STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020893	A. BUILDING: _____ B. WING _____	R-C 06/18/2026

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{M 000}	INITIAL COMMENTS On 06/04/2026 with information gathered through 06/18/2026, Surveyors conducted a verification visit and two complaint investigations at Heartfelt Cares AFH in Plover, WI. Fourteen deficiencies identified. Three of fourteen are repeat deficiencies. See Statement of Deficiency (SOD) 6D4111, dated 01/26/2026. One of two complaints substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{M 232}	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure 2 of 2 caregivers reviewed did not have a communicable disease screening within 90 days before the start of providing care.	{M 232}		

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

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{M 232}	Continued From page 1 Caregiver D and Caregiver E did not have a communicable disease screening completed within 90 days prior to providing care. This is a repeat deficiency. See Statement of Deficiency (SOD) 6D4111, dated 01/26/2026. Findings include: On 06/04/2026 at approximately 11:00 AM, Surveyors conducted a review of 2 employee records, which were provided by House Manager C. Surveyors noted the following concerns: -Caregiver D was hired 03/23/2026. Caregiver D's record did not include a communicable disease screening. -Caregiver E was hired 12/22/2025. Caregiver E's record did not include a communicable disease screening. On 06/04/2026 at approximately 1:15 PM., Surveyors reviewed concern with House Manager C that 2 of 2 caregivers reviewed did not have a communicable disease screening, within 90 days prior to the start of proving care. House Manager C stated s/he stated both employees had the TB skin test but did not get the communicable disease screening. House Manager C acknowledged both employees were missing the communicable disease screening and stated s/he would get them screened as soon as possible.	{M 232}		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or	M 262		

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M 262	Continued From page 2 walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there were two ramped exits from the facility for 1 of 1 resident who utilized a walker for mobility. The back exit patio door had an 3 inch lip and was not ramped to grade with handrails. Findings include: On 06/04/2026, at 12:00 PM, Surveyors toured the home and observed the following: The home had 2 exits from the facility. The 2 exits, located in the front and back of the facility, were identified as emergency exits. The front entrance was to grade to the front door. The back exit patio door had a three inch lip, was not to grade and did not have handrails to get to ground level sidewalk.	M 262		

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M 262	Continued From page 3 On 06/04/2026, at approximately 12:30 PM, Surveyor observed Resident 5 eating lunch in the dining room and had a walker next to him/her. On 06/04/2026, at 3:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 5 uses a walker at all times in the home and stated s/he was licensed with the back exit patio door like that. Licensee A acknowledged the back exit patio door did not meet code requirements and would need to be fixed as s/he has a non-ambulatory license.	M 262		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were evaluated using a form provided by the department to determine whether the resident was able to evacuate the home without any help within 2 minutes. Findings Include: On 06/04/2026, Surveyor reviewed Resident 4's	M 344		

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M 344	Continued From page 4 record. The record identified: -Resident 4 was admitted on 12/10/2025. -There was no evidence or documentation of Resident 4's ability to evacuate within 2 minutes. On 06/04/2026 at approximately 1:45PM, Surveyor interviewed House Manager C (HM-C). HM-C acknowledged the findings. No additional information was provided.	M 344		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were screened for communicable diseases, including tuberculosis by a physician, registered nurse or physician assistance within 90 days prior to admission or within 7 days after admission for Resident 4. Findings Include:	M 380		

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M 380	Continued From page 5 On 06/04/2026, Surveyor reviewed Resident 4's record. The record identified: -Resident 4 was admitted on 12/10/2025. -There was no documentation of Resident 4's communicable disease screening including tuberculosis. On 06/04/2026 at approximately 1:45PM, Surveyor interviewed Manager C (HM-C). HM-C acknowledged the findings. No additional information was provided.	M 380		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure a written assessment was completed for 4 of 4 residents (Resident 3, Resident 4, Resident 5 and Resident 6) within 30 days of placement. Findings include: On 06/04/2026, Surveyors reviewed Resident 3, Resident 4, Resident 5 and Resident 6's record and identified the following: -Resident 3 was admitted to the facility on 01/13/2026. Resident 3's record did not contain a	M 404		

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M 404	Continued From page 6 written assessment. Resident 3's record only contained an ISP from 01/13/2026. -Resident 4 was admitted to the facility on 12/10/2025. Resident 4's record did not contain a written assessment. Resident 4's record only contained an ISP with no date. -Resident 5 was admitted to the facility on 09/11/2025. Resident 5's record did not contain a written assessment. Resident 5's record only contained an ISP from 09/30/2025. -Resident 6 was admitted to the facility on 03/17/2026. Resident 6's record did not contain a written assessment. Resident 6's record only contained a blank ISP with no date. On 06/04/2026 at 1:00 PM, Surveyors interviewed Licensee A. Licensee A stated s/he did not complete assessments and care plans for all of the residents. Licensee A stated moving forward s/he would complete them upon admission.	M 404		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there was a statement of agreement that was dated and signed by all parties involved in developing the individual service plan for 3 of 3 residents reviewed. Resident 3, Resident 4 and Resident 5 did not have signed individual service plans.	M 420		

