STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 000}	Initial Comments On 01/06/2026 with additional information gathered through 01/13/2026, Surveyors conducted 2 complaint investigations and a verification visit at Bethel Menasha III. Two (2) of 2 complaints were substantiated. Three (3) of 3 previous deficiencies were uncorrected. Six (6) new deficiencies were identified. As a result of the survey, a total of 9 deficiencies were identified. Per state statutes a $200.00 revisit fee was assessed. Census: 7	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. Licensee C did not ensure deficiencies from the previous survey (Statement of Deficiency 6DQN12, dated 09/16/2025) were corrected or that special orders were complied with. A total of 9 deficient practices, including 3 repeat deficiencies, were identified as a result of the current survey.	N 196		

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

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N 196	Continued From page 1 Findings include: Prior to conducting the onsite visit on 01/06/2026, Surveyor reviewed the facility's compliance history. On 11/14/2025, the provider was issued a Statement of Deficiency (SOD) #6DQN12 for the previous survey ending on 09/16/2025. The SOD identified three deficiencies and included a Notice and Order letter which read in part, --"Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements." --SPECIAL ORDER: "Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for each resident with a copy of Statement of Deficiency 6DQN12 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the department, to verify compliance with Order #1. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. Required evidence will be made available to the department representatives upon request."	N 196		

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N 196	Continued From page 2 --"According to Wis. Admin. Code DHS §§ 83.13(3)(a) and 83.14(2)(h), each facility shall immediately upon receipt post next to its CBRF license, and in a public area that is visually and physically available, any citation/statement of deficiency, notice of revocation, notice of non-renewal, and any other notice of enforcement action. Citations and statements of deficiency shall remain posted for ninety (90) days following receipt. Notices of revocation, non-renewal, and other notices of enforcement action shall remain posted until a final determination is made. Therefore, the license shall immediately post this Notice and Order letter and it shall remain posted until a final determination is made." On 01/06/2026, Surveyors conducted a verification visit to confirm correction of the three deficiencies and the orders. Additional information was collected through 01/13/2026. NOTIFICATION: --On 01/06/2026 at 9:00 AM, Surveyor interviewed Administrator A and requested documentation to verify each residents' legal representative and case manager were given a copy of SOD 6DQN12 and the Notice and Order letter. Administrator A replied, "I don't know if I wrote anything down but I met with them a couple days after, we had meetings here." Administrator A subsequently said s/he met with one guardian in the sister facility (which had the same requirement) but the rest of the people s/he spoke with via phone. Administrator A did not indicate s/he provided written copies of the SOD or Notice and Order letters and confirmed s/he did not have documentation in the form of a certified mail receipt, email or in any other format	N 196		

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N 196	Continued From page 3 as evidence s/he provided notification as required. POSTING: --On 01/06/2026 at 9:30 AM, Surveyor walked through the facility and observed the SOD was not posted. Surveyor interviewed Administrator A who stated it had been posted at one point, but confirmed it was no longer posted and s/he did not know what happened to it. NEW DEFICIENCIES: As a result of the verification visit beginning on 01/06/2026, Surveyors determined three of three of the previous deficiencies were uncorrected: --Environment Safe, Clean, and Comfortable - third recite --Exterior Areas - second recite --Bath and Toilet Areas: Water Temperatures - third recite In addition, 6 new deficiencies including this one, were identified. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0366 DHS 83.34(1) Limitations On Control of Resident Funds N0368 DHS 83.34(2)(b) Accounting Method for Tracking Resident Cash N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable	N 196		

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N 196	Continued From page 4 N0492 DHS 83.45(1)(a) Exterior Areas N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperatures	N 196		
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. This Rule is not met as evidenced by: Surveyor: Hall, Nichole J. Based on observation, interview and record review, Administrator A did not supervise the daily operation of the CBRF to ensure residents received proper care and treatment, their health and safety were protected and their rights were respected. Findings include: The Department received a complaint alleging concerns with administrator oversight. During onsite visits 01/06/2026 and 01/12/2026, and with information collected through 01/13/2026, Surveyors substantiated 2 of 2	N 214		

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N 214	Continued From page 5	N 214		

complaints and identified 9 deficiencies. Of the 9 deficiencies, 3 were repeat violations.

In summary:
--Administrator A did not ensure Resident 2, Resident 3 and Resident 5 received medications as prescribed.
--Administrator A did not ensure Resident 2's individual service plan was updated based on assessment to identify interventions for refusals of toileting/incontinence care and meals.
--Administrator A did not obtain written authorization from Resident 5's legal representative to manage Resident 5's funds and did not maintain a written accounting system for use of the funds.
--Administrator A did not ensure inside environment was safe, clean and well maintained In addition, the exterior areas were not well maintained or safe. This survey marks the third consecutive survey where these deficiencies were identified.

In addition, the Department received a complaint alleging evacuations drills are never done and documentation of drills is falsified. As a result of the investigation, Surveyor identified concerns regarding compliance with the requirement to conduct fire and tornado drills to ensure residents know how to respond.

