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N 000	Initial Comments On 06/03/2026 with additional information gathered through 06/11/2026, Surveyors conducted a standard survey and two (2) complaint investigations at Bethel Menasha IV. As a result 25 deficiencies were identified. Two of (2) complaints were substantiated. Census: 8	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on observation, interviews and record review, the provider did not have evidence misappropriation of a resident's property was	N 158		

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

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thoroughly investigated for 1 of 1 resident.

Resident 3 had eight (8) Oxycodone HCl 5 mg (milligram) tablets (a pain medication) missing from the resident's medication inventory. The pharmacy delivered ninety (90) tablets of Resident 3's Oxycodone medication to the facility on 04/28/2026. Documentation revealed eighteen (18) tablets were administered to Resident 3; however, twenty-six (26) tablets were removed from the inventory. Consequently, eight (8) Oxycodone tablets were missing and unaccounted for. The facility did not have evidence the missing medication was thoroughly investigated and documented to rule out potential misconduct.

Findings include:

According to www.deadiversion.usdoj.gov/drug_chem_info/Oxycodone.pdf, dated 09/2025 indicated, "Oxycodone is a schedule II narcotic analgesic and is widely used in clinical medicine...Illicit Uses: Oxycodone abuse has been a continuous problem in the U.S. since the early 1960s. Oxycodone is abused for its euphoric effects."

The facility's undated policy and procedure titled, "Narcotic/Controlled Substance Count Policy and Protocol indicated, "Current shift caregiver must count NARCs together with oncoming shift caregiver. NARCs are always counted in the presence of two people. You CANNOT and should not under any circumstances count NARCs alone without the presence of the person who is signing them over to you...If the count is off, both staff remains in the med room until the discrepancy is resolved...Current shift is responsible and accountable for any missing

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NARCs during their shift. If at any time NARC count is off or missing during shift change, current shift is held responsible and must take the following steps: 1. No caregivers may leave the building until discrepancy is taken care of. 2. If narcotic count continues to be incorrect, House Manager/Administrator must be notified before any staff may leave the building. 3. When count is incorrect, staff may leave the building only upon permission of the administrator. 4. An Incident Report must be filled out by the current shift medication passer when count continues to be incorrect." On 06/04/2026, Administrator E sent a document titled "Medication Administration Education" completed with staff on 02/06/2026. The documentation indicated, "At the beginning of your shift, you should have counted the narcs with the last shift; both you and the last shift should have initialed in the narc count binder on the shift-to-shift page...At any time, a narcotic is punched or given, it needs to be sign out in the narc book with the date, your initial, time, how many was taking out of the card, and how many tablets are left, then also initial the back of the card...If you have any questions or need clarifications, talk to [Administrator E]."

On 06/03/2026, Surveyor reviewed Resident 3's record which indicated the resident was admitted to the facility on 04/24/2026 with diagnosis to include diabetes, tobacco use and muscle weakness. Additionally, the facility managed and administered all of Resident 3's medication. Resident 3 had a physician's order written on 04/28/2026 for, "Oxycodone HCl tablet 5 mg every eight hours as needed for acute severe pain."

On 06/04/2026, Surveyor received the delivery receipt from the facility pharmacy dated

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04/28/2026. The delivery receipt indicated on 04/28/2026 ninety (90) Oxycodone HCl 5 mg tablets were delivered to the facility for Resident 3. The delivery receipt was signed by Caregiver G.

On 06/03/2026 at 12:20 PM, during a medication cart inspection with Caregiver B, a count of controlled substances in the locked drawer was conducted. For Resident 3, the inventory of Oxycodone HCl 5 mg tablets was confirmed to be 64 tablets remaining in the medication cards. Surveyor noted the facility had a paper and electronic proof-of-use record for Resident 3's Oxycodone 5 mg tablets. The paper proof-of-use record indicated 67 tablets remaining, while the electronic proof-of-record showed 66 tablets. Both proof-of-use records were inconsistent with the actual observed inventory of 64 tablets.

On 06/03/2026 at 12:30 PM, Surveyor reviewed Resident 3's MAR's (Medication Administration Records) and electronic proof-of-use record for the Oxycodone medication with Caregiver B. A total of (14) fourteen tablets were administered to the resident from 04/28/2026 through 06/03/2026. The following was noted:
*Two (2) tablets of Oxycodone HCl 5 mg were administered to the resident from 04/28/2026 through 04/30/2026
*Eleven (11) tablets of Oxycodone HCl 5 mg were administered to the resident from 05/01/2026 through 05/31/2026
*One (1) tablet of Oxycodone HCl 5 mg was administered to the resident from 06/01/2026 through 06/03/2026

The paper proof-of-use record for Resident 3's Oxycodone medication showed four (4) additional tablets were administered, beyond those

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N 158	Continued From page 4 documented in Resident 3's MARs and electronic proof-of-use record. On 06/03/2026 at 12:35 PM, Caregiver B confirmed a total of eighteen (18) Oxycodone 5 HCl mg tablets were administered to Resident 3 from 04/28/2026 through 06/03/2026. Caregiver B verified the facility was unable to account for eight (8) of the ninety (90) tablets of Resident 3's Oxycodone medication that was delivered to the facility on 04/28/2026. On 06/03/2026 at 12:40 PM, Surveyor and Caregiver B reviewed the facility's "Shift-to-shift Narcotic Count" log used to track the inventory of controlled substances. Caregiver B indicated narcotic medications should be counted with oncoming staff at the end of every shift and recorded in the 'Shift-to-shift Narcotic Count' log. The "Shift-to-Shift Narcotic Count" log had a start date of 05/13/2026 and the following discrepancies were noted: ~No counts were documented as being completed on 05/14/2026, 05/15/2026, 05/17/2026, 05/18/2026, 05/20/2026, 05/22/2026, 05/23/2026, 05/26/2026, 05/28/2026, 06/01/2026, 06/02/2026 and 06/03/2026. ~Shifts with no staff signatures/initials and shifts with only one staff signature/initial: *05/19/2026: The PM/NOC shift had only one staff initial *05/21/2026- The PM/NOC shift was completely blank *05/24/2026- The AM/PM and PM/NOC shifts were entirely blank *05/25/2026- The NOC/AM shift had only one staff initial, and the AM/PM and PM/NOC shifts were completely blank	N 158		

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*05/27/2026- The NOC/AM shift was completely blank, and the PM/NOC shift had only one staff initial
*05/29/2026- The NOC/AM shift was completely blank, and the AM/PM shift only had one staff initial
*05/30/2026- The AM/PM shift was completely blank, and the PM/NOC shift only had one staff initial
*05/31/2026- The AM/PM shift had only one staff initial, and the PM/NOC was completely blank

On 06/03/2026 at 12:45 PM, Surveyor interviewed Caregiver B regarding the "Shift-to-Shift Narcotic Count" log. Caregiver B verified the log, lacked daily narcotic counts and staff signatures/initials for multiple shifts, and confirmed the last narc count documented was on 05/31/2026.

Note: Due to the incomplete "Shift-to-Shift Narcotic Count" log, the facility could not promptly verify the accuracy of the narcotic inventory, rule out potential drug diversion or identify specific discrepancies.

On 06/09/2026 at 4:15 PM, during the exit conference, Surveyors shared the above information with Administrator E and Licensee F regarding Resident 3's Oxycodone medication. Administrator E verified the pharmacy delivered ninety (90) tablets of Resident 3's Oxycodone medication on 04/28/2026 and no additional tablets were delivered. Administrator E noted eight (8) of the 90 Oxycodone tablets were unaccounted for. Administrator E reported staff were expected to perform a narcotic count at the beginning and end of every shift, and the outgoing and incoming shift staff were required to initial the 'Shift-to-shift' page in the narcotic binder

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N 158	Continued From page 6 to verify completion and report any discrepancies. Administrator E indicated if the narcotic count was incorrect the facility would look into it. Surveyor then shared the 'Shift-to-Shift Narcotic Count' log was found to be incomplete, with multiple days of missing counts and multiple shifts without staff signatures. Neither Administrator E or Licensee F provided documented evidence an investigation was conducted into Resident 3's missing Oxycodone medication. In conclusion, the provider did not have evidence of a thorough investigation into Resident 3's missing pain medication. A pharmacy delivery receipt dated 04/28/2026 indicated, the facility received ninety (90) Oxycodone HCl 5 mg tablets for Resident 3. The facility was unable to account for eight (8) of the ninety (90) tablets of Resident 3's Oxycodone medication. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0409 DHS 83.37(1)(i) Proof-of-use-Record	N 158		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.	N 214		

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This Rule is not met as evidenced by:
Based on observation interview and record review, Administrator E did not provide the supervision and oversight necessary to ensure residents received proper care and treatment, that their health and safety were protected and promoted and that their rights were respected. A total of 24 deficiencies were identified as a result of the survey. In addition, Administrator E did not ensure Resident 2's needs were met or employee records were accurately maintained.

The deficient practices affected 8 of 8 residents residing at the facility.

Findings include:

The Department received a complaint alleging concerns with Administrator E's oversight.

SURVEY FINDINGS

During onsite visits 06/03/2026 and 06/09/2026, with information collected through 06/11/2026, Surveyors investigated 2 complaints and conducted a survey. Surveyors made observations and conducted interviews with residents, facility staff, the visiting nurse practitioner, a legal representative and the local fire department. Surveyors also reviewed facility records, medical records and fire department records.

Based on the evidence collected, 2 of 2 complaints were substantiated and 24 deficiencies were identified. In summary:

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N 214	Continued From page 8 --Administrator E did ensure residents' rights to a safe environment were protected or that fire prevention and preparedness systems were in place. Fire evacuation drills were not conducted, residents were not assessed for their evacuation limitations, Caregivers C and Q did not receive required fire safety training and a smoking policy was not developed to designate safe smoking locations and expectations for safe disposal of smoking materials. Subsequently during the early morning hours of 06/02/2026, Caregiver C was smoking alongside the exterior of the home and his/her smoking materials caused a fire. The fire resulted in damage to the home and complete evacuation of all 8 residents. Residents experienced trauma and ongoing worry as a result of the fire. A week after the fire, the aforementioned safety gaps persisted. --Administrator E did not ensure residents' rights to be free from mistreatment, neglect and verbal abuse were protected. Interviews with residents identified Caregiver D refused to provide care, slept during third shift and engaged in verbal abuse. This impacted Residents 2, 3, 6, 7 and 8. --Administrator E did not ensure an investigation was conducted when there were noted discrepancies in the documentation intended to track and account for narcotic medication. Subsequently, 12 of Resident 3's oxycodone tablets were missing and unaccounted for. --Administrator E did not ensure residents' rights to live in the least restrictive environment were protected. The facility contained restrictive signage, doors to the kitchen, food supply and back patio were locked and resident access to food was further restricted by a system of storing	N 214		

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most food at sister facilities.

--Administrator E did not ensure residents' rights to receive medication were protected or that medication administration was provided in a manner appropriate to meet the needs of residents. This impacted Residents 1, 2, 3, 4 and 5.

--Administrator E did not ensure residents' health was monitored. Resident 6 was not medically assessed for skin integrity concerns as instructed on a 05/22/2026 hospital discharge summary and Resident 3 did not receive physical and occupational therapy evaluation and treatment as ordered by medical providers on 04/24/2026 and 05/25/2026.

--Administrator E did not ensure Resident 6's Individual Service Plan (ISP) was updated to identify needs and interventions related to meal refusals and significant weight loss and did not ensure Resident 7's ISP was updated to identify needs and interventions related to refusals of medications and showers or interventions to prevent/respond to behaviors.

--Administrator E did not ensure caregivers effectively managed Resident 6's behaviors. Caregivers did not consistently implement identified interventions to prevent and respond to behaviors as identified in the existing ISP and did not ensure the ISP was updated after Resident 6 experienced worsening psychiatric symptoms and hospital visits. Resident 6's behavior was harmful to him/herself and disruptive to other residents.

--Administrator E did not ensure Resident 2 received the necessary dietary modification for pureed food and did not ensure all residents were

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provided with food that met recommended dietary allowances. Menus were not followed and deviations were not documented. In addition, food was not stored under safe conditions.

--Administrator E did not ensure leisure time activities were provided or the environment was safe, clean, well maintained and homelike. Odors were present, the facility was not clean, hygiene supplies were not readily available and furniture and windows were in poor repair. The facility did not have carbon monoxide detection and the provider did not follow through on a recommendation from a 2024 inspection to replace a 23 year old furnace. Water temperatures were dangerously hot and the delayed egress doors would not release in 15 seconds after pressure was applied.

During the exit interview with Administrator E and Licensee F on 06/09/2026 beginning at 4:15 PM, Surveyors reviewed concerns with Administrator E's oversight as evidenced by the extent and scope of the deficiencies. Administrator E and Licensee F did not offer additional insight or information.

ADDITIONAL CONCERNS - RESIDENT 2 EXAMPLES

Example 1
Surveyors interviewed Resident 2 on 06/03/2026 at 12:25 PM. S/he immediately volunteered, "They took my phone away...for no reason...that makes me mad...(it is) a red one...they took it away to put you down more. It's depressing...It's been months.....I'm scared if I tell them I need an ambulance, they won't call for me..." Resident 2 expressed a strong preference to access his/her own phone to contact his/her friend and that s/he

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does not prefer to use the facility phone. Surveyor observed a small red device near Resident 2 and asked if that was his/her phone. S/he said no, "It's an alarm clock" and expressed worry the staff would take that too. Surveyor observed further and confirmed it was not a cell phone.

During an interview with Administrator E on 06/03/2026 at 4:45 PM, s/he confirmed the phone was missing and had been since "the first or second day [s/he] got here." Administrator E stated, "[s/he]'s hiding it somewhere...[S/he] has access to the (facility) phone anytime....I'm not sure where [his/her] phone is...I will check with staff." Surveyors informed Administrator E that Resident 2 expressed it was important to him/her to have access to his/her own phone and requested follow up on the situation.

On 06/03/2026 at 2:10 PM, Administrator E provided Surveyor with Resident 2's face sheet, current ISP and observation notes dating back to 04/01/2026. Resident 2's admission date was 12/05/2025. There was no documented history of Resident 2 hiding his/her phone, losing it or of staff helping to locate it.

On 06/05/2026, Administrator E emailed Surveyors. "[S/he] had it in [his/her] room and staff found it and gave it to [him/her]."

On 06/09/2026 at 11:43 AM, Surveyors conducted a follow up interview with Resident 2 in his/her room and observed a red phone on the nightstand. Resident 2 said it just appeared on the nightstand after Surveyors' last visit. S/he explained there is still a problem because "It's not running right. They took it away from me and then when they gave it back, I can't even use it now. It will charge up but I can't call..." Surveyor

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observed the phone on the bedside table. It was charged, but the screen displayed the wrong date and time and was equipped for "emergency calls only." Resident 2 again expressed s/he really wants to use the cell phone to call his/her friend.

On 06/09/2026 at 12:01 PM, Surveyor interviewed Caregiver B and asked about the phone. Caregiver B said in the past, Resident 2 "tried to say" staff had the phone but Caregiver B did not think it was true because there was a little red alarm clock in the room that Caregiver B thought was the phone. Caregiver B was dismissive of Resident 2's explanations of the missing phone said, "[S/he] does lose things like that. [S/he] has dementia." Surveyor asked if the phone was functional since it's been returned and Caregiver B said, "I'm not sure. That's up to [his/her] guardian and care team. They said they have tried calling; it must have been dead." Surveyor asked about efforts to inform the guardian or care team about Resident 2's need for assistance in restoring service to the phone and Caregiver B was unsure who the guardian or care team were. Surveyor asked if Resident 2's records were available in the facility, to include documentation regarding his/her legal representative status and their contact information. Caregiver B said the only records were those s/he could access on the computer and the paper records which included documentation about legal representatives were kept in Administrator E's office in the sister facility.

On 06/09/2026, at 12:25 PM, Surveyor met with Administrator E in his/her office in the sister facility and requested Resident 2's complete record. Administrator E retrieved a file from a cabinet in the office. Surveyor noted it contained

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court records which identified Resident 2's legal guardian.

Example 2
On 06/03/2026 at approximately 11:50 AM, Surveyor observed Resident 2 ask a caregiver for toothpaste. The caregiver did not assist Resident 2 with the request.

During the interview with Resident 2 on 06/03/2026 at 12:25 PM, Surveyor observed a handwritten note on the bedside table that read, "I need my toothpaste." On a different table, Surveyor observed a bottle of mouthwash and glass that held a toothbrush; no toothpaste was present with the oral hygiene supplies. Resident 2 stated to Surveyor s/he has been out of toothpaste since yesterday and added that s/he asked for staff to get him/her toothpaste but "they're not gonna do it."

On 06/03/2026 at 4:15 PM, Surveyor interviewed Caregiver U. Caregiver U said Resident 2 is "meticulous" about his/her oral care, but Caregiver U said s/he only administers medications and was unaware of the status of Resident 2's toothpaste.

