STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 04/22/2026, Surveyor conducted a complaint investigation at DeForest Place, a CBRF in DeForest. Eight deficiencies were identified. Six deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023, SOD Q1UN12, dated 05/16/2025, SOD Q1UN13, dated 09/15/2025, SOD 59UD11, dated 10/21/2025 and SOD 59UD12, dated 01/28/2026. The complaint was substantiated. Census: 4	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025, SOD Q1UN13, dated 09/15/2025, SOD 59UD11, dated 10/21/2025 and SOD 59UD12, dated 01/28/2026. Findings include: BACKGROUND INFORMATION:	N 196		

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
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 1 On 03/31/2026, the provider and the department entered into a stipulated agreement indicating the provider would relinquish the facility's license. The Department of Health Services Resident Relocation Manual provides guidance and directions to facilities that are relocating residents under the requirements of Chapter 50. The manual states, "The facility must have measures in place to ensure that the administrator's and/or facility manager's duties and responsibilities are carried out throughout the duration of the resident relocation process of a minimum of 90 -120 days. The administrator's and/or facility manager's duties and responsibilities include ... Adequate provisions for ongoing operations and management of the facility and its residents and staff during the relocation process that include ... continuation of appropriate staffing to meet the needs of all residents, ongoing assessment of each residents' care needs and the ongoing provision of necessary services and care including the provision of medications, services, supplies and treatments as ordered by the resident's physician/practitioner ... the maintenance of the physical plant, the provision of food and all other basic necessities." (Wisconsin Department of Health Services Resident Relocation Manual, 12/2025, page 19-20). CURRENT NON-COMPLAINCE On 04/22/2026, Surveyor conducted a complaint investigation alleging care concerns at the facility. The following concerns were identified: - Management/Administration: One staff member, identified as a caregiver, was present. Manager C was out ill and unable to present to the facility.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 2 Administrator A was working at an unaffiliated facility as a caregiver and unable to present to the facility. Licensee D did not communicate with Surveyor or staff while Surveyor was present at the facility. - Records: Resident and employee records were unavailable for review. Caregiver B reported records were destroyed during recent water damage. - Medication Administration: Observation, interviews and record review indicated residents had not received medication as prescribed. Observation and record review also indicated medications were administered without nurse delegation. - Food: The provider did not have a weekly menu prepared. Four of four residents and one of one staff present voiced concern with food supply and meals provided at the facility. - Personal Cares: Two of four residents, who required assistance with bathing, reported that they had not received bathing assistance in 1 to 3 weeks. The caregiver present was unaware of records to reference to determine what resident needs were. One resident reported having to present to dialysis without breakfast or clean clothing due to the overnight shift not waking him/her prior to his/her scheduled transportation to provide morning cares. - Environmental Concerns: The ceiling was exposed from water damage, unoccupied resident rooms were left with debris, including cigarettes, on the floor and the medication room door was left ajar with boxes of medications accessible. On 04/22/2026 at 11:48 a.m., Surveyor interviewed Manager C via phone. Manager C stated s/he was unable to present to the facility due to illness. Manager C stated s/he didn't have	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 3	N 196		

anyone that could present to the facility to fulfill his/her duties while s/he was out ill. Manager C stated Administrator A mostly worked from home and was not often at the facility. Manager C stated s/he was still learning how to manage things at the facility and was doing the best s/he could. Manager C stated Management Company/Licensee D had been at the facility approximately 3 times since December.

COMPLIANCE HISTORY:

On 10/02/2025, the Department issued a "Warning of Noncompliance" letter to the provider that identified the following concerns:

1. A high number of substantiated complaints.
2. Repeat citations of noncompliance.
3. Noncompliance resulting in outcome to residents.

Based on a review of the facility's compliance history since a change of ownership desk review was conducted on 05/21/2021, the department has conducted 18 regulatory visits, complaint investigations, licensing surveys, and verification visits. Nine of those visits resulted in deficiencies and/or enforcement action.

SOD 576M11, dated 10/26/2021, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies.