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M 420	Continued From page 7 Findings Include: On 06/04/2026, Surveyor reviewed Resident 3, Resident 4 and Resident 5's record. The records identified the following: -Resident 3 was admitted on 01/13/2026. Resident 3's facesheet noted s/he made his/her own decisions. Resident 3's ISP was dated 01/13/2026 and was not signed by Resident 3. - Resident 4 was admitted on 12/10/2025. Resident 4's facesheet noted s/he made his/her own decisions. Resident 4's ISP was not dated and not signed by Resident 4. -Resident 5 was admitted on 09/11/2025. Resident 5's facesheet noted s/he had a guardian. Resident 5's ISP dated 09/30/2025 was not signed by Resident 5's guardian. On 06/04/2026 at approximately 1:45PM, Surveyor interviewed House Manager C (HM-C). HM-C acknowledged the findings. No additional information was provided.	M 420		
{M 424}	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan	{M 424}		

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{M 424}	Continued From page 8 shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed (Resident 5) service plans was reviewed at least once every 6 months by the licensee, the resident, the resident's guardian and the placing agency, to determine the appropriateness of the care plan and to update the care plan as necessary. This is a repeat deficiency. See Statement of Deficiency (SOD) 6D4111, dated 01/26/2026. Findings include: On 06/04/2026, Surveyor reviewed Resident 5's records and identified the following: -Resident 5 was admitted to the facility on 09/11/2025 and had a guardian. Resident 5's Individual Service Plan (ISP) was dated 09/30/2025. Resident's ISP would have needed a review around 03/30/2026. On 06/04/2026 at approximately 1:45 PM, Surveyors conducted an exit conference with House Manager C. House Manager C confirmed Resident 5's ISP's did not get updated on 03/30/2026. House Manager C stated Licensee A would be the one who would update the ISP's and it did not get done if it was not in Resident 5's	{M 424}		

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{M 424}	Continued From page 9 record.	{M 424}		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services specified in resident individual service plans (ISP's) were provided. Resident 3 did not receive the level of supervision specified in their ISP. Findings include: On 06/04/2026, Surveyors conducted a complaint investigation. The complaint was alleging staff were not providing the correct staffing ratio's to the residents. On 06/04/2026 at approximately 11:00 AM, Surveyors interviewed House Manager C. House Manager C stated Resident 3 was a 2:1 when s/he was in the facility and when s/he transferred, then s/he was a 3:1. On 06/04/2026, Surveyors reviewed Resident 3's record and identified the following: -Resident 3's ISP dated 01/13/2026 stated the following: "Mobility/Accessibility/Enhanced Staffing Needs:	M 436		

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Transfers: 2-assist pivot transfer
Ambulation: 2-assist hand hold with gait belt; can only go a few feet with significant support
Primary mobility: wheelchair for mobility
Posture/trunk control: high fall risk; leans forward in wheelchair; limited trunk control to lean back
Left-sided weakness: does not use left arm
Orientation: able to follow directions but not fully oriented; good days oriented to person and place
Bed mobility: mostly stays in bed; cannot sit up independently; may slide on leg over bed edge
Supervision: requires supervision due to high fall risk
Medical/Infection Control/Medication
No open wounds reported
Behavior/Safety Concerns
During person cares, may scratch or hit
Frequency: daily but not every care episode
Identified trigger: personal cares"

On 06/04/2026, Surveyors reviewed Plover Police Department Report dated 02/05/2026 at 10:42 AM. The report stated the following:
"Interview with [House Manager C]
[House Manager C] stated that [Resident 3] would pick at his/her scabs on his/her legs and at times [Resident 3] would crawl around on the floor. On one occasion [House Manager C] said [Resident 3] was trying to crawl to the bathroom. [Officer] asked [House Manager C] if [Resident 3] was allowed to crawl around on the floor and [s/he] said no. [Officer] inquired how [Resident 3] would be crawling on the floor if [s/he] is supposed to be watched all the time and [House Manager C] said that [s/he, House Manager C] would have to go to the bathroom which would leave [Resident 3] alone. [House Manger C] would come back from going to the bathroom and [Resident 3] would be crawling on the floor. This

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would indicate that [Resident 3] is not getting the two to one care that is required and incidents were happening during those small gaps [s/he] was left alone. [House Manager C] stated [Resident 3] would be left alone at times and it would be for approximately 3-4 minutes. [House Manager C] indicated that during the day [Resident 3] is in the living room watching TV and [his/her] room is used for naps or sleeping."

"Interview with [Resident 3]
[Officer] asked [Resident 3] what happened with the incident where [s/he] injured [his/her] nose. [Resident 3] said [Licensee A] was instructed that [s/he] was a two person assist. [Resident 3] said [s/he] woke up displaced and reached for the edge of the bed to move [him/herself] and the bed was high with slippery sheets which caused [him/her] to fall off the bed face first. [Resident 3] said no one was in the room watching [him/her] or helping [him/her]. [Resident 3] said [s/he] called for help and got yelled at by [Licensee A] because [s/he] was going to bleed all over the floor. [Resident 3] said [s/he] would clean up the mess and [Licensee A] said "Damn right you will." [Officer] asked [him/her] how often each day [s/he] is left alone in [his/her] room. [Resident 3] stated there is rarely anyone in [his/her] room watching [him/her] and the staff is usually in the living room."