On 06/09/2026 at 11:43 AM, Surveyor conducted a follow up interview with Resident 2 in his/her room. Surveyor observed the note remained on the bedside table and the toothbrush and mouthwash were on the other table. Again, no toothpaste was present. Resident 2 said s/he still had not been provided with toothpaste since Surveyors were last there and explained s/he has had to brush with just water. S/he added, "It really makes me mad. Other staff people know what's going on. I don't have my toothpaste and they are supposed to get something for me. I asked the

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caregivers."

On 06/09/2026 at 12:10 PM, Surveyor interviewed Caregiver B and asked about Resident 2's toothpaste. Caregiver B said, "I think in the bathroom they all share a tube. [S/he] asked last week for some, could have sworn I gave [him/her] some...[s/he] mentioned [s/he] ran out...[Administrator E] gave me a tube. [Resident 2] does misplace things a lot too."

Surveyors inspected the bathroom across the hall from Resident 2's room at 12:20 PM. No toothpaste was present.

During the exit conference on 06/09/2026 beginning at 4:15 PM with Administrator E and Licensee F, Surveyor reviewed the aforementioned concerns regarding Resident 2 not receiving assistance with his/her cell phone and not having access to toothpaste for a week. Administrator E and Licensee F did not provide additional information about the cell phone and Administrator E said s/he did not know Resident 2 was out of toothpaste.

ADDITIONAL CONCERNS - TIMELY PROVISION AND ACCURACY OF RECORDS

During the entrance conference with Administrator E concluding at 10:10 AM on 06/03/2026, Surveyors requested employee and resident rosters, employee and resident records and inspection records. Surveyors also provided Administrator E with the Entrance-Exit Conference Checklist identifying the need to provide records within 2 hours.

Administrator E provided the records 4 hours later, at 2:10 PM. Surveyor noted conflicting

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N 214	Continued From page 15 information in the records. For example: An employee's hire date is used to determine compliance with training requirements (initial and continuing education) and background check requirements (initial and 4 year.) --Caregiver Q's hire date according to the roster was 07/06/2023 but the hire date on a training record was 11/20/2020. --Caregiver Q's background check results were dated 11/19/2020 and 06/03/2026 (date of the onsite visit). Conflicting documentation of hire dates made it unclear if the provider was in compliance with training and background check requirements. Surveyor collected additional information and determined the hire date on the roster was not accurate, and based on the accurate hire date, there were were deficiencies in both areas for Caregiver Q (and for Caregiver C.) Further review of the records revealed concerns with Caregiver Q's Background Information Disclosure (BID) forms. BIDs are required to be filled out by the employee at hire and every 4 years to disclose information relevant to their residence in the prior 3 years, criminal history and caregiver misconduct history. Administrator E provided Surveyors BIDs for Caregiver Q dated 11/16/2020 and 06/03/2026. Surveyor observed the handwriting in all sections of both BIDs and the signatures of both BIDS were identical and the only change was the date. Surveyor noted the signature and date section of the form is immediately preceded by a statement that reads, "I have completed and reviewed this form...and affirm that the information is true and correct as of today's date."	N 214		

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N 214	Continued From page 16 Surveyor conducted an interview with Administrator E on 06/09/2026 at approximately 12:45 PM. S/he verified Caregiver Q's hire date listed on the roster was not accurate and the correct hire date was 11/19/2020. Administrator E also acknowledged on 06/03/2026 when Surveyors requested Caregiver Q's records, s/he photocopied and used the same BID from 2020. Administrator E stated s/he had Caregiver Q come in to his/her office and add the date of 06/03/2026 on the second BID. Surveyors asked Administrator E why s/he did not have Caregiver Q complete a new BID while s/he was in the office and Administrator E did not offer an explanation. Cross Reference: N0219 DHS 83.17(1) Licensee Conduct Caregiver Background N0239 DHS 830.20(2) (a-d) Department Approved Training Course N0277 DHS 83.25 Continuing Education N0348 DHS 83.32 (3)(d) Rights of Residents: Free From Mistreatment N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0356 DHS 83.32(3)(L) Rights of Residents: Least Restrictive Environment N0358 DHS 83.32(3)(N) Rights of Residents: Safe Environment N0387 DHS 83.35 (3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change N0393 DHS 83.35(3)(b) Initial Evaluation of Evacuation Limits N0409 DHS 83.37(1)(j) Proof-Of-Use-Record N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring	N 214		

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N 214	Continued From page 17 N0432 DHS 83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0448 DHS 83.41(2)(a) Nutrition: Diet N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, Comfortable and Homelike N0525 DHS 83.47(2)(d) Fire Drills N0533 DHS 83.47)(5) Smoking Policy N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperatures N0653 DHS 83.59(4)(d)) Delayed Egress Irreversible Process	N 214		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a caregiver background check was completed for Caregiver Q every 4	N 219		

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N 219	Continued From page 18 years. Caregiver Q was hired on 11/20/2020 and an updated caregiver background check was not completed until 06/03/2026. Findings include: On 06/03/2026 at 2:10 PM, Administrator E provided Surveyor with a portion of Caregiver Q's employee records which indicated s/he was hired on 11/20/2020. The partial records contained a caregiver background check dated 11/19/2020 and a second background check dated 06/03/2026. On 06/09/2026 at 12:44 PM, Surveyor reviewed Caregiver Q's complete employee record. No other background check documentation was located in the record. Administrator E was present during the 06/09/2026 record review. Administrator E confirmed Caregiver Q was hired in November 2020 and a background check was not completed every 4 years. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(N) Rights of Residents: Safe Environment	N 219		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they	N 239		

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N 239	Continued From page 19 contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver C received fire safety training within 90 days after starting employment. Findings include: On 06/09/2026 at 12:33 PM, Surveyor reviewed Caregiver C's complete employee record. The record indicated s/he was hired on 10/23/2023 and did not contain evidence s/he received Department approved training in fire safety. On 06/09/2026, Surveyor searched the CBRF (community based residential facility) training registry to verify compliance with Department approved training in fire safety. The results did	N 239		

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N 239	Continued From page 20 not indicate Caregiver C received Department approved training in fire safety. Administrator E was present during the 06/09/2026 record review. Administrator E confirmed Caregiver C was hired in October 2023. S/he acknowledged Surveyor's review of the record and did not offer additional evidence of Department approved training in fire safety or indicate Caregiver C qualified for an exemption for the training. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 239		
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. This Rule is not met as evidenced by: Based on record review and interview, Caregiver C and Caregiver Q did not receive continuing education training in any topics during 2024 or 2025.	N 277		

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N 277	Continued From page 21 Findings include: On 06/09/2026 at 12:33 PM, Surveyor requested and reviewed Caregiver C's complete employee record for compliance with continuing education requirements. The roster indicated Caregiver C's hire date was 12/24/2025, however other portions of the record indicated Caregiver C was hired 10/23/2023. Administrator E was present during the record review and confirmed the correct hire date was 10/23/2023. Caregiver C's record did not contain evidence of continuing education training during 2024 or 2025 in any of the 6 required topics; (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. On 06/09/2026 at 12:44 PM, Surveyor requested and reviewed Caregiver Q's complete employee record for compliance with continuing education requirements. The record indicated Caregiver Q was hired in 11/20/2020. Administrator E was present during the record review and confirmed Caregiver Q was hired in November of 2020. Caregiver Q's record did not contain evidence of continuing education training during 2024 and 2025 in any of the 6 required topics; (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. During the exit conference with Licensee F and Administrator E on 06/09/2026 beginning at 4:18	N 277		

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N 277	Continued From page 22 PM, Surveyor reviewed the findings based on the review of Caregiver C and Caregiver Q's training records. Licensee F and Administrator E did not provide additional information or evidence to indicate continuing education was provided during 2024 and 2025. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(N) Rights of Residents: Safe Environment	N 277		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure all residents were free from mistreatment, neglect and verbal abuse. On 06/03/2026 and 06/09/2026, interviews with 3 residents revealed concerns of misconduct, including neglect and verbal abuse. All 3 interviews reported verbal abuse, 2 reported the third shift caregiver was sleeping or passed out	N 348		

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and 1 reported a caregiver refused to provide care. The resident interviews consistently identified Caregiver D as the responsible party. The reported misconduct impacted 5 of 8 residents who reside in the facility; Resident 2, Resident 3, Resident 6, Resident 7 and Resident 8.

Findings include:

MISTREATMENT INCLUDING VERBAL ABUSE, STAFF SLEEPING AND STAFF REFUSING CARE

The Department received a complaint alleging residents were being mistreated.

Resident 7: Surveyor interviewed Resident 7 on 06/03/2026 at 10:45 AM and asked if staff are kind and respectful. Resident 7 said, "I've had a couple that's been mean and condescending. The one is not so nice...I don't know their name...I ignore them and put it out of my mind."

Resident 2: Surveyor interviewed Resident 2 on 06/03/2026 at 12:25 PM. S/he said, "I don't like living here." S/he said Caregiver D "screams at people...I can hear [him/her] screaming at the other resident there (pointing to Resident 6's room) all the time. [S/he] screams at [him/her] and that disturbs me...They don't deserve that. It's almost like they didn't go to school and learn" how to treat residents. S/he pointed out residents "have disabilities" and it's inappropriate for staff to "scream at them." On 06/05/2026, Administrator E provided Surveyor with medical visit notes for Resident 2. Nurse Practitioner (NP) H authored a visit note 02/25/2026 which read, "reports staff has 'been screaming at [him/her].'" Surveyors conducted a return visit on 06/09/2026 and

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interviewed Resident 2 at 11:43 AM. S/he volunteered, "Some of the staff people here was [sic] kind of mean to me." Resident 2 explained s/he was referring to Caregiver D. S/he described Caregiver D as "cranky and mean" and said, "I don't like [him/her]...[S/he] was not really nice to me. [S/he] screamed at me." Resident 2 also volunteered there are, "people sleeping...on the couch...while they are supposed to be working."

Surveyors reviewed staff schedules provided by Administrator E on 06/03/2026 and noted 1 caregiver is scheduled for third shift , with a float caregiver for all 4 facilities on the campus.

Surveyor interviewed NP H on 06/08/2026. S/he verified the information in his/her visit note regarding Resident 2's report of staff screaming at him/her. NP H said s/he also shared the information verbally with Administrator E. NP H said s/he hasn't witnessed screaming, but "I will see them (caregivers) raise their voice once in a while." NP H expressed concern about caregiver reports of Resident 2's confusion and/or behaviors and said, "I think a lot of it is approach. [S/he] doesn't do well when someone is mean or yelling or telling [him/her what to do. I wouldn't like it either."

Resident 3: Surveyors interviewed Resident 3 on 06/03/2026 at 1:02 PM. S/he said "It makes me mad when other people aren't treated correctly, it's been an awful experience since the day I got here (admission date 04/24/2026).[Caregiver D] yells...like for example there is [Resident 8] who has autism. [Caregiver D] will sit there and yell, and I mean yell at [him/her]." Resident 3 said s/he understands Resident 8 is repetitive due to his/her autism, but the way s/he and other residents are treated is unacceptable. Resident 3

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also said Caregiver D yells and swears at Resident 6 and tells him/her to "shut up."

During a follow up interview with Resident 3 on 06/09/2026 at 1:45 PM, s/he volunteered additional concerns that had occurred since Surveyors were last onsite. Resident 3 reported s/he observed Caregiver D two separate times during the night shift, passed out cold in the living room snoring, with an open can of "Steel Reserve" (an American lager known for its high alcohol content) in front of her/him. Resident 3 went on to say, "During this past weekend (06/06/2026-06/07/2026), I needed assistance with wiping myself after having a bowel movement. [Caregiver N] came into the bathroom while I was on the toilet to put lotion on my legs. [Caregiver N] told me [s/he] could not assist me with wiping because [s/he] had to leave to pick up [her/his] child, but [Caregiver D] was available to help." Resident 3 reported Caregiver D refused to help her/him and consistently refuses to assist her/his with ADL's (Activities of Daily Living). Resident 3 stated s/he had not reported the above concerns because s/he feels the concerns would be ignored due to familial relationships among the staff.

On 06/09/2026 during the exit conference with Administrator E and Licensee F beginning at 4:15 PM, Surveyors shared concerns of Caregiver D being verbally abusive and sleeping during third shift. The managers denied previous knowledge of the concerns. Surveyors reviewed with Administrator E and Licensee F of the regulatory requirements to protect residents and conduct investigations into the information provided by Surveyors.

In conclusion: Surveyors conducted interviews

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N 348	Continued From page 26 with 3 residents who consistently reported concerns of verbal abuse by Caregiver D. In addition, 2 of the 3 resident interviews reported neglect (sleeping during third shift and refusing to provide care.) The reported misconduct impacted 5 of 8 residents who reside in the facility; Resident 2, Resident 3, Resident 6, Resident 7 and Resident 8. The resident interviews were corroborated in part by NP H. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 348		
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 residents received all prescribed medications in the dosages and at intervals prescribed by the practitioner. Medications for Residents 1, 2, 3, and 4 were documented as administered; however, the doses remained in their respective blister packs. Findings include: On 03/08/2026, the Department received	N 352		

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N 352	Continued From page 27 concerns regarding medication administration. On 06/03/2026 at 11:15 AM, Surveyor and Caregiver B observed the facility had one medication cart. Caregiver B explained the facility receives monthly medication blister packs with numbered compartments (1-31) to organize pills by the day of the month. Staff dispense medication by matching the date of the month to the corresponding compartment, then initial the eMAR (electronic medication administration record) within ECP. Caregiver B noted the current monthly cycle began on 05/22/2026 and ended on 06/18/2026. Resident 1 On 06/03/2026, Surveyor reviewed Resident 1's record which indicated, the resident was admitted to the facility on 06/22/2022 with diagnosis to include hypertension, bipolar disorder, and asthma. Additionally, the facility managed and administered all of Resident 1's medication. Resident 1 had physician's orders for, fluoxetine 10 mg capsule daily at 8 AM, enalapril maleate 20 mg tablet daily at 8 AM, amlodipine besylate 5 mg tablet at 8 AM, olanzapine 15 mg tablet at 8 PM, pravastatin sodium 20 mg at 8 PM, melatonin 3 mg tablet at 8 PM and docusate sodium 100 mg at 8 PM. On 06/03/2026 at approximately 11:30 AM, Surveyor observed the medication cart with Caregiver B. Surveyor observed Resident 1's eight (8) AM blister pack medication cards for fluoxetine 10 mg capsule and enalapril maleate 20 mg tablet. The following was noted: *The dose of fluoxetine remained in the card for 05/23/2026. The eMAR indicated the medication	N 352		

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was administered at 8 AM on 05/23/2026, but the medication remained in the blister pack.

*The dose of enalapril maleate and amlodipine besylate remained in the card for 05/22/2026, 05/24/2026 and 05/25/2026. The eMAR indicated the medications were administered on 05/22/2026 and 05/24/2026 despite the doses being present in the blister pack. Additionally, no documentation was present for the scheduled doses on 05/25/2026.

On 06/03/2026 at approximately 11:35 AM, Surveyor observed Resident 1's eight (8) PM blister pack medication cards for olanzapine 15 mg tablet, pravastatin sodium 20 mg tablet, melatonin 3 mg tablet and docusate sodium 100 mg capsule. The following was noted:

*The dose of olanzapine, pravastatin sodium, melatonin and docusate sodium remained in the blister pack cards for 05/22/2026, 05/23/2026, 05/24/2026 and 05/25/2026. The eMAR indicated the medications were administered on the above dates despite the doses being present in the blister packs.

Resident 2

On 06/03/2026, Surveyor reviewed Resident 2's record which indicated, the resident was admitted to the facility on 12/05/2025 with diagnosis to include hypertension, anxiety disorder, and gastroesophageal reflux disease. Additionally, the facility managed and administered all of Resident 2's medication. Resident 2 had physician's orders for famotidine 20 mg tablet at 8 PM, rosuvastatin calcium 5 mg tablet at 8 PM and quetiapine fumarate 12.5 mg tablet at 8 PM."

