his/her] left knee i [sic] than [sic] looked at it and it looked swollen compared to [his/her] right knee i [sic] asked [him/her] i [sic] [his/her] knee hurt and [s/he] kept reaching at it. I than [sic] sat [him/her] up in the recliner and put a [sic] ice pack on [his/her] left knee i [sic] told second shift to take the ice pack off around 15-20 mins." Under "Plan of Future Corrective Actions" Caregiver C documented, "continue to document and report if it gets worse call nurse or doctor."

Surveyor also reviewed a visit report dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 62 01/08/2026 from the follow up Resident 1 had with an orthopedic specialist after his/her emergency department admission on 01/05/2026. From the report, the orthopedic medical provider reviewed the imaging obtained from Resident 1's emergency department admission and diagnosed Resident 1 with a minimally displaced medial tibial plateau fracture. Resident 1 was directed to be completely non-weight bearing to his/her left lower extremity, to continue wearing his/her left lower extremity splint, and for staff to avoid direct pressure to his/her knee during cares. Resident 1 was also directed to follow a regimen of icing and elevation of his/her knee 4 times daily. From all the notes, there was no evidence of staff having conducted follow up monitoring or assessment of Resident 1's left knee between 01/01/2026, when staff first noted a change in his/her knee condition, and 4 days later 01/05/2026 when s/he was taken to the emergency department. On 02/03/2026, at approximately 1:28 p.m., Surveyor interviewed Guardian K, Resident 1's legal guardian. Guardian K reported that around 01/02/2026, a staff member from the provider called him/her to ask him/her if s/he was aware of a left knee injury experienced by Resident 1. Guardian K reported that the staff member told him/her that there was no record of Resident 1's knee being swollen and so s/he wanted to know if Guardian K knew what happened to it. Guardian K reported that it was during the course of this conversation that s/he first became aware Resident 1 had even been taken to the emergency department on 12/31/2025. Guardian K reported that now looking back, s/he believed it was possible Resident 1's knee was injured during his/her medical examination on	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 63 12/31/2025 since Resident 1 was known to be resistive to cares. Guardian K reported that after the alleged onset, however, s/he was unaware how staff were monitoring Resident 1's knee. On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator G. Coordinator G reported understanding of Surveyor's concern regarding the lack of follow up monitoring or assessment by staff of Resident 1's left knee between 01/01/2026 and 01/05/2026. Example 4 - Resident 3's recurring vomiting episodes On 01/22/2026, at approximately 10:30 a.m., Surveyor interviewed Lead Caregiver A. Lead Caregiver A reported that Resident 3 had recent issues of recurring vomiting and loose stools. Lead Caregiver A reported that s/he had taken Resident 3 to a medical appointment in which an x-ray showed s/he was experiencing a blockage of his/her bowels. Lead Caregiver A reported after that appointment Resident 3 was prescribed suppositories that were to be administered daily. Lead Caregiver A reported that Resident 3 didn't have a follow up appointment with his/her medical provider until next month. When asked how Resident 3 was doing now, Lead Caregiver A replied that Resident 3 still occasionally vomited. When asked if staff were directed to monitor Resident 3 in any way due to the ongoing vomiting, Lead Caregiver A reported they were supposed to just "watch [his/her] weight." Lead Caregiver A reported that Resident 3's weight had been stable. On 01/22/2026, Surveyor reviewed part of Resident 3's record. Resident 3 was admitted to the provider on 06/21/2021 with diagnoses	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 64	{N 431}		

including profound developmental disability, cri-du-chat syndrome, blindness, and hearing loss. In Resident 3's ISP, dated 08/07/2025, detailed that s/he could say some words but expressed him/herself by making noises making faces, or biting his/her wrist. Resident 3 was documented as requiring full assistance for cares, including requiring staff to feed him/her for all meals.

On 01/22/2026, Surveyor reviewed shift reports from 12/09/2025 -01/22/2026, where staff appeared to document notes on residents. From the shift reports, Surveyor observed the following 3 occasions in which staff documented that Resident 3 vomited:

- 12/19/2025: "Vomited on PM shift."
- 12/30/2025: "Vomited today Bedding and clothes changed."
- 01/02/2026: "Vomited after Breakfast Bedding and pants changed."

Of note, staff documented on a shift report on 12/31/2025 (a day after Resident 3 experienced a vomiting episode), "[Resident 3] still hasn't eat [his/her] food from dish morning and afternoon." Staff marked that day that Resident 3 ate only 25% of his/her breakfast. Entries for staff to record his/her intake for lunch, dinner, or any snacks were all blank. Entries for staff to record any intake by Resident 3 on 01/01/2026 were also blank and there were otherwise no notes about his/her condition. As documented above, Resident 3 then experienced a vomiting episode on the morning of 01/02/2026.