On 06/04/2026 at approximately 1:00 PM, Surveyors interviewed Licensee A. Licensee A stated Resident 3 would be in the living room a lot with staff around but when s/he went to nap or to bed, then s/he would go into his/her room. Licensee A stated staff would not be in his/her room and would sit outside of his/her room with door cracked because Resident 3 would complaint that [s/he] wanted privacy. Surveyors

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M 436	Continued From page 12 confirmed with Licensee A that Resident 3 is a 2:1 staffing ratio at all times due to his/her falls. Licensee A confirmed there was not 2:1 staffing ratio at all times when Resident 3 was living in the home. On 06/08/2026 at 7:40 PM, Surveyor interviewed Resident 3. Resident 3 stated s/he was a 2:1 but they never really had anybody with him/her at all times. Resident 3 stated they would just put him/her living room to watch him/her or when s/he was in his/her room sleeping, nobody was in there with him/her. Resident 3 stated s/he rolled out of bed when s/he first moved there because s/he was disoriented and broke his/her nose when s/he fell. Resident 3 stated nobody was in the room with him/her and s/he had to yell for help and that is when Licensee A came in and yelled at him/her stating s/he was going to bleed all over the floor. Resident 3 stated there was another time where s/he had to use the bathroom and Licensee A told him/her no because s/he had just taken him/her recently and s/he did not have to use the bathroom. Resident 3 stated s/he had to otherwise s/he would pee his/her pants. Resident 3 then crawled on the floor to the bathroom to try and use the restroom. Resident 3 stated there were no staff around to help him/her and s/he was on the floor for at least 10 minutes.	M 436		
M 440	88.07(2)(b)1 SUPERVISNG & ASSISTING WITH ADLS Supervising or assisting a resident with or teaching a resident about activities of daily living.	M 440		

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M 440	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper catheter care appropriate for Resident 5's needs resulting in Resident 5 not having his/her catheter bag emptied. Findings include: On 06/04/2026 at approximately 10:00 AM, Surveyor reviewed Resident 5's record and identified the following: -Resident 5 was admitted to the provider's home on 09/11/2025 with diagnoses including dementia. -Resident 5 had a legal guardian. -Resident 5's incident report dated 03/22/2026-03/23/2026 at 7:00 AM stated: "-Type and extent of harm/injury experienced by the member as a result of the incident: Bag not being drained puts resident at risk for UTI also uncomfortable. -Did the member of others require medical evaluation, treatment or hospitalization: Yes, oncoming staff had to switch bag and empty old one immediately. Also did ask resident if [s/he] had any pain and resident said just in [his/her] knees. -Describe what was occurring prior to the incident: Staff member was sitting on couch and said [Resident 5] needed to be changed as usual. Staff went into inspect and the bag was bulging and the tube was filled. -Incident Summary: Night staff said they had not changed bag, claimed they did not know how. -Immediate actions taken: changed bag/emptied, reported it, monitored that new bag is filling, managers contacted about how monitoring is going.	M 440		

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M 440	Continued From page 14 -Root Cause of incident: Staff refused to empty bag, claimed to not know how but obviously did not attempt to figure it out. -Describe how the incident could have been prevented: proper staff training, not neglecting resident" On 06/04/2026 at approximately 1:00 PM, Surveyors interviewed Licensee A regarding above concern. Licensee A confirmed that Resident 5 has a catheter and needs assistance in changing/emptying the bag from staff. Licensee A stated s/he was never made aware of this incident and did not see it in Resident 5's file to follow up on it and does not have catheter care listed in Resident 5's Individual Service Plan (ISP).	M 440		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure record was kept of all reports and recommendations for 1 of 1 resident (Resident 3) requested. Findings include: On 06/04/2026, Surveyors requested Resident 3's record and identified the following: -Resident 3 was admitted on 01/13/2026. -Resident 3's ISP dated 01/13/2026 stated Resident 3 is his/her own decision maker. -Resident 3's ISP stated: "Mobility/Accessibility/Enhanced Staffing Needs:	M 446		

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Transfers: 2-assist pivot transfer
Ambulation: 2-assist hand hold with gait belt; can only go a few feet with significant support
Primary mobility: wheelchair for mobility
Posture/trunk control: high fall risk; leans forward in wheelchair; limited trunk control to lean back
Left-sided weakness: does not use left arm
Orientation: able to follow directions but not fully oriented; good days oriented to person and place
Bed mobility: mostly stays in bed; cannot sit up independently; may slide on leg over bed edge
Supervision: requires supervision due to high fall risk
Medical/Infection Control/Medication
No open wounds reported
Behavior/Safety Concerns
During person cares, may scratch or hit
Frequency: daily but not every care episode
Identified trigger: personal cares"

-Resident 3's progress notes stated the following: "02/03/2026: Resident was yelling about using the bathroom, after staff just got done taking [him/her] to the bathroom 30 min prior. Resident still continued to yell about [s/he] couldn't breathe so staff called ambulance and they took him/her to the doctors."