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N 352	Continued From page 29 On 06/03/2026 at approximately 11:40 AM, Surveyor observed the medication cart with Caregiver B. Surveyor observed Resident 2's eight (8) PM blister pack medication cards for famotidine 20 mg tablet, rosuvastatin calcium 5 mg tablet and quetiapine fumarate 12.5 mg tablet. The following was noted: *The dose of rosuvastatin calcium and quetiapine fumarate remained in the cards for 05/22/2026. The eMAR indicated the medications were administered on 05/22/2026 despite the doses being present in the blister packs. *The dose of famotidine remained in the card for 05/22/2026 and 05/23/2026. The eMAR indicated the medication was administered on 05/22/2026 and 05/23/2026 despite the doses being present in the blister packs. Resident 3 On 06/03/2026, Surveyor reviewed Resident 3's record which indicated, the resident was admitted to the facility on 04/24/2026 with diagnosis to include hypertension, diabetes and depression. Additionally, the facility managed and administered all of Resident 3's medication. Resident 3 had physician's orders for acetaminophen 325 mg tablet at 8 AM, atorvastatin 20 mg tablet at 8 AM, cefuroxime axetil 250 mg tablet at 8 AM, dicyclomine 20 mg tablet at 8 AM, 12 PM and 4 PM, ferrous sulfate 325 mg at 8 AM, lactobacillus tablet at 8 AM, levothyroxine 75 mcg tablet at 7 AM, lubiprostone 24 mcg capsule at 8 AM, metoprolol tartate 100 mg tablet at 8 AM, montelukast sodium 10 mg tablet at 8 AM, quetiapine fumarate 450 mg tablet at 8 AM, senna-dss 17.2/100 mg tablet at 8 AM, vitamin B-12 tablet at 8 AM, and vilazodone 20	N 352		

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N 352	Continued From page 30 mg tablet at 8 AM." On 06/03/2026 at 1 PM, Surveyors interviewed Resident 3. Resident 3 expressed concerns regarding missed medication doses. Resident 3 indicated medication omissions have occurred regularly since her/his admission. On 06/03/2026 at approximately 12:30 PM, Surveyor observed the medication cart with Caregiver B. Surveyor observed Resident 3's eight (8) AM blister pack medication cards for acetaminophen 325 mg tablet, atorvastatin 20 mg tablet, cefuroxime axetil 250 mg tablet, dicyclomine 20 mg tablet, ferrous sulfate 325 mg tablet, lubiprostone 24 mcg capsule, metoprolol tartate 100 mg tablet, montelukast sodium 10 mg tablet, quetiapine fumarate 450 mg tablet, senna-dss 17.2/100 mg tablet, vitamin B-12 tablet, and vilazodone 20 mg tablet. The following was noted: *The dose of acetaminophen, atorvastatin, cefuroxime, and montelukast sodium remained in the cards for 05/22/2026, 05/23/2026, 05/24/2026, 05/25/2026 and 05/26/2026. The eMAR indicated the medications were administered on the above dates despite the doses being present in the blister packs. *The dose of ferrous sulfate, metoprolol tartrate, omeprazole, quetiapine fumarate, senna-dss, lubiprostone, vilzazodone, lactobacillus and vitamin B-12, remained in the cards for 05/22/2026, 05/23/2026, 05/24/2026 and 05/25/2026. The eMAR indicated the medications were administered on the above dates despite the doses being present in the blister packs.	N 352		

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N 352	Continued From page 31 Surveyor observed Resident 3's eight (8) AM blister pack medication card for dicyclomine 20 mg tablet and noted the dose remained in the card for 05/22/2026 and 05/23/2026. The eMAR indicated the medication was administered at 8 AM on the above dates, but the medication remained in the blister pack. Surveyor observed Resident 3's noon (12) PM blister pack medication card for dicyclomine 20 mg tablet and noted the dose remained in the card for 05/22/2026, 05/23/2026, 05/24/2026, 05/25/2026, 05/26/2026, 05/27/2026, 05/28/2026, 05/29/2026 and 05/30/2026. The eMAR indicated the medication was administered at 12 PM on the above dates, but the medication remained in the blister pack. Surveyor observed Resident 3's four (4) PM blister pack medication card for dicyclomine 20 mg tablet and noted the dose remained in the card for 05/22/2026, 05/23/2026, 05/24/2026, 05/25/2026, 05/26/2026, 05/27/2026 and 05/28/2026. The eMAR indicated the medication was administered at 4 PM on the above dates, but the medication remained in the blister pack. Surveyor observed Resident 3's seven (7) AM blister pack medication card for levothyroxine 75 mcg tablet and noted the dose remained in the card for 05/22/2026, 05/23/2026, 05/24/2026, 05/25/2026 and 05/26/2026. The eMAR indicated the medication was administered at 7 AM on the above dates, but the medication remained in the blister pack. Resident 4 On 06/03/2026, Surveyor reviewed Resident 4's record which indicated, the resident was admitted	N 352		

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to the facility on 11/07/2020 with diagnosis to include hypertension, depression and anxiety disorder. Additionally, the facility managed and administered all of Resident 4's medication. Resident 4 had physician's orders for, acidophilus capsule at 8 AM, calcium 600 mg tablet at 8 AM, vitamin D3 2000 IU capsule at 8 AM, sertraline 50 mg tablet at 8 AM, D-Mannose 500 mg tablet at 8 AM, magnesium oxide 400 mg tablet at 8 AM, aripiprazole 5 mg tablet at 8 AM and mirtazapine 30 mg tablet at 8 PM."

On 06/03/2026 at approximately 11:45 AM, Surveyor observed the medication cart with Caregiver B. Surveyor observed Resident 4's eight (8) AM blister pack medication cards for acidophilus capsule, calcium 600 mg tablet, vitamin D3 2000 IU capsule, sertraline 50 mg tablet, D-Mannose 500 mg, magnesium oxide 400 mg tablet, and aripiprazole 5 mg tablet. The following was noted:

*The dose of acidophilus, calcium and D-Mannose remained in the blister pack cards for 05/22/2026 and 05/23/2026. The eMAR indicated the medications were administered on 05/22/2026, and 05/23/2026, despite the doses being present in the blister packs.

*The dose of vitamin D3 remained in the card for 05/22/2026, 05/23/2026, 05/24/2026, 05/25/2026 and 05/26/2026. The eMAR indicated the medication was administered at 8 AM on the above dates but the medication remained in the blister pack.

*The dose of magnesium oxide remained in the card for 05/22/2026, 05/23/2026 and 05/24/2026. The eMAR indicated the medication was administered at 8 AM on the above dates, but the

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medication remained in the blister pack.

*The dose of sertraline remained in the card for 05/23/2026 and 05/24/2026. The eMAR indicated the medication was administered at 8 AM on 05/23/2026 and 05/24/2026, but the medication remained in the blister pack.

*The dose of aripiprazole remained in the card for 05/22/2026. The eMAR indicated the medication was administered at 8 AM on 05/22/2026, but the medication remained in the blister pack.

On 06/03/2026 at approximately 11:55 AM, Surveyor observed Resident 4's eight (8) PM blister pack medication card for mirtazapine 30 mg and noted the dose of mirtazapine remained in the card for 05/23/2026, 05/24/2026 and 05/31/2026. The eMAR indicated the medication was administered at 8 PM on 05/23/2026, 05/24/2026 and 05/31/2026, but the medication remained in the blister pack.

On 06/03/2026 at 12:30 PM, Caregiver B verified the above medications for Residents 1, 2, 3, and 4 remained in the blister pack cards and were not administered. In addition, Caregiver B confirmed the residents' eMARs documented the medications were recorded as administered when they had not been.

During exit conferences on 06/03/2026 beginning at 4:45 PM and 06/09/2026 beginning at 4:15 PM, Surveyors met with Administrator E and Licensee F to discuss the above observations regarding Residents 1, 2, 3 and 4. Specifically, medications remaining in the blister packs, despite being documented as administered. Administrator E verified the residents' monthly medication cycle began on 05/22/2026 and ended on 06/18/2026.

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N 352	Continued From page 34 Administrator E confirmed staff should be dispensing medication from the blister cards by matching the card number with the current calendar date. On 06/09/2026 at 4:15 PM, Licensee E indicated after the 06/03/2026 exit conference with Surveyors they requested a meeting with all the medication passers. Licensee F stated, "The meeting was supposed to be today, but we will have to reschedule." No additional information was provided. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 352		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the least restrictive environment. The provider utilized restrictive signage and locked the doors to the kitchen, pantry and back patio. Resident access to food was further restricted due to the provider's system of storing food supplies offsite at sister facilities.	N 356		

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N 356	Continued From page 35 Findings include: RESTRICTED ACCESS TO FOOD AND THE KITCHEN On 06/03/2026 at 10:12 AM, Surveyors conducted a tour with Caregiver B, Surveyor observed the door to the kitchen (which led to the pantry) was locked. There were no snacks or food that was accessible to residents in the common area, other than what was in the kitchen and pantry. Caregiver B explained the door was typically kept locked because Resident 7 has dementia and tries to cook which is unsafe for him/her. At 10:50 AM, Surveyor interviewed Resident 7 who said, "I don't like to cook at all. Not even one bit." Resident 7 elaborated one of the things s/he likes about living in the facility is that s/he doesn't have to cook anymore. Administrator E provided Surveyor with portions of Resident 7's record on 06/03/2026 at 2:10 PM. This included the individual service plan and observation notes dating back to 04/01/2026. Resident 7 was admitted on 09/13/2025 with diagnoses to include anxiety disorder and unspecified alcohol induced distorter. The records did not document a history of wanting to cook or other safety concerns related to access to the kitchen or food. At 11:17 AM, Surveyor observed the kitchen door remained locked. Caregiver D tried to get into the kitchen, but Caregiver B had to use his/her keys to open the door. Again, no snacks or other food was accessible to residents. After Surveyors raised the concern about the	N 356		

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locked door, staff unlocked it and kept the door open, allowing free access to the kitchen. Surveyor observed Resident 7 spent most of the day sitting in the living room or dining room. Surveyors did not observe Resident 7 enter or try to enter the kitchen. Surveyor also made observations on 06/09/2026, from 11:00 AM until 3:00 PM, and Surveyor did not observe Resident 7 enter or try to enter the kitchen

During the aforementioned tour of the kitchen and pantry, Caregiver B explained 1 of 2 shelving units in the pantry and 1 entire freezer was dedicated to Resident 8 who eats a gluten free diet and his/her food is provided by family. Surveyor noted the remaining food supply for the other 7 residents was sparse.
--Pantry: 1 bag of onions, oatmeal, 1 box instant potatoes, 1 bag of rice, 1 box of pasta, 1 ranch dressing, 6 boxes of Jello and approximately 9 cans of soup or vegetables. In addition, there was 1 partial bag of bread and butter on the kitchen counter.
--Refrigerator: 1/2 gallon of juice, 1/2 pitcher of Kool Aid, 1/2 gallon of milk, 1/2 bag of sliced apples starting to brown, 1 package of lunch meat, condiments, onions and potatoes. There were also 2 containers of unlabeled/undated leftovers.
--Freezer: 1 frozen pizza.

During an interview with Caregiver D at 9:20 AM, s/he food staples, like butter and eggs are stored in the garage at a sister facility or in the pantry at a different sister facility. S/he said today, s/he was unable to make the french toast that was on the menu because there were no eggs in this building. Caregiver D said the garage at the sister facility is locked and the only people who have access to it are Staff A, Administrator E and

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Licensee F.

On 06/09/2026 during the exit conference with Administrator E and Licensee F beginning at 4:15 PM, Surveyors reviewed the aforementioned concerns. Licensee F stated, "Not every staff we have does cooking and does cooking well and we can't be forcing them to cook for the residents. Most of the cooking is done here [in Bethel Menasha III/sister facility]...That is why we store most of the meals and groceries here." Licensee F also described how this system helps avoid staff wasting food in the other buildings. Surveyors pointed out each facility is licensed separately and each should maintain an adequate supply and variety of food and snacks, instead of relying on staff from the sister facility to deliver upon request. Licensee F maintained the supply of food in each facility was adequate.

RESTRICTIVE SIGNAGE ON DOORS AND DOOR LOCKS

On 06/03/2026 at 9:12 AM, Surveyor observed the following:
--the door to the kitchen had a posted sign with an image of an open hand and the word, "STOP"
--the west hall door (identified as an exit door on the posted exit diagram) had 2 different signs posted; 1 sign had an image of an open had and the word, "STOP" and the other sign was an image of a stop sign with the word "STOP."

On 06/03/2026 at 10:28 AM, Surveyor observed the posted house rules. Surveyor noted they were restrictive in nature and required that residents "must" get along with each other, residents "must" notify staff if not attending a meal and "must" notify and receive advance "permission" to leave the home for home visits or other outside

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N 356	Continued From page 38 activities. On 06/03/2026 at 9:05 AM and 06/09/2026 11:22 AM, Surveyors observed access to the seating are on the back patio was restricted by 2 locking mechanisms on the door the lead from the dining room to the patio. The locks were engaged and were slide bolt style. They were positioned in locations that were difficult to reach for residents; one lock was approximately 12 inches from the floor and the other approximately 12 inches from the top of the door. On 06/03/2026, Caregiver D was present during the observation. S/he said "a couple years ago" there was a resident who was an elopement risk so Licensee F installed the locks. Caregiver D said there were no longer any elopement risks in the facility. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0450 DHS 83.41(2)(c) Nutrition: Menus	N 356		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.	N 358		

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N 358	Continued From page 39 This Rule is not met as evidenced by: Based on observation, record review and interviews, the provider did not ensure all residents were safeguarded from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the residents because of the residents' conditions or disabilities. On 06/02/2026, during the early morning hours, a fire occurred at the facility after Caregiver C went outside to smoke. Caregiver C's cigarette ignited a fire on the ground, resulting in significant fire damage to the facility's exterior wall and requiring a full evacuation of all residents. At the time of the incident the facility lacked a smoking policy, a designated smoking area and smoking receptacles. Subsequent interviews with residents indicated they suffered psychosocial harm as a result of the event. One week after the fire incident safety concerns persisted; unsafe smoking practices, lack of staff and resident training on the smoking policy, and an absence of smoking receptacles. Findings include: The facility received a regular license on 07/22/2020 as a Class CS (semi-ambulatory) facility which serves residents who are ambulatory or semi-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The facility is licensed to care for 8 residents with programming for residents including traumatic brain injury, developmentally disabled, terminally ill, advanced age, physically disabled, irreversible dementia/Alzheimer's and emotionally disturbed	N 358		

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and/or have mental illness. At the time of survey there were eight residents who lived in the home.

On 06/02/2026, the department received a facility self-report which indicated, "On 06/02/2026 at 12:45-1:00 AM, "[Caregiver C] went on a break and had the float come in and watch the building while [s/he] was on break. [S/he] went outside to smoke. The ash from [her/his] cigarette fell on the ground and on top of cottonwood that was on the ground and started a fire. Staff tried to put the fire out with the fire extinguishers [s/he] got from the building, but it spread so fast [s/he] quickly called the fire dept and also pulled the fire alarm in the house. [Caregiver C] and the float got the residents out of the house all within four minutes. They were taken to another building across the driveway. The fire dept got to the facility and checked over the facility and put the fire out within 15 minutes of arrival. The fire dept checked everything and said it was all clear and residents could go back in the building as there was no damage in the house or attic. The damage was on the outside wall of the building... All MCO's were updated, guardians were notified that everyone was safe...Incident Outcome: Fire was controlled and put out within 15 minutes of arrival of the fire dept. Residents were safe and were able to return back into the building after the fire. No smoke damage, no damage to inside of the building. Residents and fire dept staff were all safe. Action Taken to Ensure Resident's Health, Safety, and Well-Being: Staff will be re-trained on smoking policy, a smoking pole will be placed at the end of the entrance of every building for staff to use, staff will be suspended for 3 days, and all staff will have a in-service conducted on smoking policy..."

On 06/03/2026 at 8:00 AM, Surveyor reviewed

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N 358	Continued From page 41 Fox Crossing Police Department report 26-1347. The report read,"On Tuesday, June 2, 2026, at approximately 12:43 AM, I, [Officer K], responded to a fire call at Bethel Assisted Living, 1670 Century Oaks Ct...The reporting party stated there was smoke and flames on the outside of the building...I spoke with [Caregiver C]. I asked [Caregiver C] if [s/he] knew how the fire started and [s/he] replied yes. [Caregiver C] said [s/he] was smoking a cigarette outside when a piece of ash fell to the ground. [Caregiver C] said there was a lot of cottonwood seed on the ground which started the fire. This caused nearby bushes to start on fire, an ultimately the building..." On 06/04/2026 at 10:35 AM, Surveyor reviewed Fox Crossing Fire Rescue report 26-000686. The report indicated the primary incident type was "Fire-Structural Involvement." The report read, "On 06/02/2026 at 12:43 AM, Fox Crossing Fire Department was dispatched along with Auto-Aid units from Appleton Fire, Grand Chute Fire, Town of Neenah, and Gold Cross Ambulance for a structural fire at 1670 Century Oaks Ct. The caller reported a fire on the outside of the building and was in the process of evacuating the residents...Responded immediately emergent and diverted from another emergency call and responded emergent to this location...Arrived on location to find smoke and flames showing on the Alpha side of the structure...Pulled a handline and extinguished fire on the exterior of the building. Once initial knockdown was completed, crew transitioned to assisting facility staff with evacuation of the residents...Gold Cross Ambulance assisted facility staff with moving residents into the assisted living building next door...The owner was advised with the exception of some water damage to the ceiling of the room	N 358		

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N 358	Continued From page 42 adjacent to the fire there was no problems in any of the other rooms and residents could returned to their rooms. Building was turned over to the owner..." Observations On 06/03/2026 at 8:30 AM, prior to entering the building, Surveyors observed the front of the building. The exterior wall of the south wing showed significant fire damage. The vinyl siding above and around the windows were melted and warped, the sheathing/wood substrate beneath the siding was exposed near the soffit. There was soot staining and fire damage beneath the eaves and around the window openings. The shrubs directly in front of the south exterior wall were browned, scorched and partially dead. Surveyors also discovered numerous discarded cigarette butts and cigarette filters scattered throughout the gravel landscape in front of the building. Portions of the gravel landscape were covered in a thin layer of cottonwood seeds. Surveyors noted there were no smoking receptacles on the property. NOTE: According to NFPA (National Fire Protection Association) 101, 2012 Edition (Section 19.7.4), outlines specific smoking regulations in healthcare facilities, emphasizing safety requirements...4.) Ashtrays and Disposal: In areas where smoking is permitted, ashtrays made of noncombustible materials must be provided. Additionally, metal containers with self-closing covers for disposing of smoking materials should be readily available in these areas. On 06/03/2026 at 10:12 AM, Surveyor conducted a tour of the facility with Caregiver B. Surveyor	N 358		

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N 358	Continued From page 43 observed two (2) unmounted fire extinguishers, on the ground by the front door. Surveyor also observed the kitchen did not contain the required fire extinguisher. Caregiver B explained the fire extinguishers from the kitchen and laundry room were used during the fire and had not yet been refilled and returned to their original locations. On 06/09/2026 at 11:10 AM, prior to entering the building, Surveyors observed the facility grounds. Surveyors observed numerous discarded cigarette butts and cigarette filters scattered throughout the gravel landscape in front of the building. Surveyors noted there were no smoking receptacles on the property. On 06/09/2026 at 11 :15 AM, Surveyors observed Resident 3 sitting outside near the front entrance ramp smoking a cigarette. Surveyors interviewed Resident 3 about the facility's smoking policy and procedure. Resident 3 verified s/he had no knowledge of the smoking policy or designated smoking area and confirmed there were no disposal bins for cigarette butts. At 11:22 AM, Surveyor observed Resident 3 returning from smoking outside and discarding her/his cigarette butt in the kitchen trash can; this observation was verified by Caregiver B. Caregiver B stated, "[Resident 3] always throws [her/his] cigarette butt(s) away in the kitchen trash can or any trash can." On 06/09/2026 at 12:03 PM, Surveyor observed Resident 3 outside near the front entrance ramp, approximately fifteen feet from the building smoking a cigarette. At 12:08 PM, Surveyor observed Resident 3 returning from smoking outside and discarding her/his cigarette butt in the kitchen trash can.	N 358		

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Resident Interviews

On 06/03/2026 at 10:35 AM, Surveyor interviewed Resident 1 regarding the fire incident. Resident 1 reported staff entered her/his room during the night and instructed her/him to evacuate. Resident 1 was directed to the 'sister building' and stated, "It took almost two hours before I could return to my room."