SOD RP9811, dated 01/18/2022, consisted of a standard survey and a complaint investigation. As a result, 4 deficiencies of non compliance were issued. The complaint unsubstantiated. The deficiencies included:
N0394 DHS 83.35(5)(b) Annual Evaluation of Evacuation Limitations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by the RN N0507 DHS 83.46(1)(f) Combustibles N0526 DHS 83.47(2)(e) Other Evacuation Drills SOD HYN111, dated 03/14/2022, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD F9GG11, dated 03/21/2022, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD RP9812, dated 09/30/2022, consisted of a verification visit. As a result, 1 deficiency of non compliance was issued. The deficiency included N0507 DHS 83.46(1)(f) Combustibles. SOD SHTU11, dated 10/18/2022, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD RP9813, dated 03/17/2023, consisted of a verification visit. No deficiencies were issued. SOD 8XKQ11, dated 08/24/2023, consisted of a survey and complaint investigation. The complaint was unsubstantiated and the survey resulted in 6 deficiencies. The deficiencies included the following: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0431 DHS 83.38(1)(g) Health Monitoring N0531 DHS 83.47(4)(a) Fire Extinguishers: Type	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 and Inspection SOD 8XKQ12, dated 02/06/2024, consisted of a verification visit. No deficiencies were issued. SOD RTTY11, dated 09/21/2023 consisted of a complaint investigation. The complaint was unsubstantiated. The survey resulted in the following deficiency: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called. SOD 7S3X11, dated 04/11/2024, consisted of a complaint investigation. The complaint was substantiated but resulted in no deficiencies. SOD CS2Z11, dated 07/12/2024, consisted of a complaint investigation. The complaint was unsubstantiated and resulted in no deficiencies. SOD Q1UN11, dated 01/06/2025 consisted of 2 complaint investigations. One complaint was substantiated. The survey resulted in the following deficiency: N0205 DHS 83.14(2)(j) Not Permit a Condition of Substantial Risk. SOD Q1UN12, dated 05/16/2025 consisted of a survey, verification visit, and 4 complaint investigations. Three of 4 complaints were substantiated. The survey resulted in 24 deficiencies, which included the following: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0239 DHS 83.20(2)(a) Department-Approved Training Courses N0301 DHS 83.28(3) Provide Admission Agreement As Required	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 6 N0302 DHS 83.28(4)(a)1. Resident Health Screening And Documentation N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limits N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0397 DHS 83.36(1)(b)2. Qualified Staff In Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0423 DHS 83.37(3)(g) Medication Storage: Controlled Substances N0427 DHS 83.38(1)(c) Leisure Time Activities N0432 DHS 83.38(1)(h) Medication Administration N0446 DHS 83.41(1)(b) Equipment N0450 DHS 83.41(2)(c)2. Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0509 DHS 83.46(1)(a) Ventilation Z0010 DHS 50.065(2)(bb) Determine Final Disposition Of Charge SOD Q1UN13, dated 09/15/2025 consisted of a verification visit and 3 complaint investigations. Two of 3 complaints were substantiated. The survey resulted in 18 deficiencies, which included the following: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 7 N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0355 DHS 83.32(3)(k) Rights Of Residents: Self-Determination N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0455 DHS 83.41(1)(a) Food Supply N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0509 DHS 83.46(2)(a) Ventilation N0637 DHS 83.59(1) Proper Exit Locations, Sidewalks, Driveways	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 8 SOD 59UD11, dated 10/21/2025 consisted of 3 complaint investigations. Three of 3 complaints were substantiated. The survey resulted in 11 deficiencies, which included the following: N0164 DHS 83.12(4)(b)Reporting When Law Enforcement Is Called N0172 DHS 83.12(6) Documentation Requirements For Written Report N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0409 DHS 83.37(1)(j) Proof-Of-Use Record N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0425 DHS 83.38(1)(a) Personal Cares N0454 DHS 83.42(1) Resident Record Maintained SOD 59UD12, dated 01/28/2026, consisted of 2 verification visits and 4 complaint investigations. Four of 4 complaints were substantiated. The survey resulted in 12 deficiencies, which included the following: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0409 DHS 83.37(1)(j) Proof-of-Use Record N0423 DHS 83.37(3)(g) Medication Storage: Controlled Substances	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 9 N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean And Comfortable N5202 DHS 83.46(1)(a) Comfortable Y3234 DHS 50.09(1)(e) Treatment SOD ZXLO11, dated 04/22/2026 consisted of 1 complaint investigations The complaint was substantiated. The survey resulted in 8 deficiencies, which included the following: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0416 83.37(2)(e) Other Administration Given Or Delegated By RN N0419 83.37(3)(c) Medication Storage: Locked Cabinet N0425 83.38(1)(a) Personal Cares N0450 83.41(2)(c) Nutrition: Menus N0479 83.42(2) Resident Records Safeguarded N0481 DHS 83.43(1) Environment Safe, Clean And Comfortable In summary, during the past 6 years, the provider has had surveys by the department resulting a total of 86 deficiencies, including 15 of 25 substantiated complaints. Surveyor made attempts to review all concerns with Administrator A on 04/24/2026 at 10:49 a.m. and 04/27/2026 at 8:27 a.m. at the phone number provided to Surveyor by Administrator A via phone on 04/22/2026. The number Surveyor called did not have a voicemail set up, leaving Surveyor unable to leave a message. Calls were not	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 10 returned.	N 196		