On 06/04/2026 at approximately 11:00 AM, Surveyors interviewed House Manager C. House Manager C stated s/he was not sure why Resident 3 went out to the hospital because s/he was out of the country and not working at that time but the only time s/he remembers resident going out is when s/he fell and fractured his/her nose when s/he was first admitted. Surveyors requested to review Resident 3's incident reports and hospital visits from when s/he was admitted and the most recent incident on 02/03/2026.

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M 446	Continued From page 16 House Manager C stated s/he could not find the information and that if it was not in Resident 3's record, then s/he was not sure where it was. On 06/04/2026 at approximately 1:00 PM, Surveyors interviewed Licensee A. Licensee A stated House Manager C should have all the documentation in Resident 3's record. Surveyor stated House Manager C could not locate any incident reports or hospital visit reports. House Manager C stated s/he would have to look and send them to Surveyors when s/he was at the facility. As of 06/08/2026 at 5:00 PM, Surveyors did not receive any additional information.	M 446		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents requiring assistance took the correct dosage at the correct time and communicated effectively with the physician for Resident 4. Resident 4 was administered another resident's medication.	M 462		

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M 462	Continued From page 17 Findings Include: On 06/04/2026, Surveyor reviewed Resident 4's undated individual support plan (ISP). The ISP identified Resident 4 required "Full medication administration by staff." On 06/04/2026, Surveyor reviewed Resident 4's record. Surveyor noted an incident report dated 03/19/2026 at 8:00AM. The incident report noted the following: "Member [Resident 4] was given wrong meds/missed morning meds ...Staff rushed and provided wrong meds containing vitamins and asprin [sic] ...Manager called/vitals taken ... went to hospital (for appointment) vitals taken again ..." Further review of the record revealed an after-visit summary dated 03/19/2026 with an arrival time of 12:40PM. The after visit-summary stated, "Today's Visit ... a Medicare annual wellness visit ..." The after-visit summary did not address anything related to the medication error. On 06/04/2026, Surveyor interviewed House Manager C (HM-C). HM-C advised s/he was not working during the timeframe of the medication error. HM-C could not identify which resident's medication Resident 4 was administered. HM-C could not verify if the physician was notified, or if the medication error was discussed at the appointment on 03/19/2026. Resident 4 was administered another resident's medication on 03/19/2026 at approximately 8:00AM as identified in the incident report. The after-visit summary noted Resident 4 was seen at a medical appointment at 12:40PM. Surveyor could not find evidence Resident 4's medication	M 462		

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M 462	Continued From page 18 error was communicated to the physician before or during the appointment.	M 462		
{M 464}	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a physician's authorization to administer medications was obtained prior to medication administration for 3 of 3 residents reviewed. Resident 4, Resident 5 and Resident 6 did not have a physician's order for staff to administer resident medications. This is a repeat deficiency. See statement of deficiency (SOD) 6D4111, dated 01/26/2026. Findings Include: On 06/04/2026, Surveyor reviewed Resident 3 and Resident 4's record. The records identified -Resident 4 was admitted on 12/10/2025. Resident 4's undated individual support plan (ISP) stated Resident 4 required, "Full medication	{M 464}		

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{M 464}	Continued From page 19 administration by staff." The record had no documentation of an order to administer his/her medications. -Resident 5 was admitted on 09/11/2025. Resident 5's individual support plan (ISP) dated 09/30/2025 stated Resident 5's medications were managed by staff.." The record had no documentation of an order to administer his/her medications. -Resident 6 was admitted on 03/17/2026. Resident 6's individual support plan (ISP) dated 03/17/2026 stated Resident 6's medications were administered and supervised by staff daily.." The record had no documentation of an order to administer his/her medications. On 06/04/2026 at approximately 1:45PM, Surveyor interviewed House Manager C (HM-C). HM-C acknowledged the findings. No additional information was provided.	{M 464}		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it.	M 556		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 3) was able to make decisions related to his/her activities. Resident 3 was not able to use the facility phone when s/he wanted to call his/her spouse.

Findings include:

On 06/04/2026, Surveyors reviewed Resident 3's record and identified the following:
-Progress notes dated 01/29/2026: "Resident had a rough night. Had a snack and took all of [his/her] med's. [S/he] kept rolling out of bed and trying to hurt [him/herself]. Also kept arguing with staff because we would not give [him/her] the phone @ 1 AM to call [his/her spouse]. Also [s/he] keeps picking at [his/her] skin and making [him/herself] bleed. When toileted or transferred [s/he] drops down and puts dead weight on the staff. Last toileted at 4:00 AM. Has been on and off sleeping all night."

On 06/04/2026 at approximately 11:30 AM, Surveyors interviewed House Manager C regarding above concern. House Manager C stated s/he is the one that wrote the progress note. House Manager C stated they did not allow resident to use the phone because it was too late to be calling anybody and his/her spouse did not want them to call them at late at night. House Manager C confirmed Resident 3 is his/her own decision maker but his/her spouse told staff not to let Resident 3 call him/her that late.