On 06/03/2026 at 10:45 AM, Surveyor interviewed Resident 7. S/he recalled the fire and said someone woke him/her up and told him/her to "get out now." Resident 7 said, "I fell back asleep. Then it dawned on me. I jumped up and I put on the least amount of clothes I could find" and exited the building. Resident 7 added, "We didn't know what to do. We decided what we were gonna do, we were gonna run to the nearest building not on fire. The fire dept was already out there ripping down stuff. It was scary. I was a little bit traumatized." During a follow up interview with Resident 7 on 06/09/2026 at 11:31 AM, s/he reiterated that s/he smokes occasionally and stated no one from the facility has told him/her about a designated smoking area or where s/he should dispose of cigarette butts. Resident 7 said when s/he is done smoking, s/he brings the cigarette butts "back in the house and throws them in the trash." Resident 7 added, "We don't have a designated spot to dump them or anything."

On 06/03/2026 at 11:10 AM, Surveyor interviewed Resident 2 regarding the fire incident. Resident 2 stated, "The fire traumatized me. It was horrendous, we had to be evacuated in the middle of the night and had to walk to another building..." Resident 2 expressed ongoing distress seeing the fire residue from her/his

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N 358	Continued From page 45 bedroom window and it being a constant reminder of the event. Resident 2 reported s/he has observed several staff and residents smoking frequently in front of the building. During a follow up interview on 06/09/2026 at 11:31 AM, Resident 2 volunteered, "I'm not in a good mood. I'm just upset and worried about the fire, who started it and will it happen again." On 06/03/2026 at 1:02 PM, Surveyors interviewed Resident 3. Resident 3 told Surveyors s/he smokes outside in front of the facility but brings his/her extinguished smoking materials back inside to put in the garbage can. S/he pointed out to surveyors there were no receptacles outside to dispose of smoking materials. During the interview, Resident 3 recalled the fire on 06/02/2023 and indicated there was a large accumulation of white cottonwood fluff on the ground that resembled snow. Resident 3 stated, "[Caregiver C] had been outside smoking and flicked a cigarette into a pile of the cottonwood, causing it to catch fire and spread quickly." Resident 3 reported being awoken at approximately 1:00 AM by two firefighters who instructed her/him to evacuate using her/his wheelchair. Resident 3 indicated the fire was "very triggering" causing her/him emotional distress due to past trauma; her/his family member died in a fire, and her/his grandparents home was destroyed by a fire, which was her/his safe place. During a follow up interview on 06/09/2026 at 11:10 AM, Resident 3 reported s/he had no knowledge of the facility's smoking policy or designated smoking area and confirmed there were no smoking receptacles for her/his to discard her/his cigarette butts. Staff Interviews	N 358		

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N 358	Continued From page 46 On 06/03/2026 at 9:23 AM, Surveyors asked Administrator E about the fire incident. Administrator E stated, "We more or less had a fire incident that did damage to the outside of building. Everyone was out in around four minutes, under four minutes actually. Staff got residents to another building...It took the fire department 15 minutes to get the fire out." Surveyors then asked how the fire occurred. Administrator E stated, "[Caregiver C] had the float come over to watch the building while [s/he] was on break. [Caregiver C] went outside to smoke and apparently the tip of the cigarette fell on the ground and a fire started because it landed on the fuzzy white stuff out there and ignited." Surveyors then asked Administrator E if residents and staff were allowed to smoke on facility grounds. Administrator E indicated staff and residents were allowed to smoke on facility grounds in the middle of the front parking lot away from the house or in their cars. When questioned about the facility's smoking policy, Administrator E noted the current smoking policy and procedure was developed on 06/02/2026, in response to the fire. Administrator E verified an official smoking policy did not exist before the incident and training for all staff regarding the new policy was scheduled to occur "soon." Surveyors questioned when staff training was going to take place. Administrator E stated, "It's gonna be next week sometime, I'm trying to get everything situated." Surveyors pointed out to Administrator E there were no smoking receptacles on the property. Administrator E confirmed and stated, "We ordered some and they should be here Friday (06/05/2026)." Surveyors shared the observations of numerous discarded cigarette butts and cigarette filters scattered throughout the gravel landscape in front of the building. Administrator E stated, "Right,	N 358		

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that's why we are getting the receptacles." Surveyors then asked if the fire incident affected the residents in any way. Administrator E stated, "They were fine. They were having fun with the whole thing, they wanted to get marshmallows out and have s'mores."

On 06/03/2026 at 8:51 AM, Surveyors interviewed Caregiver D. Surveyors asked if residents and staff were allowed to smoke on facility grounds. Caregiver D stated, "Yes." Surveyors then asked where smoking was allowed or if the facility had a designated smoking area. Caregiver D stated, "In the back of the building. When I smoke I go out back on the porch. I've never been told about a designated area. [Licensee F] told me if I'm gonna smoke go out back on the patio, but I was doing that before [s/he] told me." Surveyors questioned if the facility provided smoking receptacles to discard the cigarettes butts. Caregiver D stated, "We're talking to [Administrator E] about that, this is the only building that doesn't have a place to throw away your cigarettes butts...Now especially since the fire I think they're going to put out non-combustible containers." Surveyors asked Caregiver D how s/he disposes of her/his cigarette butt(s). Caregiver D stated, "I put mine out, make sure nothing is lit and I throw the cigarette butt in the kitchen trash can or flush it down the toilet to be safe."

On 06/09/2026 at 11:25 AM, Surveyor asked Caregiver B if smoking was allowed on the facility grounds. Caregiver B confirmed smoking was allowed by staff and residents and said the designated smoking area was "on the back patio." Caregiver B said around the time of the fire on 06/02/2026, the cottonwood trees on the property near the back porch were releasing their

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N 358	Continued From page 48 seeds and the ground was covered with it. S/he said that is what caused the fire on 06/02/2026. Surveyor observed the back patio during the interview, and there were no receptacles for disposing of smoking materials. On 06/09/2026 at 4:15 PM, during the exit conference with Administrator E and Licensee F. The above information was shared. Licensee F indicated they ordered smoking receptacles from Amazon on 06/02/2026, which arrived on 06/05/2026 but were too small. Licensee F indicated they intend to return the small smoking receptacles and purchase larger ones. Licensee F reported the fire extinguisher from the hallway was moved to the kitchen until the used fire extinguishers are refilled by the service company. Licensee F and Administrator E were questioned about staff training to address the smoking policy and fire safety. Administrator E provided a "Meeting Sign-In Sheet" for staff at all Bethel Assisted Living facilities. The "Meeting Sign-In Sheet" listed several operational and safety topics including Fire drills and Fire safety to be addressed during a 06/05/2026 meeting. Surveyors noted signatures from staff at sister facilities rather than staff listed on the facility staff roster. The facility's staff roster included a total of fourteen (14) staff who worked in the building. Only one of the 14 staff listed on the facility staff roster signed the sheet to verify their presence and acknowledgement of these protocols. When questioned Administrator E confirmed the training was incomplete, stating, "Staff still have to meet with me...I'm not done with all staff training." Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0525 DHS 83.47(2)(d) Fire Drills	N 358		

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N 358	Continued From page 49 N0533 DHS 83.47(5) Smoking Policy	N 358		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the legal representatives for Resident 7 and Resident 2, were involved the development of their individual service plans (ISPs). Findings include: On 06/08/2026 at 11:34 AM, Surveyor conducted an interview with Resident 7's legal representative, Family S. Family S said Resident 7 was admitted in September 2025 and s/he "found it difficult to get in contact" with	N 387		

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N 387	Continued From page 50 Administrator E for care planning. S/he explained, "It wasn't until our first care planning with (the managed care organization -MCO) that I signed a lot of backdated paperwork from [Resident 2]'s original admittance...[Administrator E] wasn't available when [Resident 2] moved in and several months later when we finally met, we rolled it all into one big meeting" with the facility and the MCO. On 06/09/2026 beginning at 12:56 PM, Surveyor reviewed resident records. Administrator E was present and stated s/he is responsible for ISP development. Resident 7's record indicated s/he was admitted on 09/13/2025. The first comprehensive ISP (required within 30 days of admission) signed by Family S was 01/23/2026; four months after admission. Surveyor also reviewed Resident 2's record. S/he was admitted on 12/05/2025, was protectively placed by the courts and had a legal guardian. Resident 2's record did not contain an ISP signed by the guardian acknowledging their involvement in, understanding of and agreement with the plan. On 06/09/2026 beginning at 4:18 PM, Surveyors conducted an exit conference with Licensee F and Administrator E and reviewed the aforementioned concerns. Administrator E did not provide additional information. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change	N 387		

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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, observation and interview, the provider did not ensure Resident 6 and Resident 7's individual service plans (ISPs) were updated when there were changes in needs or mental condition, to identify the change and the associated interventions the provider would offer to meet the residents' needs. Resident 6's ISP was not updated to identify meal refusals, an emergency room visit for dehydration and weight loss of 28 lbs in 30 days or the interventions the provider would offer to encourage acceptance of meals/fluids and monitor Resident 6's intake. Resident 7's ISP was not updated to identify tendencies to refuse medications or associated interventions caregivers could use to encourage acceptance of medications. Resident 7's ISP	N 389		

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N 389	Continued From page 52	N 389		

identified his/her tendency to refuse showers and to display behaviors, but did not identify the interventions the provider would offer to meet Resident 7's needs in those areas.

Findings include:

RESIDENT 6

Surveyor reviewed portions of Resident 6's record, provided by Administrator E on 06/03/2026 at 2:10 PM and 06/05/2026 at 4:17 PM. The records included his/her face sheet, observation notes, after visit summaries/notes and the current ISP.

Resident 6 was admitted 06/30/2021 and had diagnoses to include schizophrenia, starvation ketoacidosis, intellectual disabilities and severe protein-calorie malnutrition.

The record indicated Resident 6 was sent to the emergency room on 03/17/2026 "due to dehydration."

Visit notes authored by NP H read:
--03/25/2026, "Staff report concerning behavioral changes including...refusal to eat and drink...Current recorded weight 246.6 lb."
--04/22/2026, "28 lb. weight loss this interval...Current recorded weight 217.0 lb."

Observation notes dating back to 04/01/2026 documented s/he refused meals on 04/15, 04/16, 04/17, 05/06 and 05/15.

Resident 6 was admitted to the hospital on 05/18/2026 due to continued behavioral changes.
--05/22/2026 discharge summary recorded a weight of 218.7 lb.

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N 389	Continued From page 53 Resident 6's ISP current as of 06/03/2026, was silent to his/her pronounced weight loss and meal refusals. The ISP did not identify interventions to encourage acceptance of meals/fluids or to monitor weight or food/fluid intake. On 06/09/2026 at 8:19 AM, Surveyor interviewed Nurse Practitioner (NP) H. NP H confirmed Resident 6 was hospitalized in May 2026 due to escalating behavioral symptoms, including paranoid delusions and the belief that food was poisoned. NP H stated to his/her knowledge, the provider did not have defined strategies to encourage meal acceptance or monitor intake and acknowledged these interventions would be beneficial for Resident 6. RESIDENT 7 Medications Surveyor interviewed Resident 7 on 06/03/2026 at 10:50 AM. Resident 7 said staff assist him/her with medications and volunteered concerns. S/he explained s/he is forgetful and s/he would like the caregivers explained "what I'm taking and what I'm taking for." Resident 7 said caregivers don't do that unless s/he refuses to take the medications. Resident 7 said, "They get frustrated. If they just reminded me every week or so...that would help a lot." Surveyor reviewed portions of Resident 7's record, provided by Administrator E on 06/03/2026 at 2:10 PM and 06/05/2026 at 4:17 PM, including his/her April and May 2026 medication administration records (MARs),	N 389		

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observation notes dating back to 04/01/2026 and the current ISP.

MARs:
--April; refusals documented on 4/11, 4/27, 4/28 and 4/30
--May; refusals documented on 05/01, 05/05, 05/06, 05/08 and 05/15

On 06/08/2026 at 11:34 AM, Surveyor interviewed Resident 7's legal representative, Family S. Family S stated sometimes caregivers either don't have or don't take the time to explain Resident 7's medications to him/her, and s/he thinks it is an intervention that could be helpful in reducing Resident 7's refusals.

Resident 7's ISP was silent to the tendency to refuse medications or interventions to increase his/her acceptance or medications.

Behaviors
--An observation note dated 05/23/2026 read, "Resident was yelling...and another resident asked [him/her] to stop but [s/he] refused, I also instructed [him/her] to calm down and return to [his/her] room but [s/he] did not comply. [S/he] then attempted to engage in a physical altercation with the other resident. When [s/he] tried to approach the resident, I prevented [him/her] from moving forward, at that point [s/he] began pushing me with [his/her] walker. [Administrator E] was notified."

--Surveyor observed Resident 7 and Resident 6 yelling at each other in the living room on 06/03/2026 at 4:03 PM.

Resident 7's ISP read, "very angry when being redirected due to aggressive behaviors towards

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staff and other residents. [S/he] tried [sic] to [parent] the residents." The ISP did not identify interventions to prevent or respond to behaviors.

Showers
Observation notes (quoted as written):
--04/04: "staff has been asking resident if [s/he] wanted a shower resident has refused..."
--05/29: "res pee in the kitchen was told to come out and have a shower and [s/he] got agitated with staff approached x2 third approach was actually made by [Family S]...also had no luck with getting res to shower."
--05/30: "res was wet and approached res x4 to assist with shower [s/he] refused every time"

During the aforementioned interview with Family S, s/he confirmed Resident 7 refuses showers and questioned whether staff are using effective approaches to encourage acceptance. Family S said, " I think that it is again, the skill and demeanor and commitment level of the staff who are encouraging or helping [him/her]."

On 06/09/2026 at 8:19 AM, Surveyor interviewed NP H and Surveyor asked about refusals of medications and showers. NP H replied, "I'm sure it's approach. [S/he] does like to stay in bed, but when I wake [him/her], [s/he] is polite with me, not mad that I woke [him/her]. Showers in general and cares in general are very questionable (at the facility) and said sometimes Resident 7 has a strong odor." NP H said s/he believes staff need training on how to better approach residents.