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, interview and record review, the provider did not ensure 2 of 4 residents reviewed received their medications as prescribed. Resident 4 did not receive docusate sodium, tamsulosin, vitamin D3, polyvinyl eye drops, stool softener and oxycodone as prescribed. Resident 2 did not receive eye lubricant, chlorhexidine and ciclopirox cream as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) 8XKQ11, dated 08/24/2023, SOD Q1UN12, dated 05/16/2025 and SOD 59UD12, dated 01/28/2026. Findings include: On 04/22/2026, Surveyor conducted a complaint investigation alleging medication concerns at the provider's facility. On 04/22/2026 at approximately 11:00 a.m., Surveyor reviewed the provider's electronic	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 charting program, dated 04/01/2026 to 04/22/2026, and medication cart with Caregiver B. Caregiver B stated s/he was just going through the medication cart to make a list of medications that were unavailable and needed to be ordered. The following concerns were identified: Example 1 - Resident 4: Resident 4 admitted to the provider's facility on 12/26/2024 with diagnoses of depression and chronic pain. Resident 4's medication supply did not contain the following: - Docusate Sodium 100 mg - Ordered 2 times daily. *The medication was documented as administered 9 of 43 times it was due. There were 29 notations of the medication being unavailable starting 04/01/2026. - Tamsulosin Hcl .4 mg - Ordered 1 time daily. *The medication was docum ented as administered 4 of the 22 times it was due. There were 17 notations of the medication being unavailable starting 04/01/2026. - Vitamin D3 2000 unit - Ordered 1 time daily. *The medication was documented as administered 6 of the 22 times it was due. There were 16 notations of the medication being unavailable starting 04/02/2026. - Polyvinyl 1.4% eye drops - Ordered 1 time daily. * The medication was documented as administered 8 of the 21 times it was due. There were 7 notations of the medication being unavailable starting 04/06/2026. - Stool softener - Ordered 2 times daily. * The medication was documented as administered 9 of the 43 times it was due. There were 29 notations of the medication being unavailable starting 04/02/2026.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 Resident 4's physician orders included Oxycodone Hcl 20 mg (Start Date: 03/02/2026) 4 times daily. Resident 4's electronic medication record documented Oxycodone Hcl 20 mg as administered 29 of the 86 times it was due from 04/01/2026 to 04/22/2026. Notations documented the medication as unavailable 39 times from 04/01/2026 to 04/22/2026. The medication cart contained 2 medication cards, packaged with 50 combined Oxycodone Hcl 20 mg tablets, dated 04/20/2026 and labeled as PRN. Caregiver B clarified these medication cards were being used for Resident 4's scheduled administration. Surveyor and Caregiver B were unable to locate medication cards labeled as Resident 4's scheduled Oxycodone. On 04/22/2026 at approximately 12:35 p.m., Surveyor interviewed Resident 4. Resident 4 voiced concern with not receiving his/her medications as prescribed. Resident 4 stated s/he had just gone over a week without receiving his/her pain medication and was still uncomfortable from the experience. Resident 4 stated s/he had to resolve the medication issues with pharmacy him/herself. Example 2 - Resident 2: Resident 2 admitted to the provider's facility on 03/05/2021 with diagnoses including schizoaffective disorder and end stage regnal disease. Resident 2's medication supply did not contain the following: - Eye Lubricant - Ordered 4 times daily. *The medication was documented as administered 17 of 85 times it was due. There were 55 notations of the medication being	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 unavailable starting 04/01/2026. - Chlorhexidine Rinse - Ordered 2 times daily. *The medication was documented as administered 21 of 43 times it was due. There were 2 notations of the medication being unavailable starting 04/10/2026. - Ciclopirox cream - Ordered 2 times daily. *The medication was documented as administered 6 of 43 times it was due. There were 22 notations of the medication being unavailable starting 04/01/2026. On 04/22/2026 at approximately 12:00 p.m., Surveyor interviewed Resident 3. Resident 3 stated s/he had run out of several medications and had his/her family member working to resolve the issues. Resident 3 voiced frustration that s/he could hardly see and couldn't remember anything because s/he wasn't getting his/her medications.	N 352		
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 observation, interview and record review, the provider did not ensure medications delivered rectally were administered by a registered nurse, licensed practical nurse within the scope of their license or by a non-licensed	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 14 employee who has been delegated. Findings include: On 04/22/2026 at approximately 11:15 a.m., Caregiver B stated s/he needed to step away for a minute to administer a suppository. On 04/22/2026 at approximately 11:30 a.m., Caregiver B informed Surveyor s/he had administered Resident 2 a suppository. Surveyor asked Caregiver B if s/he had been delegated by a nurse at the facility to administer suppositories. Caregiver B stated s/he had been trained and delegated by a nurse at this/her other employer, which was an unaffiliated facility. On 04/22/2026 at approximately 11:35 a.m., Surveyor reviewed Resident 2's record. Resident 2 admitted to the provider's facility on 03/05/2021. Resident 2's physician orders included Bisacodyl 10 mg suppository (Start Date: 02/23/2026) - Instill 1 suppository rectally once daily as needed for constipation. On 04/22/2026 at 11:48 a.m., Surveyor interviewed Manager C via phone. Manager C stated s/he was out ill and unable to be present at the facility. Manager C stated a nurse was no longer employed at the facility. Surveyor requested Caregiver B's employee file. Manager C stated s/he would direct Caregiver B to the employee files maintained at the facility. On 04/22/2026 at approximately 12:20 p.m., Surveyor and Caregiver B reviewed employee files located at the facility and were unable to locate a file for Caregiver B.	