On 06/08/2026 at 7:40 PM, Surveyor interviewed Resident 3. Resident 3 confirmed House Manager C and Licensee A would deny him/her access to the facility phone to contact his/her

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M 556	Continued From page 21 spouse.	M 556		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from physical, sexual or mental abuse, neglect, and financial exploitation or misappropriation of property. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure Resident 3 was free from neglect. Resident 3 was a 2:1 staffing ratio at all times and facility did not follow the staffing ratio which led to Resident 3 falling multiple times, breaking his/her nose on 01/21/2026 due to unsupervised fall, and crawling on the ground multiple times to try and get assistance from staff. Resident 3 was admitted to the hospital on 02/03/2026 with elevated lactic acid level and open wounds and did not return to the facility. Findings include: DHS 88.02(19) indicates the definition for "Neglect" means significant danger presented to a person's physical or mental health because the person responsible for his or her care is unable or fails to provide adequate food, shelter, clothing, medical care, or dental care. On 06/04/2026, Surveyor reviewed resident record for Resident 3 and identified the following: -Resident 3 was admitted to the facility on 01/13/2026 with diagnosis of Wernicke's Disease, Alcoholic cirrhosis of liver, intraventricular hemorrhage, subarachnoid hemorrhage, chronic pain, hepatic encephalopathy, and gait/mobility abnormalities.	M 572		

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-Resident 3 is his/her own legal decision maker.
-Resident 3's Individual Service Plan (ISP) dated 01/13/2026 stated the following:
"Mobility/Accessibility/Enhanced Staffing Needs:
Transfers: 2-assist pivot transfer
Ambulation: 2-assist hand hold with gait belt; can only go a few feet with significant support
Primary mobility: wheelchair for mobility
Posture/trunk control: high fall risk; leans forward in wheelchair; limited trunk control to lean back
Left-sided weakness: does not use left arm
Orientation: able to follow directions but not fully oriented; good days oriented to person and place
Bed mobility: mostly stays in bed; cannot sit up independently; may slide on leg over bed edge
Supervision: requires supervision due to high fall risk
Medical/Infection Control/Medication
No open wounds reported
Behavior/Safety Concerns
During person cares, may scratch or hit
Frequency: daily but not every care episode
Identified trigger: personal cares"

A hospital history and physical examination report for Resident 3 dated 02/03/2026 indicated:
"The Care Coordinator's role was clearly explained, with information tailored to preferred language and
learning style. [Resident 3] and/or caregiver demonstrated understanding. Responsibilities were outlined, including
discharge planning, connecting the patient with appropriate community and healthcare resources, and addressing
psychosocial or clinical barriers to care coordination.
[Resident 3] resides at Heartfelt AFH. [Resident 3] needs assistance with all ADL's. [Resident 3]

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uses the following assistive devices; Commode, Grab bars, Transfer board, Walker, Wheelchair. [Resident 3] will be transported at discharge by Managed Care Organization contracted providers. Patient does not have a PCP and needs a referral at discharge.
2/3:
Writer notified that [Spouse] of [Resident 3] called concerned that facility is bringing [him/her] drugs. [Spouse] states that [s/he] did bring [Resident 3] a nicotine pen but was told no. Writer then notified that [Resident 3] is stating that the facility is neglecting [him/her] and hurting [him/her].
Writer and CNA met with [Resident 3] in [his/her] room. [Resident 3] states that [s/he] is always alone in [his/her] room, when [s/he] calls out for help, [s/he] is told no and states [s/he] had tried to change [his/her] briefs by [him/herself] and got hurt while crawling to the commode. Abrasion 2 inch's long on [his/her] right knee noted from this instance. Multiple other abrasions seen. CNA then asked [Resident 3] if s/he could look at [his/her] other injuries. 2 inch purple bruise on right upper thigh, 4 inch yellow/green bruise on left side.
Writer called [Licensee A]
[Licensee A] states that [s/he] believes [Resident 3] is on drugs and that [Spouse] is bringing them. Writer stated
that drug screen is negative besides what is prescribed. [Licensee A] noted to become angry with writer and stated that "it just wasn't showing on our test then" and that "[s/he] has other residents dealing with this issue and will not stand for it".
Writer again stated that [Resident 3] is not on drugs besides [his/her] prescribed benzodiazepines. [Licensee A] stated that must be the drugs [s/he] is taking. Writer attempted to state the meds [s/he] is prescribed that are

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benzodiazepines, however [Licensee A] began talking over writer stating that [Resident 3] isn't sleeping due to being on drugs and that "[s/he] isn't going to say [s/he] wont take [Resident 3] back but that [s/he] needs to be on something to help [him/her] sleep like Seroquel". Writer again states that [Resident 3] is on scheduled seroquel and ativan as needed. [Licensee A] states that's not true. Med list read word for word to [Licensee A]. [Licensee A] then begins looking through [Resident 3's] meds and states that [s/he] does in fact see that [Resident 3] is on seroquel and ativan now.
Writer contacted [Managed Care Organization (MCO)]. [MCO] states that [Resident 3] is supposed to have a 2-1 staff with a 3rd available as needed for transfers. [MCO] states experiencing concerns while at the home as well. [Resident 3] was not being supervised when they arrived. [Licensee A] has a philosophy of "letting residents do "whatever" and they will learn to behave". They noted med mismanagement. [Licensee A] was also accusing [him/her] of being manipulative and pocketing drugs. [Resident 3] had dropped a med and didn't realize it. They are not allowing [Resident 3 to have [his/her] phone, not allowing [him/her] to have snacks (noted that [Resident 3] had a gastric bypass and typically eats small meals/snacks multiple times a day instead of 3 big meals), and states not wanting [spouse] to visit [him/her].
Adult Protective Services (APS) report made by writer and [Managed Care Organization Social Worker (SW)].
2/4:
APS and [MCO] came to talk to writer and [Resident 3]. [Resident 3] expressed the same story today as yesterday. [Resident 3] also stated that [Licensee A] "throws [him/her] around" and that's how [s/he] got the bruises on [his/her] side