Resident 7's ISP read, "Bathing: document all refusals as [s/he] will refuse to shower and stay in [his/her] wet depends and will urinate all over the floor. [S/he] will refuse to change [his/her] clothes and depends when soiled." The ISP did not

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N 389	Continued From page 56 identify interventions to encourage acceptance of cares or showers. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0356 DHS 83.32(3)(l) Rights of Residents: Least Restrictive Environment N0431 DHS 83.38(1)(g) Health Monitoring N0433 DHS 83.38(1)(i) Behavior Management	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident was evaluated using the Department approved Resident Evacuation Assessment form within 3 days of admission, or at any subsequent point, to determine whether the resident is able to evacuate the facility within 4 minutes without any help or verbal/physical prompting, and what types of limitations the residents may have that prevent	N 393		

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N 393	Continued From page 57 the resident from evacuating within the applicable period of time. Three (3) of 3 records reviewed did not contain evidence the evaluations were completed. Findings include: On 06/09/2026 beginning at 12:56 PM, Surveyor met with Administrator E and reviewed records for 3 residents that were maintained in paper form.. --Resident 6 was admitted on 06/30/2021. The record did not contain documentation of an evacuation evaluation assessment. --Resident 7 was admitted on 09/13/2025. The record did not contain documentation of an evacuation evaluation assessment. --Resident 2 was admitted on 12/05/2025. The record did not contain documentation of an evacuation evaluation assessment. Surveyor informed Administrator E the records did not include the Resident Evacuation Assessment forms and requested the evaluations for all 8 residents currently residing in the facility. Administrator E began looking in ECP (electronic record system.) Surveyor asked Administrator E if the evaluations were maintained in ECP or in the paper records. S/he replied, "Either or." Administrator E then printed one Resident Evacuation Assessment form from ECP for Resident 8, looked through some stacks of papers on and near his/her desk and said, "I'm not sure where they're at. I'm going to have to re-do everybody's." Administrator E confirmed s/he did not have evidence to show the Resident Evacuation Assessment forms were completed for Residents 1-7.	N 393		

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N 393	Continued From page 58 Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment N0525 DHS 83.47(2)(d) Fire Drills	N 393		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the proof-of-use record for Resident 3's scheduled II medication was accurate and audited on a daily basis. Findings include: According to www.deadiversion.usdoj.gov/drug_chem_info/Oxycodone.pdf, dated 09/2025 indicated, "Oxycodone is a schedule II narcotic analgesic and is widely used in clinical medicine...Illicit Uses: Oxycodone abuse has been a continuous problem in the U.S. since the early 1960s. Oxycodone is abused for its euphoric effects."	N 409		

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N 409	Continued From page 59 On 06/03/2026, Surveyor reviewed Resident 3's record. Resident 3 had a physician's order written on 04/28/2026 for, "Oxycodone HCl 5 mg tablet every eight hours as needed for acute severe pain." On 06/04/2026, Surveyor received the delivery receipt from the facility pharmacy dated 04/28/2026. The delivery receipt indicated on 04/28/2026 ninety (90) Oxycodone HCl 5 mg tablets were delivered to the facility for Resident 3. The delivery receipt was signed by Caregiver G. On 06/03/2026 at 12:20 PM, Surveyor noted the facility had a paper and electronic proof-of-use record for Resident 3's Oxycodone 5 mg tablets. Resident 3's paper proof-of-use record for Oxycodone HCl 5 mg tablets indicated the start of eighty-three (83) tablets on 05/13/2026, when ninety (90) tablets were delivered on 04/28/2026. Surveyor also noted the following discrepancies with Resident 3's paper proof-of-use record: ~Staff did not record the time the medication was given on 05/16/2026, 05/18/2026, 05/21/2026, 05/22/2026, 05/25/2026, and 05/29/2026. ~On 05/29/2026 the count revealed 74 tablets remained. The next line showed an ending balance of 70 tablets remaining. The count dropped from 74 tablets to 70 tablets, without any documentation indicating the date, time, staff initials, the amount used or wasted, leaving three tablets unaccounted for. ~The last count entered on the proof-of use record revealed an ending balance of 67 tablets (a drop of three tablets from the prior line of 70) and contained no documentation indicating the date, time, staff initials, the amount used or wasted, leaving an additional three (3) tablets	N 409		

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N 409	Continued From page 60 completed unaccounted for. Note: Resident 3's paper proof-of-use record revealed several documentation failures and an unexplained deficit of six (6) Oxycodone tablets. In addition, the paper proof-of-use record did not have evidence daily audits of the counts were conducted. Resident 3's electronic proof-of-use record for Oxycodone HCl 5 mg indicated ninety (90) tablets were received from the pharmacy on 04/28/2026. A duplicate inventory entry recorded by Administrator E on 04/28/2026, resulted in an incorrect documented inventory of 180 tablets. Between 04/28/2026 through 05/08/2026, four tablets were documented as administered. On 05/13/2026, Administrator E deducted 93 tablets from the count to correct the duplicate inventory resulting in a documented balance of 83 tablets. After the correction of the duplicate entry the remaining balance should have been 86 instead of 83, resulting in three tablets being left unaccounted for. On 06/01/2026, Administrator E deducted six (6) tablets from the count, dropping the count from 73 to 67, without any documentation indicating when the tablets were administered or who administered the tablets. In addition, the electronic proof-of-use record for Resident 3's Oxycodone medication did not contain evidence daily audits of the counts were conducted. On 06/03/2026 at approximately 2:00 PM, Surveyors interviewed Administrator E regarding Resident 3's electronic proof-of-use record for the Oxycodone medication. Administrator E confirmed the pharmacy delivered ninety (90) tablets of Resident 3's Oxycodone medication on 04/28/2026 and no additional tablets were	N 409		

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N 409	Continued From page 61	N 409		

delivered to the facility. Administrator E verified s/he deducted ninety-three (93) tablets from the count on 05/13/2026 to correct the inventory because the pharmacy sent ninety (90) tablets, not 180 tablets. However, Administrator E did not provide a reason for the deduction of the three (3) additional tablets s/he deducted on 05/13/2026. When Surveyor questioned Administrator E about the six (6) tablets s/he deducted from the count on 06/01/2026, Administrator E explained s/he adjusted the count as a corrective measure to ensure the proof-of-use record accurately reflected the physical inventory remaining in the cards.

Note: On 06/03/2026, the paper proof-of-use record indicated 67 tablets remaining, while the electronic proof-of-record showed 66 tablets. Both proof-of use records were inconsistent with the actual observed inventory on 06/03/2026 of 64 tablets.

On 06/09/2026 at 4:15 PM, during the exit conference, Surveyors shared the above information with Administrator E and Licensee F. Administrator E acknowledged the proof-of-use records did not contain evidence daily audits were completed. Administrator E indicated due to issues with the electronic narc counts, s/he implemented a new policy on 02/06/2026 for staff to document the count every shift on the 'Shift-to-shift Narc Count' log in the narc binder. Administrator E stated staff were expected to fill out the 'Shift-to-shift Narc Count' log every shift to ensure audits were completed daily. Surveyor then shared the 'Shift-to-Shift Narcotic Count' log was found to be incomplete, with multiple days of missing counts and multiple shifts without staff signatures. No additional information was provided by Administrator E or Licensee F.

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N 409	Continued From page 62 Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	N 409		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure residents were provided a structured daily activity program to meet the interests and capabilities of the residents. Interviews with 4 residents, 1 staff and 1 visiting medical provider consistently indicated activities are not provided. During 2 of 2 onsite visits, Surveyors did not observe staff engage residents in the activities listed on the calendar, or in any other activities.	N 427		

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N 427	Continued From page 63 Findings include: The posted activity calendar listed the following for 06/03/2026: --8:00 AM: sit n fit --10:00 AM: balloon ball toss --2:00 PM: better get outside During the onsite visit on 06/03/2026, Surveyors did not observe any of the aforementioned activities. Throughout the day, residents were in the common area watching TV. Interviews consistently indicated activities do not occur. On 06/03/2026 at 9:20 AM, Surveyors interviewed Caregiver D. S/he said Caregiver A used to do activities with residents, but s/he had not been around lately. Caregiver D said s/he did not complete the "sit n fit" activity" scheduled for 8:00 AM and said s/he can't conduct activities when working at the facility alone. On 06/03/2026 at 10:28 AM, Surveyor interviewed Resident 1. S/he stated, "Typically we sit in the living room and watch what's on the TV. [Caregiver A] sometimes does activities with us, but [s/he's] not here often." Surveyor showed [Resident 1] the facility's posted June 2026 activity calendar and asked if s/he would participate in the activities listed on the colander. [Resident 1] confirmed s/he would participate in the listed activities; however, [s/he] verified no such activities took place on 06/01/2026, 06/02/2026, or the morning of 06/03/2026. On 06/03/2026 at 10:50 AM, Surveyor interviewed Resident 7. S/he said they "mostly	N 427		

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watch TV" but s/he would like to participate in an activity like exercise.

On 06/03/2026 at 11:10 AM, Surveyor interviewed Resident 2 and s/he reported a lack of scheduled activities at the facility. Resident 2 explained residents generally spend their time watching TV in the living room. When shown the June 2026 activity calendar, [Resident 2] expressed a willingness to engage in the activities listed on the June 2026 calendar. Resident 2 verified no activities occurred during the period of 06/01/2026 through the morning of 06/03/2026 and stated, "No activities occur here. There's not enough staff to do activities."

On 06/03/2026 at 11:28 AM, Surveyor interviewed Resident 6. Resident 6 said there have not been activities in a while since Caregiver A doesn't come to this facility anymore. Resident 6 said s/he'd love to do activities like Bingo or Yahtze. On 06/03/2026 at 2:10 PM, Administrator E provided Surveyor with Resident 6's individual service plan (ISP). The ISP identified Resident 6 had mental health diagnoses and displayed behaviors. The ISP noted "not having enough attention" and "boredom" were triggers for behaviors.

On 06/09/2026 at 8:19 AM, Surveyor interviewed Nurse Practitioner (NP) H. NP H said s/he has several patients at the facility and s/he visits monthly. NP H said outside of holiday parties, s/he has "never" observed staff engaging residents in activities.

On 06/09/2026, from 11:00 AM until 3:00 PM, Surveyor made observations while in the facility. Residents were observed in the living room watching television. No other activities were

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N 427	Continued From page 65 provided or made available by staff during the four-hour observation. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0433 DHS 83.38(1)(i) Behavior Management	N 427		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a 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.	N 431		

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This Rule is not met as evidenced by:
Based on interviews and record review, the provider did not make necessary arrangements for therapy services or document communication with the resident's physician and other health care providers for Resident 3 and Resident 6.

Resident 3 was admitted to the facility on 04/24/2026 with orders for PT (Physical Therapy) and OT (Occupational Therapy) to evaluate and treat. Despite these orders and a follow-up order on 05/26/2026, no referrals had been made at the time of the survey. Resident 3 had been at the facility for over forty (40) days without receiving any therapy evaluations or services.

Resident 6 was discharged from a 4 day hospital admission on 05/22/2026. The discharge instructions were to be seen for a "wound recheck" in 3 days. As of 06/09/2026, the resident had not been seen by his/her primary care provider or another provider and the ISP was not updated to identify the change or interventions to monitor the wound.

Findings include:

RESIDENT 3

On 06/03/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 04/24/2026 and had diagnoses to include muscle weakness, lymphedema, diabetes, and anxiety. Resident 3 was alert and oriented and her/his own decision-maker. Admission orders signed by Resident 3's physician on 04/24/2026 outlined the need for PT and OT for evaluation and treatment. There was no evidence the facility sent a referral or made arrangements for Resident 3 to be evaluated by physical and occupational therapy

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N 431	Continued From page 67 services as ordered on 04/24/2026. On 06/04/2026, Surveyor reviewed a physician rounding form for Resident 3 dated 05/26/2026. Orders were received by the in-house physician (SFNP-Sequoia Family Nurse Practitioner-H) for Resident 3 to be seen for PT/OT to evaluate and treat, for lymphedema, unsteadiness on feet and back pain. Again, there was no evidence the facility sent a referral or made arrangements for Resident 3 to be evaluated by physical and occupational therapy services as ordered. On 06/03/2026 at 1:00 PM, Surveyors interviewed Resident 3. Resident 3 indicated s/he had not received PT/OT services since admission to the facility, and no one had told her/him why. Resident 3 stated, "My legs and feet are really swollen compared to what they have been. They're so swollen I can't fit my compression socks on, which I think therapy could help me with this...This facility knew before I even came here I was supposed to have PT/OT, but it hasn't happened." On 06/05/2026 at 7:30 AM, Surveyor asked Administrator E to provide all referrals for PT/OT and along with any notes from admission to present for Resident 3. At 1:00 PM, Administrator E responded, "[NP-H's office] has sent the order to [Home Health Service Company-Y] we are waiting for them to call us back to set [her/him] up." No additional documentation was received. On 06/09/2026 at 8:30 AM, NP (Nurse Practitioner)-H indicated s/he works exclusively with Administrator E for all orders and communication. NP-H indicated s/he does not receive timely updates or confirmations from Administrator E regarding when	N 431		

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referrals/appointments are made to ensure residents are seen and get the care they need. NP-H indicated Resident 3 was currently experiencing mobility issues and has not yet started therapy which was ordered on admission and again on 05/26/2026. NP-H stated, "[Administrator E] had [Resident 3's] therapy orders I wrote on 05/26/2026 and [s/he] should've followed-up with [Home Health Service Company-Y]."

On 06/08/2026 at 8:53 AM, Surveyor spoke with HHSCDCS (Home Health Service Company Director of Clinical Services)-I regarding Resident 3. HHSCDCS-I stated, "I don't see anyone with that name or date of birth in our system with an active or even declined PT/OT referral." HHSCDCS-I went on to say, "When we receive a referral we gather the needed documents including an order from the physician. Once the documents are received we work with our scheduling department and typically see the resident within 48 hours. If we get a PT/OT referral and can't accept it we will let the facility, resident or who ever made the referral know why we couldn't accept the referral...Even if a referral gets declined we would've documented the reason, but [Resident 3] is not in our system at all and no referrals have every been made."

Note: At the time of survey Resident 3 had been at the facility for forty (40) days and there had been no therapy referrals or evaluations completed.

On 06/09/2026 at 4:15 PM, during the exit conference with Administrator E and Licensee F, Surveyors shared the above information. Administrator E and Licensee F were unable to provide any written evidence a referral for PT/OT

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was was made for Resident 3.
RESIDENT 6

Surveyor reviewed portions of Resident 6's record, provided by Administrator E on 06/03/2026, 06/05/2026 and 06/08/2026. The records included an after visit summary from a hospital admission 05/18/2022 - 05/22/2026 which included instructions for follow up "in 3 days for wound check."

On 05/29/2026 (7 days later), Administrator E authored an observation note that read, Please check for a wound as I saw [his/her] discharge papers that says [s/he] needs to follow up on a wound. But doesn't tell me where the wound is. Please do a skin check on [him/her] and update me please." The notes did not include a response or results of the skin check.

The individual service plan, current as of 06/03/2026, did not identify any risks or history of skin integrity concerns.

Surveyor interviewed Nurse Practitioner (NP) H on 06/09/2026 at 8:19 AM. NP H said s/he is Resident 6's primary care provider. NP H said s/he was aware of the hospitalization, but was not informed of the discharge instructions to be seen regarding a wound, and to his/her knowledge Resident 6 had not seen any other medical providers related to wounds. NP H expressed frustration that Administrator E often does not promptly report changes in condition to him/her.

On 06/09/2026 at 12:01 PM, Surveyor interviewed Caregiver B. S/he said Resident 6 does not have any wounds or pressure injuries and added, "I checked this morning and [s/he] doesn't have one." Caregiver B said in May,

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Resident 6 "had one on [his/her] bottom because [s/he] was refusing to change" but that had resolved. Caregiver B reiterated s/he just gave Resident 6 a shower last week and Resident 6 did not have any wounds.

On 06/09/2026 at 2:45 PM, Surveyor interviewed Resident 6 and asked if s/he had any sores. Resident 6 said, "Yes somebody told me I have bedsores." Surveyor asked if s/he has them now and Resident 6 said s/he does and they hurt a little. At 3:38 PM, Resident 6 agreed Surveyors could observe while Caregiver T did a skin assessment. Prior to doing the assessment, Caregiver T said s/he did not know if Resident 6 had any sores. During the skin assessment, Surveyors observed a linear cluster of 4 sores in Resident 6's right abdominal fold; 3 of 4 sores were open. Surveyors also observed the area around the sores was reddened. Resident 6 stated s/he has not been to the doctor since s/he has been out of the hospital and caregivers are not applying cream, powder or other medication to the sores.

On 06/09/2026 at approximately 3:50 PM, Administrator E provided Surveyors with Resident 6's May and June 2026 medication administration records (MARs). On 03/05/2025, Nystatin powder was ordered as needed for reddened skin up to 3 times daily as needed. In addition on 03/05/2025, zinc oxide ointment was ordered for "irritated skin" and "prevention" 3-4 times daily as needed. Neither medication was documented as administered in May or June.