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 419	Continued From page 15	N 419		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were kept locked with the key available only to personnel identified by the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) 59UD11, dated 10/21/2025. Findings include: The provider is licensed to serve up to 20 residents with primary diagnoses including advanced age, terminally ill and irreversible dementia/Alzheimer's. On 04/22/2026 the provider's census was 4. On 04/22/2026 at approximately 10:40 a.m., Surveyor observed the door to the provider's medication room completely ajar. The medication room had 3 large bins and a plastic bag full of medications. Medications appeared to be for residents that had been discharged from the facility. Medications included gabapentin, terazosin, acetaminophen, trazadone, senna-docusate, wixela inhaler, doxycycline and metformin. On 04/22/2026 at approximately 10:40 a.m., Surveyor interviewed Caregiver B. Caregiver B stated s/he was unsure why the medications were at the facility. On 04/22/2026 at 11:40 a.m., Surveyor	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 419	Continued From page 16 interviewed Resident 1. Surveyor observed a wheeled walker in his/her room. Resident 1 reported that s/he had the ability to leave the facility independently to go to appointments and get groceries. On 04/22/2026 at approximately 12:30 p.m., Surveyor observed Resident 4 mobilizing in/out of the facility to use tobacco products.	N 419		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure personal care services were provided. Resident 1 and Resident 3 did not receive adequate assistance with personal cares. This is a repeat deficiency. See Statement of Deficiency (SOD) 59UD11, dated 10/21/2025.	N 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 425	Continued From page 17 Findings include: On 04/22/2026 at 11:40 a.m., Surveyor interviewed Resident 1. Resident 1 stated s/he required set-up/standby assistance for bathing and had not received assistance in 3 weeks. On 04/22/2026 at approximately 12:00 p.m., Surveyor interviewed Resident 2. Resident 2 voiced concerns regarding lack of care. Resident 2 reported s/he was supposed to receive bathing assistance every Tuesday, Thursday and Saturday, but had not received bathing assistance in 8 days. Resident 2 also reported that s/he was supposed to be woke, assisted with dressing and served breakfast prior to leaving for dialysis 3 times per week at approximately 5:30 a.m. Resident 2 stated s/he often woke to his/her transportation driver honking the horn at the entrance because the overnight caregiver was sleeping and failed to wake Resident 2. Resident 2 stated s/he has had to go to dialysis in dirty clothing and with no breakfast. On 04/22/2026 at approximately 12:15 p.m., Surveyor interviewed Caregiver B and requested resident individual service plans (ISP). Caregiver B stated s/he did not have access to ISPs. When asked how Caregiver B knew what assistance residents required, including if they were scheduled for a shower, Caregiver B stated s/he would have been notified by the caregiver who worked the shift prior. Caregiver B was unable to identify any documentation regarding residents' personal care needs. Caregiver B then contacted Manager C to request ISPs and was informed resident records were lost during recent water damage at the facility.	N 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(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 425	Continued From page 18 On 04/22/2026 at approximately 12:20 p.m., Surveyor reviewed observation notes for the past 30 days in the provider's electronic charting program. Surveyor was unable to locate documentation indicating bathing assistance had been offered or completed for Resident 1 and Resident 2.	N 425		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure weekly written menus were prepared and made available to residents. The provider did not follow a menu. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025 and Q1UN13, dated 09/15/2025. Findings include: On 04/22/2026, Surveyor conducted a complaint investigation alleging care concerns at the facility. On 04/22/2026 at 10:35 a.m., Surveyor toured the provider's facility and was unable to locate a menu.	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 450	Continued From page 19 On 04/22/2026 at 10:40 a.m., Surveyor interviewed Caregiver B. Caregiver B stated s/he did not have a menu to follow. Caregiver B stated the facility was short on food at times, but that s/he was usually able to make frozen foods, such as pizza or sloppy joes. Caregiver B stated management had just gone grocery shopping the day prior to Surveyor's visit so s/he was able to prepare eggs for breakfast. On 4/22/2026 at 11:40 a.m., Surveyor interviewed Resident 1. Resident 1 stated s/he and other residents had gone without a meal more than once in the past few weeks. Resident 1 stated s/he used a benefit through his/her managed care organization to go out and purchase his/her own food to have in his/her room. On 04/22/2026 at approximately 12:00 p.m., Surveyor interviewed Resident 2. Resident 2 stated there were times residents went without meals. On 04/22/2026 at 12:08 p.m., Surveyor observed Caregiver B contact Manager C to ask what should be prepared for lunch. On 04/22/2026 at approximately 12:30 p.m., Surveyor interviewed Resident 3. Resident 3 stated residents had gone without a meal more than once over the past 2 to 6 weeks. On 04/22/2026 at approximately 12:35 p.m., Surveyor interviewed Resident 4. Resident 4 stated the provider's meal quality was very poor. Resident 4 stated the facility rarely had milk and would serve cereal with no milk. Resident 4 stated at times peanut butter on bread or instant potatoes with instant gravy were considered meals. Resident 4 voiced frustration that the	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 450	Continued From page 20 provider believed such meals were adequate for adults.	N 450		
N 479	83.42(2) Resident records safeguarded. The licensee shall ensure all resident records are adequately safeguarded against destruction, loss or unauthorized access or use. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were safeguarded against destruction or loss. Resident records were lost when the facility had water damage. Findings include: On 04/22/2026, Surveyor conducted a complaint investigation. As part of the investigation, Surveyor requested resident records from Caregiver B. Caregiver B allowed Surveyor access to resident medication administration records and observation notes via the provider's electronic charting program. Caregiver B reported that s/he was unaware of any additional records. Caregiver B then contacted Manager C to ask about additional resident records. Manager C informed Caregiver B that resident records were lost during recent water damage at the facility.	N 479		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 21	N 481		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure a safe, clean, comfortable and homelike environment was provided.