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and thigh. [Resident 3] also states that [Licensee A] has been giving [him/her] a med that [s/he] has never seen before to "help [him/her] sleep". [Resident 3] states this pill makes [him/her] so out of it and [s/he] does not want to take it. [Resident 3] does not believe this to be any of [his/her] scheduled medications as it is
a different shape and color. APS is opening a DQA investigation into the facility. [Resident 3] is not to return to Heartfelt Cares AFH."
"Trauma/Abuse Assessment
-Physical Abuse: Yes, present (various injuries in different stages of healing, does not match correlated care)
-Verbal Abuse: Yes, present (Patient verbalizes that [s/he] is being yelled at and mistreated by group home staff.)
-Emotional Abuse: Yes, present (Patient verbalizes that [s/he] is being yelled at and mistreated by group home staff.)"

Plover Police Report dated 02/10/2026 at 1:50 PM
"COMPLAINT
On Thursday, February 05, 2026, [Officer], was assigned to assist Portage County Adult Protective Services workers with a complaint against Heartfelt Group Home located at 510 White Oak Ave. in the Village of Plover. The original complainant from Social Worker at Aspirus Stevens Point who stated that [Resident 3] is a client of the group home and requires a lot of one on one care. [Resident 3] was admitted to Aspirus Stevens Point Hospital with numerous bruises, skin tears and scrapes. [Resident 3] informed the staff the injuries are from having to "scoot" [him/herself] around on the floor to get to the restroom since [s/he] cannot walk on [his/her] own. [Resident 3] said the staff at Heartfelt Group Home is not assisting with [his/her] needs to get

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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around the facility and are yelling at [him/her] and hurt [him/her]. [Resident 3] said the owner of the Heartfelt Group Home, [Licensee A] is very aggressive with [him/her]. There are also concerns that [Resident 3] is not getting the proper medication while at the facility. [Resident 3] was placed at the group home by Managed Care Organization care team."

"CONTACT WITH APS
[Officer] spoke to [APS] over the phone and agreed to meet at the Plover Police Department to discuss the case. [APS] explained to [Officer] that [Resident 3] was taken to Aspirus of Stevens Point on 02/03/26 and after arriving the staff noticed the injuries to [Resident 3] and [s/he] also verbally told them what had been happening at the facility. The Aspirus Hospital staff called to make a report to Portage County Adult Protective Services [(APS)]. [APS] indicated that they already made contact at the hospital and spoke to [Resident 3]. They stated that [Resident 3] is to have a 2-1 staffing and a 3rd staff member for transfers. This means that Heartfelt Group Home is paid to have 2 staff members with [Resident 3] at all times and a third to help with transfers. The staffing need for [Resident 3] is extra to whatever staffing is already being provided at the group home on a daily basis. There are concerns that the staffing requirement is not being met by Heartfelt Group Home due to all the injuries on [Resident 3], where [s/he] had to drag [him/herself] to the bathroom because staff will not help [him/her] or [s/he] is afraid to ask for help because the staff gets mad and yells at [him/her]. APS explained that [Resident 3] has Kors Wernicke's Encephalopathy, which is an alcohol induced dementia, but [Resident 3] has been very lucid and consistent on [his/her] story to the hospital staff and APS. There was another

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concern that [Licensee A is accusing [Resident 3's spouse] of bringing in drugs, possibly a vape, to the facility in an attempt to ensure that [Resident 3's spouse] cannot come to the facility anymore. This would make it so [Resident 3's spouse] cannot see how [Resident 3] is treated at the facility. It was agreed that [APS] and [Officer] would try and make contact with [Licensee A] at Heartfelt Group Home and speak to [him/her] about the aforementioned concerns."