During the exit conference with Administrator E and Licensee F beginning at 4:18 PM, Surveyor reviewed the aforementioned concerns. Administrator E acknowledged Resident 6 had

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N 431	Continued From page 71 not been seen for wound follow up as instructed on the 05/22/2026 discharge summary and said to his/her knowledge, Resident 6 did not have wounds. Surveyors shared their observations of the wounds as well as the review of the MARs. Administrator E and Licensee F did not provide additional information. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change N0432 DHS 83.38(1)(h) Medication Administration	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interviews and record review, the provider did not provide medication services, including procedures to assure the accurate administering of all medications, to meet the needs of residents.	N 432		

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N 432	Continued From page 72 In 1 of 1 medication cart Surveyor discovered, open inhalers for Resident 1 and Resident 5 without an open/expiration date, an opened bottle of Tums without a label and an opened insulin pen without a resident name, pharmacy label or date when the pen was opened and/or expired. Additionally, a dorm sized refrigerator, which housed Resident 3's insulin, had a heavy buildup of frost/ice around the freezer compartment, did not contain a thermometer and was not being monitored to ensure proper temperatures were being maintained. Findings include: Division of Quality Assurance Insulin Storage Guide publication dated 06/2023 indicated, "...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows: 1. Never freeze: frozen insulin should be thrown away...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert...6. Unopened, in-use insulin should be stored in a refrigerator at a temperature of 36 degrees F (Fahrenheit) to 46 degrees F..." ~Review of the Trulicity Manufacturer's insert revised 03/2026 indicated, "Store Trulicity pens in the refrigerator at 36 degrees F to 46 degrees F...Do not freeze..." ~Review of the Lantus Solostar Manufacturer's insert revised 05/2025 indicated, "Before first use keep new pens in the refrigerator between 36 degrees F to 46 degrees F. Do not freeze. Do not use Lantus if it has been frozen...After 28 days, throw your opened Lantus pen away---Even if it still has insulin in it." ~Review of Advair Diskus inhaler Manufacturer's	N 432		

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insert revised 03/2026 indicated, "Discard Advair Diskus one month after opening..."
~Review of the Breo Ellipta inhaler Manufacturer's insert revised 05/2023 indicated, "The discard date is 6 weeks from the date you open..."

On 06/03/2026, Surveyors requested the facility's most recent annual review of the medication administration and storage system. Administrator E provided the review which was completed on 08/11/2025 by the facility's pharmacy titled, "Pharmacist Medication Management Survey." The review documented, "...Any practices identified as caution (C) must be noted and explained in the comment section...(C) Refrigerator temperatures monitored and maintained at 36 - 46 degrees F. No thermometer in refrigerator (C) All medications including OTC are properly labeled and short-dated products have been clearly labeled with expiration dating...[Resident 5's] Advair not noted when opened. Expires 30 days from open date."

On 06/03/2026 at 12 PM, Surveyor observed the facility's medication cart with Caregiver B. Located within the top drawer of the med cart, Surveyor observed an opened Breo Ellipta inhaler for Resident 1 and an opened Advair inhaler for Resident 5, with no dates indicating when the inhalers were opened or expired. Caregiver B confirmed both inhalers were open and contained no dates of when they were opened or expired. The bottom drawer of the med cart contained an opened Lantus Solostar pen, which was loose in the drawer. The Lantus insulin pen contained no resident name, pharmacy label or date to confirm when the pen was opened or expired. Caregiver B verified the insulin pen in the med cart was

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N 432	Continued From page 74 opened and did not contain a resident's name, pharmacy label or a date to determine when the pen was opened or expired. Surveyor then observed a bottle of Tums in the bottom drawer. The bottle of Tums contained no resident name or pharmacy label, which was verified by Caregiver B. On 06/03/2026 at 12:10 PM, Surveyor and Caregiver B observed a dorm sized refrigerator located in the medication room. Located within the refrigerator were several unopened Trulicity pens for Resident 3. No thermometer was inside or outside the refrigerator. Surveyor noted the refrigerator had a heavy buildup of frost/ice around the freezer compartment, extending several inches around the freezer section. Caregiver B verified the refrigerator was used for resident medication and contained no thermometer. Surveyor asked Caregiver B if the facility monitors or logs the temperatures for the refrigerator to ensure temperatures were within accepted parameters. Caregiver B indicated staff do not monitor or record temperatures for the medication refrigerator. On 06/09/2026 at 4:15 PM, during the exit conference with Administrator E and Licensee F, Surveyors shared the above observations. No additional information was received. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 432		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 433		

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resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure services were provided to manage Resident 6's behaviors that were harmful to him/herself or others.

Resident 6 had complex psychiatric diagnoses to include schizophrenia. The provider did not ensure caregivers implemented interventions identified in the individual service plan (ISP) to mitigate behaviors. Resident 6 had episodes of yelling, throwing things, self-harm, unclothing and aggression directed at staff and the behaviors were disruptive to the other residents. In addition, Resident 6's ISP was not updated based on assessment when s/he experienced worsening psychiatric symptoms and a 4 day hospital admission to identify the change or associated interventions. In addition, the ISP was not updated to identify the availability and rational for PRN (as needed) psychotropic medication to manage behaviors.

Findings include:

Surveyor reviewed portions of Resident 6's record, provided by Administrator E on 06/03/2026, 06/05/2026 and 06/08/2026. This included the face sheet, current individual service plan (ISP), observation notes since 04/01/2025,

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N 433	Continued From page 76 May 2026 medication administration records (MARs) and after visit summaries/notes from medical providers Resident 6 was admitted to the facility on 06/30/2021. S/he had diagnoses to include schizophrenia, delusional disorder, severe protein-calorie malnutrition and unspecified intellectual disabilities. The current ISP read in part (quoted as written): --Attitude: "3/7/26 medication are being changed by md please watch for any behaviors and notify md with changes." --Self-Abusive: "3/12/26 is having behaviors where [s/he] is putting [him/herself] on the floor, hitting [him/herself] self... MD aware and will look at [his/her] medications." . --Destructive: "when [s/he] is mad...will destroy [his/her] personal items and throw them around in [his/her] room and break things. Contact [Administrator E] when and if [s/he] does this. [S/he] can come and talk to [Administrator E] to settle [him/her] down." --Aggressive/Combative: "Triggers - anger not having enough attention, boredom. Resident o read, watch movies and animals. Loves one on one attention...try's harm [him/herself] have [sic] violent behaviors...rocks back and forth and shakes [his/her] leg. 3/5/26 Resident started having behaviors after meds were decreased. Document all behaviors so we can keep...md updated. 3/1/26 Resident is now saying [s/he] is allergic to clothes, water, everything...refuses to wear clothes...Staff to build rapport, be respectful, be empathetic, be professional, offer choices focus on success. Staff to say i [sic] see you are upset, i]sic] don't want to upset you any more i am going to walk away and give you time. I will	N 433		

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come back when your [sic] ready. Staff to redirect the behavior speak to [him/her] quietly and in a soft voice. Reassure... is going to be safe. 3/5/26 As above. 3/12/26 As above. 3/17/26 As above."
--Chronic Illness: " will create sickness to get staff attention. [s/he] will also mimic other people's symptoms for attention. 3/17/26 was sent to ER due to behaviors, refusing to take [his/her] meds...(urinary tract infection) was gone but it was found that [s/he] now has bilateral pulmonary embolism will start on blood thinners."
--"Using psychotropic medications related to specific behaviors. See MAR for medications...Goals & Outcomes: Appropriate use of medications will be maintained...behaviors to be controlled as allowed by progression of disease process."

The ISP:
--did not indicate if psychotropic medications were scheduled or PRN (as needed); and if PRN did not include a detailed rational for use.
--did not include an alternative for times when Administrator E was not on campus
--did not specify how staff would distinguish attention seeking behaviors from legitimate medical concerns
--was not updated after 03/17/2026 related to behavior management needs and interventions

Visit notes from Nurse Practitioner (NP) H during March and April 2026:
--03/25: "Seen at the [emergency department/ED]...recently due to psychotic features, elopement behavior, and hallucinations...diagnosed with a urinary tract infection...has had multiple recent emergency department visits due to psychiatric changes..."
--04/22: "experiencing episodes where [s/he] is out of contact with reality...has experienced

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N 433	Continued From page 78 significant weight loss d/t (due to) decreased appetite and delusions toward food being 'poison'...makes delusional statements such as [his/her] [family] is in prison and people are trying to murder [him/her]...anxious and paranoid...incontinent of urine, occasional bowel...Can be non-compliant with toileting schedule..." Caregiver observation notes 04/13 through 05/15 documented episodes of yelling, throwing things, unclothing and aggression directed at staff: --04/13: "is disturbing other residents by screaming and yelling obscene words...was asked by other resident to please stop but [s/he] would not, staff asked [him/her] to go to [his/her] room if [s/he] could not stop disturbing other residents. [S/he] refused." --04/18: refused medications believing s/he had already been administered his/her family's medication. Management notified. --04/19: "acting up all day...keeps saying how someone is out to get [him/her]...started to throw [his/her] glasses at staff ask [sic] resident to stop...staff will continue to monitor." Management will be notified. --04/24: "screaming" all day and evening. Staff has "redirected." Will monitor and notify management. --04/29: upset, believed s/he was given the wrong medication. Staff asked resident to relax and "take a breather...lunged at staff and threw [his/her] walker at staff...multiple attempts made to de escalate [sic] and resident continued to be very physical...in [his/her] room throwing all of [his/her] personal belongings around...will continue to monitor and management is aware...MD was called and will start [him/her] on Haldol .5mg bid to help with the psychosis."	N 433		

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N 433	Continued From page 79 --04/30: (Author: Caregiver D) 8:00 AM, in common area wearing a brief and told to put pants on. Refused until caregiver said s/he would call management. 9:45 AM, was "screaming and yelling, so I went asked [him/her] why...and to stop, so [s/he] decides to beat [him/herself] up and...started yelling and saying that I hit [him/her] when it is [him/her] hitting [him/herself]." 10:15 AM, "once again came out of [his/her] room in [his/her] brief...told [him/her] [s/he] needed to go back to [his/her] room s/he trid [sic] to attackme [sic] with [his/her] walker." --05/06: "decided that [s/he] was going to poop on [him/herself]" while sitting in the tv room "did not even attempt to go to restroom..." --05/12: in the common area unclothed, "screaming from the top of [his/her] lungs...pushing staff and yelling for no reason...staff asked multiple times to calm down and stop putting hands on staff and [s/he] continued." Given a "PRN ABH-1 GEL" and "staff will continue to monitor and management was notified." --05/15: "has been screaming, 'we are all going to go blind'...management will be notified of any concerns." On the aforementioned dates, the notes did not indicate caregivers used the interventions identified in the ISP to include building rapport, being empathetic, focusing on success, offering choices and giving space. Surveyor reviewed the May 2026 MAR. Between 05/01 and 05/29/2026, Resident 6 had a PRN order for ABH-1 Gel. The MAR instructions were to administer 1 ml topically to the back of the neck 3 times daily as needed. The MAR did not identify the medication as a psychotropic medication or otherwise indicate the reason for	N 433		

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use, however ABH-1 gel can be used to treat anxiety and delirium. The medication was administered 05/06, 05/08, 05/10, 05/12, 05/16 and 05/30, all by Caregiver U. The MAR did not include information to indicate why it was administered or whether it was effective.

On 05/18/2026, Administrator E authored an observation note indicating Resident 6 was sent to the ED to be evaluated for possible admission to a psychiatric facility for medication evaluation and stabilization. S/he noted Resident 6 was paranoid, hallucinating and currently sitting in [his/her] chair naked with sunglasses on. ED evaluation determined s/he had low potassium levels and s/he was admitted directly to the hospital.

On 05/22/2026, Resident 6 was discharged back to the facility from the hospital. There were no observation notes regarding changes in behavior management needs or interventions and no updates to the ISP.

On 06/09/2026 at 1:02 PM, Surveyors interviewed Resident 3. S/he said Resident 6's room is across the hall from him/hers, and Resident 6 has been very disruptive by yelling, throwing things and disturbing Resident 3's sleep.

On 06/09/2026 at 8:19 AM, Surveyor interviewed NP H. NP H expressed concern that Resident 6's psychiatric and behavioral needs are not being met by the provider. [S/he] noted caregivers do not consistently use effective approaches or re-approaches, and that language barriers of caregivers may further impede effective communication with Resident 6.

NP H added approach is an issue "across the

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N 433	Continued From page 81 board" and at times s/he has concern caregivers are using inappropriate approaches which may trigger behaviors and/or be ineffective in managing them. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0348 DHS 83.32 (3)(d) Rights of Residents: Free From Mistreatment N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change	N 433		
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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were provided with food that meets the recommended dietary allowance based on dietary guidelines or that Resident 2's therapeutic pureed diet was provided. Findings include: EXAMPLE 1: THERAPEUTIC DIET FOR RESIDENT 2 On 06/03/2026 at 11:10 AM, Surveyor interviewed	N 448		

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Resident 2 in his/her bedroom. Resident 2 reported significant difficulties with oral intake due to esophageal issues and lack of bottom teeth or dentures. Resident 2 stated, "I have to have my food mashed up to swallow it." Resident 2 expressed frustration with staff not providing soft food or assistance with cutting up his/her meals. Surveyor noted Resident 2 had severe arthritis in his/her fingers and hands preventing him/her from cutting food independently. Resident 2 reported unintended weight loss, currently under 100 pounds and expressed significant anxiety and fear of the weight loss. Resident 2 stated, "I worry about my weight every day. I don't want to die from lack of food."

Surveyor reviewed portions of Resident 2's record, provided by Administrator E on 06/03/2026 and 06/05/2026. This included the face sheet, ISP current as of 06/03/2026 and visit notes from Nurse Practitioner (NP) H. Resident 6 was elderly, protectively placed at the facility on 12/05/2026 and had a legal guardian.

Resident 6's current ISP contained conflicting information about his/her dietary needs. In the "Choking" section it read, "has swallowing issues, so cut up [his/her] food into small pieces" and the "Eating" section read, "needs to have [his/her] food pureed, [s/he] likes soft foods, pudding, Jello, yogurt, bread soaked with milk...will eat apple sauce...food needs to be pureed in the blender."

On 06/09/2026 at 11:43 AM, Surveyor conducted a follow up interview with Resident 2. Resident 2 again stated s/he is supposed to "eat soft things" but "they have so many people (caregivers) coming in and I have to tell 100 people and they don't do it. It's too much for them. I have to mash

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everything. I can't swallow that well; they will not do this for me. I'm just sick of telling them."

During the interview, Surveyor observed a handwritten note on Resident 2's nightstand. The note read in part, "cannot swallow food of pizza." Surveyors observed the same note during the interview on 06/03/2026, however the portion about pizza was added after the 06/03 observation. Surveyors also recalled during the 06/03/2026 facility visit, pizza was served for the dinner meal. Surveyors asked Resident 2 about the note. S/he said s/he wrote it and explained, "That's what I had lately, pizza. I take the top off and I soak it all in water. Pizza is the worst thing. People have pizza here a lot. That's why I'm losing weight." Resident 2 said when s/he is served certain foods, s/he will "dunk" it in the beverage, "but it's still hard."

On 06/09/2026 at 12:30 PM, Surveyor observed Caregiver B plate and serve Resident 2 the lunch meal which consisted of a sloppy joe sandwich, canned corn, potatoes chips and a glass of milk. The meal was not pureed or cut up. Resident 2 did not eat the corn and placed the potatoes chips into his/her glass of milk. Resident 2 stated, "I put anything that's too hard for me in my milk to soften it, because I have problems with my esophagus. I can't eat the corn or I'll choke on it...I've given the staff a note from my doctor about needing soft food, but they don't follow it, there's just too many staff working here." At 12:54 PM, Resident 2 informed Caregiver B s/he was unable to consume the corn or chips due to a 'bad esophagus.' Surveyor observed Caregiver B acknowledge the statement but provided no verbal response or follow-up to Resident 2.

On 06/09/2026 at 1:15 PM, following the lunch

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meal, Surveyor interviewed Caregiver B. When asked about Resident 2 softening chips in his/her milk, Caregiver B confirmed and stated, "Yeah, [s/he] does that. [Resident 2] has esophagus problems." Caregiver B further confirmed the care team was aware of Resident's 2 preference for soft food, but there was no physician's order for a modified diet. Surveyor then asked Caregiver B if s/he was aware Resident 2's ISP indicated a pureed diet and food to be cut up. Caregiver B stated, "Does the ISP state that? That must be new...I will have to go look at the ISPs again...I don't always have time."
Surveyor conducted an interview with NP H on 06/09/2026 at 8:19 AM. NP H confirmed Resident 2 has swallowing issues and has specifically requested a pureed diet. Surveyor asked about the February 2026 visit note where staff said Resident 2 was confused when s/he reported not receiving the pureed diet. NP H said in hindsight, s/he is not confident in the accuracy of staff reporting. S/he explained sometimes, staff describe residents a certain way but when s/he conducts monthly visits s/he does not observe the same behavior. NP H said s/he has not observed Resident 2 to display same confusion staff have reported.

During the exit conference with Administrator E and Licensee F beginning at 4:18 PM, Surveyors shared the aforementioned concerns. Administrator E acknowledged Resident 2 has "swallowing issues" and requests a pureed diet and added, "I haven't heard [s/he] has had issues with it."