On 01/22/2026, at approximately 2:00 p.m., Surveyor requested from Coordinator G all medical visit notes and emergency department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 65 visit notes for Resident 3 since 12/09/2025. On 01/30/2026, Surveyor reviewed incident reports for Resident 3. Five incident reports, dated 12/20/2025, 12/21/2025, 12/27/2025, 01/03/2025, and 01/18/2025, detailed occasions that Resident 3 vomited. Surveyor noted that these 5 occasions of vomiting were separate from the 4 occasions documented in the shift reports. On 01/30/2026, Surveyor reviewed Resident 3's MARs for December 2025 and January 2026. On 12/22/2025, staff documented having held Resident 3's nutritional supplement drink for 3 of 3 administrations due to Resident 3 having vomited. Surveyor noted that this occasion of vomiting was separate from the occasions identified in both the incident reports and shift notes. From the above information, Surveyor noted a total 9 occasions that Resident 3 vomited between 12/19/2025 - 01/22/2026, including: 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/27/2025, 12/30/2025, 01/02/2026, 01/03/2026, and 01/18/2026. On 01/30/2025, Surveyor reviewed the sole medical report for Resident 3 provided by Coordinator G. The report, dated 12/10/2025, detailed notes from a virtual visit that day Resident 3 had with his/her primary care provider's (PCP's) office. The note detailed that Resident 3 was "being seen today with caregiver to discuss recent xray [sic] results and episodes of vomiting. Has had episodes of vomiting over the weekend and last week - last episode of vomiting was over the weekend. Vomiting continues to occur shortly after eating." Within the medical provider's "Assessment/Plan" section,	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 66	{N 431}		

the following was documented, "1. Vomiting ...Occurring intermittently - last episode of vomiting was approx. 3-4 days ago ..." During the visit, and due to Resident 3's reported symptoms of vomiting and chronic constipation Resident 3's medical provider directed for him/her to begin a clear liquid diet until s/he had a repeat x-ray of his/her abdomen on the morning of 12/12/2025 out of "concerns for possible ileus."

On 01/30/2026, at approximately 10:08 a.m., Surveyor e-mailed Coordinator G to request notes from the 12/12/2025 medical provider follow up that was indicated from Resident 3's 12/10/2025 visit note (above). At approximately 2:03 p.m., Coordinator G e-mailed Surveyor back and reported that Lead Caregiver A had called Resident 3's PCP office in order to obtain the report Surveyor requested. Coordinator G reported that as soon as the report was received s/he would provide it to Surveyor.

On 02/02/2026, at approximately 11:35 a.m., Coordinator G e-mailed Surveyor additional medical visit reports and reported, "I know you wanted the attached on Friday (regarding [Resident 3]) but the PCP's Office [sic] just faxed them over today."

From the additional reports provided and reviewed by Surveyor on 02/02/2026, Surveyor observed the following:

- Visit on 11/19/2025 in which one of Resident 3's chief complaints was "continued vomiting." The note documented, " ...presents today for evaluation of ongoing vomiting that began in October per caregiver. Unsure of frequency of episodes however, it is mentioned that they typically occur immediately after eating. Caregiver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 67	{N 431}		

reports [s/he] often cries out prior to vomiting, uncertain if this indicates pain or distress; baseline behavior is typically very quiet. [S/he] also has intermittent loose stools and receives a daily suppository unless stools are already loose. Last vomiting episode occurred on Monday." The note also detailed, "Abdominal X-ray obtained today shows gaseous distention of the stomach and colon with moderate stool volume in the left colon and rectum, improved compared to the prior imaging on 09/29/25. The new post-prandial vomiting may be related to increased intraluminal gas. Recommend simethicone after meals to help relieve gas."

Surveyor noted that from Resident 3's MARs, Resident 3 was started on simethicone tablets which were administered by staff three times daily.

- Visit on 12/12/2025 (2 days after the first visit report reviewed by Surveyor on 01/30/2026): " ...Patient is nonverbal, spoke with caregiver [Lead Caregiver A] ...Persistent diffuse gaseous distension of small bowel and colon on x-ray today. No new reports of vomiting since last visit 2 days ago. Tolerating liquid diet well ...Discussed continuing clear liquid diet through Saturday, if no new vomiting episodes may progress to very bland soft foods such as applesauce or bananas ..."