"HEARTFELT GROUP HOME CONTACT
[APS] and [Officer] went to the group home on 02/05/26 at approximately 10:42am. There was a dumpster outside the facility with a large piece of green carpet in it, but was not able to see if there was any blood on it. [Officer] observed a paper sign on the front door saying cell phone were prohibited in the building, [APS] knocked on the door and employee, [Caregiver F], answered the door. [APS] introduced themselves and asked [Caregiver F] if [Licensee A] was at the facility. [Caregiver F] said [s/he] was not at the facility but would call [him/her] on the phone. After entering the group home APS pointed to a bedroom with a number "8" on the door. [Officer] observed there were several dark stains on the carpet. [Officer] captured several photos from outside the room of the stains. [Caregiver F] indicated that Room "7" was originally [Resident 3]'s room (01/20/2026) but after about one day [s/he] was moved to Room 8, which is the room with the stains that [Officer] observed. [APS] had [Caregiver F] show [him/her] inside Room 8 and while in there [Officer] took closer photos of the dark stains on the floor. [APS] asked [Caregiver F] about the staffing of the clients and [Caregiver F] said there are two staff on [Resident 3] and one staff member taking care of [Resident 5], who requires a one on one staffing. There is a another client at

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the group home [Resident 4] that does not have specific staffing needs. [Caregiver F] said one staff member stays with [Resident 3] while the other staff member helps out with whatever else needs to be done at the group home. [APS] questioned [Caregiver F] about the stains on the carpet and [s/he] said the stains were from [Resident 3]. When asked what happened [Caregiver F] said [s/he] wasn't at the group home when the stains got on the carpet but said the stains are feces or maybe blood. [Caregiver F] said [s/he] has never personally seen [Resident 3] on the floor. [Caregiver F] did indicate that Room 7 and Room 8 share a bathroom and the carpet in the dumpster outside is from Room 7 where laminate flooring is being installed. [Officer] looked in the living room area of the residence to see if there was any blood or stains on the floor, but due to the dark and blended colors of the carpet [Officer] was not able to identify any specific spots. [APS] went through [Resident 3's] file and it was discovered that [Resident 3] arrived at the facility on 01/20/2026. [Resident 3's] paperwork indicated that on 01/13/2026 [s/he] did not have any "wounds" on [his/her] body, indicating all of [Resident 3's] wounds were suffered after arriving at Heartfelt Group Home. It was also discovered that the first night at the group home which would be 01/20 or 01/21 depending on the time of night [Resident 3] fell out of bed and broke [his/her] nose. Another employee arrived at the group home, verbally identified as, [House Manager C]. [House Manager C] stated that [Resident 3] came to the facility with the wounds on [his/her] legs. [House Manager C] also said that [Resident 3] picks at the scabs. [Officer] spoke to [House Manager C] in the living room about [Resident 3]. [Officer] asked [him/her] about the dark spots on the floor in [Resident 3's] room. [House Manger C] said

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that was from [Resident 3] picking at [his/her] scabs and at times [Resident 3] would crawl around on the floor. On one occasion [House Manager C] said [Resident 3] was trying to crawl to the bathroom. [Officer] asked [House Manager C] if [Resident 3] was allowed to crawl around on the floor and [s/he] said no. [Officer] inquired how [s/he] would be crawling on the floor if [s/he] is supposed to be watched all the time and House Manger C said that [s/he, House Manager C] would have to go to the bathroom which would leave [Resident 3] alone. [House Manager C] would come back from going to the bathroom and [Resident 3] would be crawling on the floor. This would indicate that [Resident 3] is not getting the two to one care that is required and incidents were happening during those small gaps [s/he] was left alone. [Officer] asked how long [Resident 3] is left alone for at times and [s/he] said approximately 3-4 minutes. [House Manager C] indicated that during the day [Resident 3] is in the living room watching TV and [his/her] room is used for naps or sleeping."

INTERVIEW WITH [RESIDENT 3]
On 02/05/26 [APS and Officer] went to Aspirus of Stevens Point Room to interview [Resident 3]. [APS] had already interviewed [Resident 3] on a previous occasion. When [APS and Officer] arrived at the room [APS and Officer] were told that [Resident 3] had MRSA which was not previously known so we put on gowns and gloves as requested by the hospital staff. [Officer] met with [Resident 3] and introduced [him/herself]. [Officer] observed that [Resident 3] had a bandage on [his/her] right leg and several small scabs on both legs near [his/her] knees. [Resident 3] stated that [s/he] did not have any of [his/her] current wounds before showing up at Heartfelt Group Home. [Resident 3] said [s/he]

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obtained the wounds by "scootching"(dragging) [him/herself] across the carpet to try and get to the bathroom. [Resident 3] had to drag [him/herself] across the carpet because if [s/he] tried to yell to get help [s/he] would get reprimanded by some of the staff, specifically [Licensee A]. [Resident 3] said the rest of the staff would try and help [him/her] to the bathroom. If [Resident 3] would call for help in the early morning [Licensee A] would tell [him/her] that now that [s/he(Resident 3)] woke everyone up with [him/her] yelling for help that [s/he(Resident 3)] would have to stay up and wouldn't be getting any breakfast, food, coffee or blankets. [Licensee A] would also tell [Resident 3] that [s/he] would have to just sit in [his/her] wheel chair and stay there. Hospital staff arrived to help [Resident 3] move around so I could take pictures of some of [his/her] wounds. [Officer] was shown an approximate 1 inch circular bruise on [Resident 3's] left shoulder which was previously seen by [APS]. [Resident 3] was also supposed to have a bruise on [his/her] left side/rib area. [Officer] did not observe a definitive bruising but did see some possible discoloration of the skin so [Officer] took a photo of the area. [Officer] observed a small scab on [Resident 3's] left leg just below the knee. [Resident 3's] right leg had a small scab which was approximately 1/4 inch by 1/2 inch on the knee. On the outside of the right leg, [Officer] observed large area of approximately 3 inches long by an 1 inch wide that had raw flesh. This appeared to be the area that took the most damage on [his/her] body as [s/he] tried to drag [him/herself] to the bathroom. [Resident 3] indicated [his/her] wounds started developing shortly after [s/he] broke [his/her] nose and getting reprimanded for yelling for help. [Resident 3] said it is a lose-lose situation because if [s/he] calls for help [Licensee A] yells