EXAMPLE 2: RECOMMENDED DAILY ALLOWANCE

The Department received a complaint about the

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N 448	Continued From page 85 food. NOTE: "By following the US Department of Agriculture's Dietary Guidelines for Americans 2025-2030, you can make healthier food choices. The newest guide encourages eating minimally processed whole foods that are naturally high in nutrients. It discourages consuming highly processed foods...The basis for a healthy diet includes whole foods such as vegetables, fruits, nuts, seeds, meats, eggs, whole grains, beans, dairy, and seafood...VEGETABLES AND FRUIT: EAT FRUITS AND VEGETABLES THROUGHOUT THE DAY...Eat whole vegetables and fruits in their original form, raw or cooked...Try to make sure you aren't only picking options from the starchy group....Frozen, dried, canned fruits and vegetables with little to no added sugar are also good options...Most children and adults should eat between 1 1/4 to 4 or more servings of vegetables and 1 to 2 1/2 servings of fruit a day. Examples of a serving include: 1 cup (100 grams) raw or cooked vegetables - 2 cups (60 grams) of raw, leafy greens - 1 cup (100 grams) raw fruit - 1/4 cup dried fruit..." Source https://medlineplus.gov/ency/article/002093.htm, retrieval date 06/23/2026. During the onsite visit on 06/03/2026, Surveyors observed 3 of 3 meals. Residents were not offered whole foods such as fruits and vegetables during the meals. Surveyors did not observe whole foods such as fruits and vegetables offered at any other time throughout the day. 06/03/2026: --Breakfast: oatmeal and toast. No fruit or vegetable was provided. --Lunch: beef stroganoff, cake and Kool Aid. No	N 448		

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N 448	Continued From page 86 fruit or vegetable was provided. --Dinner: pizza (served from a restaurant take out/delivery box.) No vegetable toppings were visible. No fruit or vegetable was provided. Furthermore, the food supply in the facility consisted of minimal amounts fruits and vegetables. The only fruit was a bag of sliced apples in the refrigerator, it was half full and the apples were starting to brown. Fresh vegetables were limited to potatoes and onions (canned vegetables were present.) Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0387 DHS 83.35 (3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change	N 448		
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 the menu was followed or that all deviations were documented on the menu. Findings include:	N 450		

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N 450	Continued From page 87 On 06/03/2026, Surveyors reviewed the facility's menu for the day and observed all 3 meals. Surveyor noted the following: --breakfast meal listed on the menu was french toast and toast. The meal served was oatmeal and toast. --lunch meal listed on the menu was cheesy tuna casserole bread/butter. The meal served was beef stroganoff, cake and Kool aid --dinner meal listed on the menu was leftovers. The meal served was (delivered) pizza On 06/03/2026 at 9:05 AM, Surveyor interviewed Caregiver D. S/he said the reason s/he substituted oatmeal for french toast was because there were no eggs available in the facility. On 06/03/2026 at 10:30 AM, Surveyor interviewed Resident 1. Resident 1 reported frequent deviations from the scheduled meal plan, because the facility lacks the required ingredients. Resident 1 then stated, "This morning we were supposed to have french toast, but staff didn't have the ingredients to make it, and I like french toast." On 06/09/2026, Surveyors returned to the facility and reviewed the menu. The only deviation documented from 06/03/2026 was beef stroganoff in place of tuna casserole. Surveyors reviewed the facility's menu for 06/09/2026, observed Caregiver B cleaning up breakfast and observed the lunch meal. Surveyors noted the following: --breakfast meal listed on the menu was french toast. Caregiver B was cleaning up a pot of	N 450		

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N 450	Continued From page 88 oatmeal at 11:30 AM when Surveyors arrived and confirmed it was the breakfast meal. --lunch meal listed on the menu was pork chops, potatoes, veggies. The meal served was sloppy joe sandwich, canned corn, potatoes chips and milk On 06/09/2026 during the exit conference with Administrator E and Licensee F beginning at 4:15 PM, Surveyor reviewed the aforementioned concerns. Administrator E and Licensee F did not provide additional information. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0356 DHS 83.32(3)(L) Rights of Residents: Least Restrictive Environment	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

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N 452	Continued From page 89 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary conditions: Findings include: During a tour of the facility with Caregiver B beginning at 10:12 AM on 06/03/2026, Surveyor observed the following: --Pantry: dry goods were not properly sealed including a bag of chips, a bag of popcorn and cereal. --Refrigerator: was dirty with spills and food crumbs. There was a rotting bag of celery, an unlabeled foiled covered pan of what appeared to be cake, an unlabeled/undated clear wrapped bowl of what appeared to be tuna or chicken and an unsealed bag tortillas that had dried up. Caregiver B said the s/he would throw out the celery because it was old and s/he threw out the leftover cake. Surveyor asked what was in the bowl with the clear wrap and Caregiver B replied, "I'm not sure so going in the garbage." N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0481 DHS 83.43(1) Environment Safe, Clean, Comfortable and Homelike	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable	N 481		

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N 481	Continued From page 90 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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was clean, comfortable, well maintained and homelike. Rooms were not clean and free from odor, toilet paper holders were empty in 3 of 4 bathrooms and furniture and windows were in poor repair. The home lacked carbon monoxide detection and the provider did not follow through on an inspection recommendation from 2024 to replace a 23 year old furnace. Findings include: Furnace and Carbon Monoxide Detectors During a tour of the facility on 06/03/2026 beginning at 10:12 AM, Surveyor did not observed carbon monoxide detection in the facility. Again on 06/09/2026 at 12:10 PM, Surveyor did not observe carbon monoxide detection. During the 06/09/2026 observation, Licensee F was present and Surveyor inquired about the detectors. Licensee F said they should be in both hallways and asked Caregiver B where they were. Caregiver B immediately went into the medication room, went into the closet and retrieved 1 carbon monoxide detector. S/he gave it to Licensee F and said s/he was told to "take it down" by a different staff person because it was beeping. Licensee F told Caregiver B s/he should	N 481		

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N 481	Continued From page 91 have just changed the battery. Upon request on 06/03/2026, Administrator E provided Surveyors with the most recent furnace inspections. --An inspection dated 08/10/2022 identified a 2022 Bryant furnace in good condition and a 1993 Carrier furnace in good condition. --An inspected dated October 2024 also identified the Bryant furnace in good condition but recommended replacement of the Carrier furnace due to "secondary heat exchanger is pitting and leaking." --Surveyor noted the 2024 inspection report also recommended furnace replacement of a furnace in Bethel Menasha I, a sister facility. On 06/04/2026 at 12:52 PM, Surveyor contacted Company W and spoke with Person V. Person V said Company W did not replace the Carrier furnace in Bethel Menasha IV since the October 2024 inspection. On 06/05/2026, Surveyor sent an email to Administrator E and wrote, "Have any furnaces in building 4 been replaced in the past 3 years? If so, please provide receipt." In response, Administrator E faxed Surveyor an estimate from Company W for a new furnace in Bethel Menasha IV, with a quote date of 06/19/2025 and an quote expiration date of 07/19/2025. On 06/09/2026 during the exit conference beginning at 4:18 PM, Surveyor reviewed the aforementioned concerns that the recommended furnace replacement from October 2024 had not occurred. Licensee F maintained the furnace was replaced by Heating Company W and provided a receipt.	N 481		

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N 481	Continued From page 92 On 06/10/2026, Surveyor reviewed the receipt from Heating Company W. It documented a new Payne furnace was installed on 02/03/2025, however the "Work Location" was Bethel Menasha I and did not offer evidence the furnace was replaced in Bethel Menasha IV. On 06/10/2026 at 7:44 AM, Surveyor contacted Heating Company W and again spoke with Person V. Person V reiterated they did not replace the furnace in Bethel Menasha IV and the replacement work on 02/03/2025 was in Bethel Menasha I. S/he stated this could be verified by observing the current furnaces in Bethel Menasha IV; s/he explained if the furnace brands are Bryant and Carrier that would indicate they have not been replaced (because the replacement furnace on 02/03/2026 in Bethel Menasha I was a Payne.) Upon request on 06/10/2026, Licensee F emailed Surveyor photos of the 2 furnaces in Bethel Menasha IV; the name brands were Bryant and Carrier, indicating the recommended furnace replacement did not occur. Activity Room On 06/03/2026 and again on 06/09/2026, Surveyors observed the activity room. The "Activity Room" contained numerous plastic storage totes, bags of clothing, and cardboard boxes placed throughout the room. Personal belongings and stored items were located on tables, chairs and other furniture surfaces, limiting the intended use. The accumulation of belongings reduced the usable space within the room and created a cluttered environment with limited clear walking and seating area. On 06/09/2026 at 11:45 AM, Surveyor observed Resident 3 in the activity room at one of the	N 481		

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tables writing/reading. Resident 3 stated, "I don't have a table in my room so I had to asked [Caregiver B] to clear off a table so I could write/journal."

Dining Room & Kitchen
On 06/03/2026 and again on 06/09/2026, Surveyors observed three 3 dining room wooden chairs with upholstered seat covers with significant wear and staining. One chair had a very large circular ring from soiling or spillage. At least 2 of the chairs had loose legs, making them unsafe to sit on. Caregiver D said [s/he] previously put a note on the chairs not to use them because they weren't safe, but s/he didn't know what happened to the note. Two of (2) dining room chandlers had several burned out light bulbs. The dining room windows were unable to close completely. The kitchen floors were in need of sweeping and screens were dirty and difficult to see through.

Resident 1, Resident 2 and Resident 6's bedrooms

Resident 1: On 06/03/2026, Resident 1's bedroom door would not latch when closed. Resident 1 was unable to lock his/her door or close the door because it would not latch and stay closed, which affected the resident's right to privacy; this observation was verified by Caregiver B.

Resident 2: On 06/03/2026 at 11:10 AM, Surveyor interviewed Resident 2 in his/her bedroom. Surveyor observed Resident 2 did not have a window covering. A spring-loaded roller blind was found on the floor. Resident 2 reported the blind was non-functional and presented a safety hazard. Surveyor investigated why the blind was

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failing to operate correctly. The blind was placed back on the track. After lowering the blind, Surveyor attempted to raise it with a downward tug. The resulting tension caused the roller tube to rotate and retract the blind rapidly, which forced it off the track, resulting in the blind falling and posing a risk for injury. Resident 2 indicated s/he feels unsafe using the window blind, as it frequently falls off the track when attempting to open and is "Dangerous."

Resident 6: On 06/03/2026 at 10:45 AM, Resident 6's bedroom door would not latch when closed unless Surveyor applied significant pressure on it. Surveyors also observed the floor was un-swept and littered with popcorn and other debris. Resident 6 said, "When it gets this bad" staff will eventually sweep the floor. There was an odor consistent with urine in the room and the bedding was wet. Caregiver B was present and stated s/he had not yet had time to change the bedding, adding that the urine soaked sheets were new from this morning. Surveyor observed the plastic mattress protector underneath the soiled sheets contained a hole approximately 4 inches by 2 inches. Surveyor noted this compromised the moisture barrier and allowed urine to reach the cloth mattress. During the return visit on 06/09/2026 at 11:34 AM, the damaged mattress protector remained in use and had not been replaced. The room again had an odor of urine. On both 06/03/2026 and 06/09/2026, Resident 6 stated that the hole in the mattress protector had been there for "months."

On 06/08/2026 at 11:34 AM, Surveyor interviewed Resident 6's legal representative, Family R. Family R stated Resident 6 needs staff assistance with maintaining the cleanliness of his/her room and changing him/herself and

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N 481	Continued From page 95 sheets after episodes of incontinence. Family R said s/he visits regularly, and the condition of the room is "dependent on the staff levels at the facility who is working that particular day." S/he said when they are short staffed or when certain staff are working, the urine soaked bedding "tends to set there until they get around to it." Family R stated s/he has noticed a frequent smell of urine but was unaware Resident 6's mattress protector was in need of replacing. Hallway On 06/03/2026 and again on 06/09/2026, Surveyors observed a dirty hallway ceiling vent with a lot of dust buildup outside the south bathroom. Living Room On 06/03/2026 and 06/09/2026, surveyors observed all 3 seat cushions on the dark burgundy faux-leather couch were severely worn, stripping the material's color and leaving the cushions a lighter, beige color. Similar wear was observed on the arms of the couch. A cream colored chair had a circular area of staining on the seat cushion and dark areas of discoloration on the fabric of the arm. The base of the coffee table had a layer of debris and dust. The facility fish tank was poorly maintained, with an unknown dark substance coating approximately half of the interior glass surface. The buildup was concentrated in heavy, dark patches, compromising the visibility of the enclosure. Bathrooms On 06/03/2026 at 11:18 AM, surveyors observed the following conditions in the south hall small bathroom: the sink faucet was severely corroded, the toilet paper dispenser was empty and contained no supplies, a dark discoloration	N 481		

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N 481	Continued From page 96 resembling fecal matter was present on the exterior front surface of the toilet bowl and an unidentified, dark brown solid substances resembling fecal matter located on the floor. At 12:09 PM, Surveyors observed the dark substances remained on the exterior of the toilet bowl and the floor. During this observation, one of the substances on the floor was partially flattened, appearing as if it had been stepped on. This created a risk for tracking and cross-contamination. On 06/03/2026 at 11:44 AM, surveyors observed that the toilet paper dispenser in the west hall small bathroom was empty. On 06/03/2026, during morning observations until at least 1:30 PM, the large bathroom in the west hall remained in disarray. Used towels, resident clothing, and full garbage bags were left accumulating in the shower, on the floor and on the countertops. At 12:05 PM on 06/03/2026, Resident 6 was using the toilet in this bathroom and called out for someone to bring toilet paper because the holder was empty. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment	N 481		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of	N 525		

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N 525	Continued From page 97 the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure fire drills were conducted at least quarterly with both employees and residents and documentation did not include all required information. The documentation of fire drills did not indicate a fire drill was conducted in each quarter during 2025, did not include total evacuation time and did not include evidence that drills were limited to the employees working at the time. In addition, interviews with 2 residents and 1 caregiver indicated they never participated in a fire drill at the facility. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: terminally ill, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged,	N 525		

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developmentally disabled and physically disabled.

On 06/02/2026, Administrator E submitted a self-report to the Department reporting a fire that occurred on 06/02/206 between 12:45 AM and 1:00 AM. The report also noted Caregiver C and Caregiver J evacuated all residents from the building "within 4 min."

Surveyors interviewed Administrator E on 06/03/2026 at 9:32 AM about the fire evacuation. S/he stated, "everyone was out in around 4 minutes, under 4 minutes actually. I was proud of my staff." During a follow up interview at approximately 4:00 PM, Administrator E stated the self-report was the only documentation of his/her review of the fire incident.

Surveyor interviewed Fox Crossing Fire Department Captain L on 06/08/2026. Contrary to Administrator E's interview and report, Captain L indicated residents were not fully evacuated by caregivers upon his/her arrival to the fire. Captain L said they responded within 4-5 minutes of receiving the call. Upon arrival, Captain L said s/he observed a single caregiver evacuating a resident. Captain L said s/he asked the caregiver, "Is anyone else still in the house?" and the caregiver replied, "Yes, 2 or 3." Captain L said, " I had my crew hit the fire again, and then told them (my crew), 'Head into the house, we got 2-3 people we need to get out.'" Captain L said after the firefighters entered the facility to evacuate residents, the police department arrived on scene and provided additional assistance with evacuating residents.

Surveyor reviewed Fox Crossing Police Department report 26-1347 on 06/03/2026 at 8:00 AM. The report read, "On Tuesday, June 2, 2026,

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N 525	Continued From page 99 at approximately 12:43 AM, I, [Officer K], responded to a fire call at Bethel Assisted Living, 1670 Century Oaks Ct...The reporting party stated there was smoke and flames on the outside of the building. Upon arrival I met with Fox Crossing Fire Department (FCFD) [Captain L]...I asked if everyone was evacuated from the building and [s/he] said no. I went into the facility where I located a [resident] who refused to exit their bed. [Officer M] arrived and worked on getting the [resident] out of the property..." Upon request on 06/03/2026, Administrator E provided staff schedules and documentation of fire drills. --During 2025, fire drills were documented during the 1st, 2nd and 4th quarter of the year. No fire drills were documented between 07/01-09/30/2025 (3rd quarter.) Total evacuation times were not documented. The documentation did not identify the staff member who conducted the drills, making it unclear if drills were limited to the employees scheduled to work at that time. --During 2026, fire drills were documented on 03/12/2026 at 10:00 PM, 05/03/2026 at 6:00 AM and 06/02/2026 at 12:45 AM. The 06/02 entry read, "Fire...out within 4 min" Total evacuation time for the March and May drills were not documented. The documentation did not identify the staff member who conducted the drills, making it unclear if drills were limited to the employees scheduled to work at that time. Surveyor interviewed Caregiver D (hire date 12/30/2024) on 06/03/2026 at 8:51 AM. According to the schedule, s/he worked 05/02/2026 beginning at 6:00 PM until 6:00 AM on 05/03/2026. Caregiver D said s/he usually works third shift but will also fill in for 1st shift. Caregiver D said s/he has never participated in a	N 525		

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fire drill.

Surveyor interviewed Resident 3 (admission date: 04/24/2026) on 06/03/2026 at 1:02 PM. S/he recalled the fire and said, "I was woken up at like quarter to one in the morning by two fire fighters telling me I needed to...get out of the building. Some people were outside already. [Caregiver C] was running around trying to get everyone out."

Surveyor interviewed Resident 7 (admission date 09/13/2025) on 06/03/2026 at 10:45 AM. S/he said s/he has never participated in a fire drill at the facility. S/he recalled the fire and said, "We didn't know what to do but then we acted according to our lives depended on it. We ran out of the building as quick as we could away from the fire. We huddled together and got our best opinion (about what to do)." Resident 7 said at that point the firefighters told the residents to move away from the building. Resident 7 recalled, "That's when we started jumping over fire lines" to move away from the building.