- Visit on 12/17/2025 (5 days after the last visit): " ...Seen with caregiver, [Lead Caregiver A] today. Patient is doing well - tolerating bland foods. No more episodes of vomiting ...Recommend continuing with bland foods for the next 2-3 days and then can continue to advance diet as tolerated ...Monitor for recurrence and/or vomiting ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 68 Consistent with the medical visit report, Surveyor noted from both the shift notes and available notes in Resident 3's record that Resident 3 was not documented to have experienced vomiting between the periods of his/her 3 medical visits from 12/10/2025 through 12/17/2025. However, as documented above, Resident 3 was documented to experience 9 episodes of vomiting after 12/17/2025. Surveyor observed that Resident 3's initial vomiting episode during this period, 12/19/2025, was consistent with the timeframe during which his/her diet would have been advanced to his/her regular diet, as per his/her medical provider's directive from the 12/17/2025 visit note. From the reports made available from Resident 3's record, there was no evidence that staff followed up with Resident 3's medical provider to communicate the reemergence of his/her vomiting episodes. On 02/03/2026, at approximately 11:48 a.m., Surveyor interviewed Medical Assistant P from Resident 3's primary care provider's office. Medical Assistant P reported that between 12/19/2025 - 01/03/2026 (the timeframe during the bulk of which Resident 3's vomiting episodes occurred) there was no evidence the provider's office was notified about Resident 3's ongoing regular vomiting episodes. Medical Assistant P confirmed that if a call was received on behalf of Resident 3, a record would have been created because the front desk staff would have transcribed the call and sent the information to the appropriate clinical staff for follow up. Medical Assistant P reported that the medical provider's office would have wanted to be informed about the recurrent instances of Resident 3's vomiting	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 431}	Continued From page 69 due to it being an ongoing issue s/he was experiencing. Medical Assistant P reported that the medical provider would have "absolutely" wanted to see Resident 3 for a follow up about his/her vomiting. Medical Provider P reported that on 01/30/2026, a communication entry was made in Resident 3's medical record due to a caregiver from the provider having requested care summaries for Resident 3 (consistent with the report from Coordinator G earlier that the provider's staff had to specifically obtain his/her medical visit notes during the course of the survey after having been requested by Surveyor). On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator G. Coordinator G reported understanding of Surveyor's concern regarding the lack of follow up with Resident 3's medical provider given the re-emergence of his/her recurrent vomiting episodes and denied having any follow up questions or concerns. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 431}		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician.	N 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 448	Continued From page 70	N 448		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that Resident 2 was provided with the therapeutic diet ordered by his/her medical provider on 3 occasions from 01/13/2026 - 01/14/2026.

Findings include:

On 01/22/2026, at approximately 9:25 a.m., Surveyor interviewed Lead Caregiver A regarding the needs of residents. Lead Caregiver A reported that Resident 2 had a gastrostomy tube (g-tube) since approximately March 2025, through which s/he received g-tube feedings, but has always been allowed to have food orally as well. Lead Caregiver A reported that it wasn't until recently that Resident 2 showed an interest in consuming food orally. Lead Caregiver A reported that despite this his/her g-tube feeding orders remained unchanged.

On 01/22/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/07/2024 with diagnoses including cerebral palsy and seizure disorder. Resident 2's individual service plan (ISP), dated 12/05/2025, documented, "[Resident 2] receives nutrition via g-tube - Jevity 1.5 Calorie with Fiber (8:00 am; 12:00 pm; 4:00 pm; & 8:00 pm)." A medical provider order within Resident 2's record identified that Resident 2 was to receive 1 Jevity carton at 8:00 a.m. and 12:00 p.m. and 2 cartons at 4:00 p.m. and 8:00 p.m.

Surveyor reviewed the medication administration records (MARs) for Resident 2 for December 2025 and January 2026, where staff appeared to document his/her g-tube feeding administrations. The administration for Resident 2's 2 Jevity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 448	Continued From page 71	N 448		

cartons at 4:00 p.m. and 8:00 p.m. on 01/13/2026 were marked as "Administered - Detailed" and "Skipped," respectively. The administration of Resident 2's single Jevity carton at 8:00 a.m. on 01/14/2026 was marked as "skipped."

On 01/30/2026, Surveyor reviewed an expanded MAR, provided by Licensed Practical Nurse (LPN) F, which contained additional details about the above entries. Surveyor observed the following:

- 01/13/2026 (4:00 p.m.) Jevity entry: "only had one jevity since we only had one left"

- 01/13/2026 (8:00 p.m.) Jevity entry, which was marked as "Skipped": "need refill"

- 01/14/2026 (8:00 a.m.) Jevity entry, which was marked as "Skipped": "need refill"

On 01/30/2026, Surveyor reviewed shift notes, where staff documented food intake for the provider's residents, including Resident 2. For breakfast, lunch, and dinner on 01/13/2026, as well as breakfast on 01/14/2026, staff documented that Resident 2's only food intake was via his/her g-tube. An entry for "snacks" was blank on both days. Surveyor noted that Resident 2 would have gone without food (including his/her g-tube feeding) after his/her 4:00 p.m. Jevity administration on 01/13/2026, which was reduced by half in accordance with the limited supply on hand, until 12:00 p.m. on 01/14/2026, when his/her Jevity was next documented as administered.

On 02/05/2026, at approximately 2:00 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) G.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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 448	Continued From page 72 Coordinator G reported understanding of Surveyor's concern and denied having any follow up questions or concerns. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 448		