This is a repeat deficiency. See Statement of Deficiency (SOD) Q1UN12, dated 05/16/2025, SOD Q1UN13, dated 09/15/2025 and SOD 59UD12, dated 01/28/2026.

Findings include:

The provider is licensed to serve up to 20 residents with primary diagnoses including advanced age, terminally ill and irreversible dementia/Alzheimer's. On 04/22/2026 the provider's census was 4.

On 04/22/2026 at approximately 10:35 a.m., Surveyor toured the provider's facility and observed the following concerns:

- Ceiling tiles at the entrance of the facility are removed, exposing wires and insulation.
- An alarm continuously sounds.
- Unoccupied rooms remain unlocked and accessible. Many of the unoccupied rooms contain leftover belongings and/or garbage. One room had cigarettes scattered on the floor.

On 04/22/2026 at approximately 10:40 a.m., Surveyor interviewed Caregiver B. Caregiver B stated s/he worked very part-time at the facility. Caregiver B stated some of the environmental concerns were due to water damage and that s/he was unable to turn the sounding alarm off.

On 04/22/2026 at 11:40 a.m., Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018519	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEFOREST PLACE	206 N MAIN STREET DE FOREST, WI 53532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 22 interviewed Resident 1. Surveyor observed a wheeled walker in his/her room. Resident 1 reported that s/he had the ability to leave the facility independently to go to appointments and get groceries. On 04/22/2026 at approximately 12:30 p.m., Surveyor observed Resident 4 mobilizing in/out of the facility to use tobacco products. The provider did not maintain a safe environment. Two of four residents residing at the facility reported and/or were observed mobilizing independently.	N 481		