Surveyor interviewed Resident 6 (admission date 06/30/2021) on 06/03/2026 at 11:28 AM. Surveyor asked if s/he has ever participated in fire evacuation drills at the facility. Resident 6 recalled fire drills at 2 other places s/he resided but said s/he has not participated in fire drills since living at this facility. Resident 6 said after the fire, Administrator E told residents the evacuation was considered their "practice."

During an interview with Licensee F and Administrator E on 06/09/2026 beginning at 3:51 PM, Surveyor reviewed concerns that interviews with 3 residents and 1 caregiver indicated fire drills were not completed as documented and according to information from the fire and police

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N 525	Continued From page 101 departments, caregiver(s) were not able independently evacuate the facility during the fire as documented in the self-report. Both managers maintained fire drills had been conducted. Licensee F said s/he would send documentation by the fire alarm system monitoring company to show evidence of times the system was put in test mode during drills. On 6/10/2026, the provider faxed documentation of email communication dated 06/10/2026 between Administrator E and Fire and Security Company O. An email from Fire and Security Company O read, "Administrator E, I went back 3 months for each location for test history, 3 of these 4 accounts do not have a test history...Bethel Assisted Living 1670 Century Oaks Court - No Test History." On 06/11/2026 at 9:34 AM, Surveyor interviewed Administrator Assistant P from Fire and Security Company O. S/he verified they can only go back 3 months to determine if the fire detection system was put in test mode, and on 06/10/2026 when they checked the past 3 months for this facility, there was no record of the system being put into test mode. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment N0393 DHS 83.35(3)(b) Initial Evaluation of Evacuation Limits	N 525		
N 533	83.47(5) Smoking policy. Smoking. Each CBRF shall develop and	N 533		

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implement a written policy on smoking. The policy shall designate areas where smoking is permitted, if any, and shall be clearly communicated to residents. Designated smoking areas shall be well ventilated or have an alternate means of eliminating smoke.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not develop and implement a written policy on smoking.

Findings include:

On 06/02/2026, the department received a facility self-report indicating a full facility evacuation was required on 06/02/2026, due to an exterior wall fire. The fire was sparked by Caregiver C's cigarette during the early morning hours, leading to structural damage to the outside of the building.

On 06/03/2026 at 9:23 AM, Surveyors interviewed Administrator E and asked if residents and staff were allowed to smoke on facility grounds. Administrator E indicated staff and residents were allowed to smoke on facility grounds in the middle of the front parking lot or in their cars. Surveyors then asked Administrator E for the facility's Smoking Policy and Procedure. Surveyors reviewed the facility's undated Smoking Policy and Procedure, which indicated, "1. Staff can only smoke in the designated area away from the building. If a staff is found smoking cigarettes or E-Cig's in the building at any time, that Staff member may not smoke at Bethel Assisted Living any more. There is NO SMOKING of any kind inside of Bethel Assisted Living. If staff is found smoking in the facility that staff member will be terminated 2. When smoking a cigarette is

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completed, the bud [sic] of the cigarette must be placed in the smoking receptacle. Do not throw cigarette butts on the ground or driveways. If we continue finding cigarette butts on the grounds at Bethel Assisted Living, we will make it mandatory that smoking is only allowed in your car only. No one can bring a cigarette bud [sic] back inside the building. If a staff is found with a cigarette bud [sic] inside Bethel Assisted Living that person will not be able to smoke anymore and will be terminated on the spot. 3. Also, no smoking is allowed in front of the building. Only designated area's which are in the back of the building or in your car. 4. At no time is any building allowed to not have a caregiver in that building. Someone must always be in the building. If your out smoking make sure the float is in your building watching the residents while your on break."

Immediately following review of the above smoking policy, Surveyors questioned Administrator E regarding the policy being unclear about the designated smoking area. It identified the designated area as being "away from the building" but then also stated it was allowed in the "back of the building." Furthermore, the developed policy contraindicated Administrator E's previous statement that smoking was permitted "in the middle of the front parking lot." Administrator E acknowledged the discrepancies and said s/he would revise the policy. Administrator E confirmed the smoking policy and procedure was created on 06/02/2026 in response to the fire incident that occurred by an employee discarding his/her smoking materials alongside the building in an area covered with cottonwood seeds. Administrator E said prior to the 06/02/2026 fire, there was not a smoking policy and since the new policy was just written, staff had not yet been educated on it. Surveyors

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then asked when staff training was going to occur regarding the newly created smoking policy and procedure. Administrator E stated, "It's gonna be next week sometime, I'm trying to get everything situated."

On 06/04/2026, Administrator E sent Surveyors a revised Smoking Policy and Procedure to clarify the designated smoking area, with a note there would be a staff meeting on 06/05/2026 at 10 AM. Surveyors compared the revised Smoking Policy and Procedure with the version provided on 06/03/2026 and identified the following changes: "1. Staff can only smoke in the designated area away from the building, in the middle of the driveway, away from the house...2. No one can bring a cigarette back inside the building as it could start a fire inside the building. 3. Also, no smoking is allowed in front of the building. Only designated area's, which are in the middle of the driveway away from the house or in your car..."

On 06/03/2026 and again on 06/09/2026, Surveyors observed the facility grounds. Surveyors observed numerous discarded cigarette butts and cigarette filters scattered throughout the gravel landscape in front of the building. No smoking receptacles were found on the property.

On 06/03/2026 at 8:51 AM, Surveyors interviewed Caregiver D and asked if smoking was allowed on facility grounds. Caregiver D stated, "yes" and explained smoking is allowed in the back of the facility off the attached wooden deck. S/he added, "When I smoke, I go out back on the porch. I've never been told about a designated smoking area. [Licensee F] has said if I'm gonna smoke go back there. I was doing that before [s/he] told me." Surveyors questioned weather

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the facility provided smoking receptacles for the proper disposal of cigarette butts. Caregiver D stated, "We are talking to [Administrator E] about that, as this is the only building that doesn't have a place to throw away your cigarettes butts...Especially since the fire they're going to get some type of non-combustible containers." Surveyors then asked Caregiver D how s/he disposes of her/his cigarette butt(s). Caregiver D stated, "I put out my cigarette and make sure nothing is lit. Then I throw the cigarette butt in the kitchen trash can or flush it down the toilet to be safe." Surveyor noted this practice violates the policy requiring extinguished cigarettes to be "placed in the smoking receptacle."

On 06/09/2026 at 11:25 AM, Surveyor asked Caregiver B if smoking was allowed on the facility grounds. Caregiver B confirmed smoking was allowed by staff and residents and said the designated smoking area was "on the back patio." Surveyor noted this information contradicts the revised policy which specifies the designated smoking area was in the middle of the driveway, away from the house or inside a vehicle. Caregiver B said around the time of the fire on 06/02/2026, the cottonwood trees on the property near the back porch were releasing their seeds and the ground was covered with it. S/he said that is what caused the fire on 06/02/2026. Surveyor observed the back patio during the interview, and there were no receptacles for disposing of smoking materials. Surveyor noted this was inconsistent with the policy that indicated extinguished cigarettes "must be placed in the smoking receptacle."

On 06/03/2026 at 10:45 AM, Surveyor interviewed Resident 7, who stated s/he smokes occasionally in the front of the building. During a

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follow up interview with Resident 7 on 06/09/2026 at 11:31 AM, s/he reiterated that s/he smokes occasionally and stated no one from the facility has told him/her about a policy regarding the designated smoking area or where s/he should dispose of cigarette butts. Resident 7 said when s/he is done smoking, s/he brings the cigarette butts "back in the house and throws them in the trash." Resident 7 added, "We don't have a designated spot to dump them or anything."

On 06/03/2026 at 1:02 PM, Surveyors interviewed Resident 3. Resident 3 said s/he smokes in front of the house and disposes of his/her smoking materials inside the home. Surveyors noted this conflicted with the policy provided by Administrator E. Resident 3 denied receiving education on smoking locations or disposal of smoking materials at admission or after the 06/02/2026 fire.

On 06/09/2026 at 11:10 AM, Surveyors observed Resident 3 smoking near the front entrance of the house and asked about the facility's smoking policy. Resident 3 reported s/he had no knowledge of the facility's smoking policy or designated smoking area and confirmed there were no smoking receptacles for her/his to discard her/his cigarette butts. At 11:22 AM, Surveyor observed Resident 3 return from outside and dispose her/his cigarette butt in the kitchen trash can. Surveyor noted this was inconsistent with the policy that indicated extinguished cigarettes "must be placed in the smoking receptacle...No one can bring a cigarette back inside the building as it could start a fire inside the building."

On 06/09/2026 at 4:15 PM, during the exit conference with Administrator E and Licensee F.

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N 533	Continued From page 107 The above information was shared. Licensee F indicated they ordered smoking receptacles through Amazon on 06/02/2026 and they were delivered on 06/05/2026 but were too small. Licensee F indicated they intend to return the small smoking receptacles and purchase larger ones. Licensee F and Administrator E were questioned about the staff meeting scheduled for 06/05/2026, which was intended to address the smoking policy. Licensee F and Administrator E confirmed the staff meeting took place but could not locate documentation or an attendance list when requested by Surveyors. Surveyors provided Administrator E time to locate staff training records regarding the smoking policy. At 4:25 PM, Administrator E provided a "Meeting Sign-In Sheet" for staff at all Bethel Assisted Living facilities specifically located in Appleton, Darboy, Kaukauna and Ripon. The "Meeting Sign-In Sheet" listed several operational and safety topics. Surveyors noted Fire drills and Fire safety were two of the many listed topics to be addressed during the 06/05/2026 meeting. Surveyors observed the sheet consisted of columns for staff signatures to verify their presence and acknowledge they have been informed of these protocols. Surveyors identified discrepancies on the "Meeting Sign-In Sheet" noting signatures from staff at sister facilities rather than staff listed on the facility staff roster. The facility's staff roster included a total of fourteen (14) staff who worked in the building. Only one of the 14 staff listed on the facility staff roster signed the sheet. When questioned Administrator E confirmed the training was incomplete, stating, "Staff still have to meet with me...I'm not done with all staff training." Cross Reference: N0358 DHS 83.32(3)(n) Rights of Residents:	N 533		

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N 533	Continued From page 108 Safe Environment N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 533		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview and record review, the provider did not ensure the temperature of water fixtures used by residents did not exceed 115°F or that the water heater was set to a temperature of at least 140°F. On 06/03/2026, water temperatures at 4 of 4 faucets used by residents were between 130.6°F and 157.9°F. On 06/09/2026, the water heater was set to 130°F. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: terminally ill, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged,	N 617		

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N 617	Continued From page 109 developmentally disabled and physically disabled. On 06/03/2026 beginning at 12:09 PM, Surveyor tested the water temperatures at the sink faucets of 4 of 4 common use bathrooms. These are the only bathrooms in the facility. --south hall large bath/shower room: 157.9°F --south hall small bathroom: 134.6°F --west hall large bath/shower room: 140°F --west hall small bathroom: 130.6°F NOTE: "Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability..." Source: DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017 On 06/03/2026 at 4:07 PM, Surveyor observed the temperature setting on the water heater. It was set to "very high." During an interview with Licensee F and Administrator E on 06/03/2026 beginning at 4:45 PM, Surveyor reviewed the concerns with the dangerously high water temperatures and the observation the water heater was set to "very high." Licensee F acknowledged the concerns and said someone must have turned up the water heater too high without his/her knowledge.	N 617		

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N 617	Continued From page 110 NOTE: "On the typical gas water heater temperature control knob, you will find various settings. 'Off' is sometimes labeled as 'Low' or has a solid circle indicator. Choosing this setting will heat the water to 90-100 degrees Fahrenheit. Next on the dial is 'Hot,' sometimes indicated with a triangle, which will get your water to 120 degrees Fahrenheit. Your dial may feature additional settings marked with...A, B and C, for 130, 140 and 150 degrees Fahrenheit, respectively. The 'Very Hot' setting is for 160 degrees Fahrenheit..." Source: https://www.constellationhome.com/blog/water-heater-temperature/, retrieval date 06/17/2026. On 06/04/2026 at 8:00 AM, Surveyor reviewed the provider's "Policy and Procedure for Water temps." [sic] It read, "POLICY: Daily temperatures will be taken in all Residents [sic] rooms in all buildings. The thermometer is in the left hand drawer in each building. They should be ready every day and documented below and handed in monthly...If water temp [sic] is above 114, Contact [sic] [Administrator E]...and report as soon as possible..." The document contained charting of water temperatures dating back to 01/18/2026. All temperatures were between 110°F and 112°F. The charting did not indicate who tested the temperatures. Temperatures were not charted daily. During May 2026, temperatures were charted 5/4, 05/11 and 05/18. No temperatures were charted for June 2026. On 06/09/2026, Surveyor observed the temperature setting on the water heater had been turned down. It was sent to "A" (130°F.) NOTE: "Domestic hot water systems are	N 617		

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N 617	Continued From page 111 frequently identified as the source of Legionella during Legionellosis outbreaks. The term "domestic" applies to all non-process water used for lavatories, showers, and drinking fountains in commercial, industrial, and multi-family residential settings. Water heaters maintained below 60°C (140°F) and that contain scale and sediment may foster Legionella growth..." Source: https://www.osha.gov/legionnaires-disease/control-prevention, retrieval date 06/17/2026. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment	N 617		
N 653	83.59(4)(e) Delayed egress: irreversible process release Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: An irreversible process will occur which will release the latch in not more than 15 seconds when a force of not more than 15 pounds is applied for 3 seconds to the release device. Initiation of the irreversible process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, re-locking shall be by manual means only. This Rule is not met as evidenced by: Based on record review, interview and observation, the provider did not ensure the	N 653		

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N 653	Continued From page 112 delayed egress doors released the latch in 15 seconds after pressure was applied. Two of 2 delayed egress doors did not open after 15 seconds after pressure was applied, and would only open after a code was entered on the keypad. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: terminally ill, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, developmentally disabled and physically disabled. On 06/03/2026 at 2:52 PM, Surveyors tested the functionality of 2 of 2 delayed egress doors at the facility by turning the handle and applying pressure on the door for at least 3 seconds. The door did not alarm and did not open after 15 seconds and only opened by entering a code on the keypad. While testing the doors Resident 6 volunteered, "the fire department inspector was here and said they didn't work." During an interview with Licensee F and Administrator E on 06/03/2026 beginning at 4:45 PM, Surveyors reviewed concerns with the delayed egress doors. Licensee F acknowledged the concerns. S/he stated there were no current residents at risk for elopement, so s/he would disable the magnetic locking mechanism on the doors until they could be fixed. On 06/04/2026 and 06/09/2026, Surveyor reviewed inspection reports from the local fire department. --An inspection occurred on 01/13/2026 and the	N 653		

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documentation read, "While conducting inspections at [Bethel Menasha IV], I found that an exit door...was not operating properly. Specifically, the delayed-release feature was not functioning as required for emergency egress..."

--A re-inspection occurred on 03/31/2026 and the documentation read, "Upon conducting the re-inspections...the (violation) had not been corrected. While testing the doors, I met with the maintenance person, who stated that [s/he] was unaware of any outstanding violations requiring repair. [S/he] requested that I speak with [Administrator E] to determine where the communication breakdown may have occurred. I subsequently met with [Administrator E], who also indicated that [s/he] was unaware of any open violations and believed that all required repairs had been completed. I reviewed my inspection records with [him/her], showed [him/her] the documented violations, and physically identified the affected items within the buildings. [S/he]requested a list of the outstanding violations so that corrective action could be taken. I verbally provided the information regarding the exit door deficiencies, and while I was present, the manager placed a call to arrange for testing and repairs of the doors in all buildings. Following our meeting, I forwarded the inspection information for both properties via email. The property manager confirmed receipt of the emails."

Surveyor conducted an interview with Account Executive X from Fire and Security Company O on 06/11/2026 at 8:56 AM. Account Executive X stated their company provides service for the fire detections systems and the delayed egress doors. S/he stated the only time they had been onsite at this facility during 2026 to repair the

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BETHEL MENASHA IV	1670 CENTURY OAKS COURT MENASHA, WI 54952

(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 653	Continued From page 114 doors was on 04/06/2026. Account Executive X said the next communication they received from the facility about the doors was on 06/03/2026 and they were trying to find time in their schedule to return to service the doors. During an interview with Licensee F and Administrator E on 06/09/2026 beginning at 3:51 PM, Surveyor reviewed concerns with the delayed egress doors and noted the problems were first identified during a Fire Department inspection in January 2026.Licensee F and Administrator E did not offer evidence they were actively monitor functionality of the doors between the most recent repair on 04/06/2026 and present. Licensee F said s/he would send surveyors documentation of his/her efforts to repair the doors. On 06/09/2026 and 06/10/2026, Licensee F forwarded email correspondence with Account Executive X. The first notification from Licensee F to Account Executive X that the delayed egress doors were not opening after 15 seconds, was on 06/03/2026 at 4:22 PM. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment	N 653		