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at [his/her] and if [s/he] tries to drag [him/herself] to the
bathroom [s/he] gets yelled at for trying to do it [him/herself]. [Officer] asked [Resident 3] what happened with the incident where [s/he] injured [his/her] nose. [Resident 3] said [Licensee A] was instructed that [s/he] was a two person assist. [Resident 3] said [s/he] woke up displaced and reached for the edge of the bed to move [him/herself] and the bed was high with slippery sheets which caused [him/her] to fall off the bed face first. [Resident 3] said no one was in the room watching [him/her] or helping [him/her]. [Resident 3] said [s/he] called for help and got yelled at by [Licensee A] because [s/he(Resident 3)] was going to bleed all over the floor. [Resident 3] said [s/he] would clean up the mess and [Licensee A] said "Damn right you will." [Resident 3] said [s/he] is not allowed to use [his/her] phone. [Officer] asked [him/her] how often each day [s/he] is left alone in [his/her] room. [Resident 3] stated there is rarely anyone in [his/her] room watching [him/her] and the staff is usually in the living room. [Resident 3] says [s/he] doesn't spend a lot of time in the living room and is in [his/her] room on a mattress on the floor most of the time. [Officer] asked [Resident 3] if there are two workers with [him/her] most of the time and [s/he] said "No." [Resident 3] said [House Manager C] is a good employee and takes care of the residents to the best of [his/her] ability. [Officer] asked [Resident 3] if [s/he] wanted to go back to Heartfelt Group Home and [s/he] said [s/he] did not because [s/he] doesn't deserve to take the daily ridicule. [Resident 3] said [s/he] just wants to rehabilitate and be able to walk. A hospital employee came into the room and informed us that when [Resident 3] was admitted to the hospital after breaking [his/her] nose the records indicated there were no injuries or

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wounds on [his/her] legs,
which indicated the wounds occurred after 01/21/26 at Heartfelt Group Home. [Resident 3] also said [s/he] was being accused of doing drugs but [s/he] does not take drugs. Aspirus staff confirmed that [Resident 3] did not have anything other than prescribed medication in [his/her] system. [Resident 3] said [his/her spouse], has visited [him/her] a couple times and has wanted to take [Resident 3 out to eat, but [Licensee A] said that wasn't allowed. It should be noted that during [Officer's] interview [Resident 3] became very emotional and cried at several points because of the way [s/he] feels [s/he] is treated at Heartfelt Group Home. After the interview [Officer] spoke to [APS] who said that [Resident 3's] story has been consistent with the Aspirus medical staff, [APS] and [Officer]."

On 06/04/2026 at approximately 1:00 PM, Surveyors and Officer G interviewed Licensee A. Licensee A stated s/he believed Resident 3 was on drugs and that is why s/he had all the behaviors. Licensee A stated that Resident 3 would crawl on the floor and be yelling at staff and asking for drugs. Licensee A stated Resident 3 received all the scabs and the wound on his/her leg from crawling on the floor. Licensee A stated Resident 3 was a 2:1 staffing ratio at all times. Licensee A stated Resident 3 would want some privacy so staff would leave Resident 3's room and sit outside of Resident 3's room by door with it cracked a little bit to hear if Resident 3 would need something. Surveyors requested to review incidents and documentation that showed Resident 3 was crawling on the floor and had drug seeking behaviors because it was not listed in Resident 3's ISP. Licensee A stated all of that should be in his/her record at the facility. House Manager C confirmed there was no incident

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M 572	Continued From page 33 reports or documentation of Resident 3's falls/crawling on the floor and/or drug seeking behavior. On 06/08/2026 at 7:40 PM, Surveyor interviewed Resident 3. Resident 3 stated s/he was a 2:1 but they never really had anybody with him/her at all times. Resident 3 stated they would just put him/her living room to watch him/her or when s/he was in his/her room sleeping, nobody was in there with him/her. Resident 3 stated s/he rolled out of bed when s/he first moved there because s/he was disoriented and broke his/her nose when s/he fell. Resident 3 stated nobody was in the room with him/her and s/he had to yell for help and that is when Licensee A came in and yelled at him/her stating s/he was going to bleed all over the floor. Resident 3 stated there was another time where s/he had to use the bathroom and Licensee A told him/her no because s/he had just taken him/her recently and s/he did not have to use the bathroom. Resident 3 stated s/he had to otherwise s/he would pee his/her pants. Resident 3 then crawled on the floor to the bathroom to try and use the restroom. Resident 3 stated there were no staff around to help him/her and s/he was on the floor for at least 10 minutes.	M 572		