On 01/06/2026 at 9:53 AM, Surveyor interviewed Resident 5. Resident 5 said fire evacuation drills are not conducted. The only thing s/he described is when an outside company comes in and tests the detectors. Surveyor asked Resident 5 if s/he knows where s/he would go in the event of a tornado. S/he replied, "Well I can't go in my closet, it's pretty small ...I don't know."

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N 214	Continued From page 6 On 01/06/2025 at 11:52 AM, Surveyor interviewed Resident 1. Resident 1 said there have not been fire or tornado drills at the facility. Surveyor asked if s/he would know where to go if there was a tornado and s/he replied, "No. " On 01/06/2026 at 4:18 PM, Surveyor reviewed documentation of evacuation drills provided by Administrator A. --Fire: drills were documented every other month in 2025 with the most recent drills documented on 10/06/2025 and 12/11/2025. For each drill it was documented 2 staff participated, but names were not identified. In addition, exact total evacuation time was not documented. For example, for the recent 2 drills it was documented "<4 min." --Tornado: during 2025 drills were documented on 02/24, 04/21 and 10/06. During an interview at 4:30 PM with Administrator A, Surveyor noted the documentation for fire drills did not meet the requirement to document the exact total evacuation time. Administrator A confirmed and described rounding the time to the nearest minute. NOTE: during a previous survey ending 4/24/2025, Surveyor provided technical assistance to Administrator A about ensuring drills were completed and exact total evacuation time was documented. Surveyor asked for the names of the two staff that conducted the last two fire drills. Administrator A said the two staff were s/he and Licensee C, explaining they conduct all fire drills together. S/he added that sometimes they include the caregiver that is working. Surveyor requested the name of the caregiver working on 10/06/2025. Administrator A looked on his/her computer and said, "Must have been someone who is no longer	N 214		

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N 214	Continued From page 7 here. It's not showing up. When someone leaves they disappear off the schedule." Surveyor asked Administrator A his/her thoughts on why 2 resident interviews indicated neither types of drills were done and they did not know where to go in the event of a tornado. Administrator A said s/he did not know why they would say that because s/he and Licensee C do the drills. On 01/13/2026 at 9:04 AM, Surveyor interviewed Licensee C and noted his/her responses were inconsistent with Administrator A's. Licensee C said the drills are done "once a month" and s/he does the drills along with the caregiver on duty. Licensee C said Administrator A only participates in fire drills when s/he (Licensee C) is not there. Licensee C said s/he does not conduct tornado drills and said those are Administrator A's responsibility. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Law N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0366 DHS 83.34(1) Limitations On Control of Resident Funds N0368 DHS 83.34(2)(b) Accounting Method for Tracking Resident Cash N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0492 DHS 83.45(1)(a) Exterior Areas N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperatures	N 214		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

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N 352	Continued From page 8 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. Resident 3 did not receive his/her prescribed tamsulosin hydrochloride, escitalopram, and omeprazole medication during the 8 AM medication pass on 01/04/2026 as the medication remained in the blister card, and the medications were not charted as given. Additionally, Resident 3 did not receive his/her prescribed levothyroxine medication during the 8 AM medication pass on 01/05/2026 as the medication remained in the blister pack card, even though the medication pass was charted as given. Resident 5 did not receive his/her prescribed aripiprazole medication during the 8 AM medication pass on 01/02/2026 and 01/05/2026 as the medication remained in the blister pack card, even though the medication pass was charted as given. Resident 2 did not receive his/her prescribed aripiprazole medication during the 8 AM medication pass on 12/09/2025, 12/18/2025, 12/27/2025, 12/29/2025, 12/31/2025, 01/02/2026, 01/03/2026, 01/04/2026 and 01/05/2026 as the	N 352		

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medication remained in the blister pack card, even though the medication pass was charted as given.

Findings include:

On 10/23/2025, the Department received concerns regarding medication administration.

On 01/06/2026 at 8:30 AM, Surveyor and Caregiver E observed the facility had one medication cart. Caregiver E explained the facility receives monthly medication blister packs with numbered compartments (1-31) to organize pills by the day of the month. Caregiver E indicated medications were dispensed by correlating the date of the month with the matching number on the blister pack card. Once the medication is punched out and administered, staff initial the eMAR (electronic medication administration record), within ECP.

Resident 3

On 01/06/2026, Surveyor reviewed Resident 3's record which indicated, the resident was admitted to the facility on 12/30/2025 with diagnosis to include depression, gastroesophageal reflux disease and enlarged prostate. Additionally, the facility managed and administered all of Resident 3's medication. Resident 3 had physician's orders for, "Tamsulosin hydrochloride 0.4 mg capsule daily, escitalopram 10 mg tablet daily, omeprazole 20 mg capsule daily and levothyroxine 50 mg tablet daily."

On 01/06/2026 at approximately 9:00 AM, Surveyor observed the medication cart with Caregiver E. Surveyor observed Resident 3's eight (8) AM blister pack medication cards for

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tamsulosin hydrochloride, escitalopram, and omeprazole and noticed an extra dose remained in each card for 01/04/2026. Surveyor then observed Resident 3's levothyroxine eight (8) AM blister pack card and noticed an extra dose remained in the card for 01/05/2026. Caregiver E acknowledged the observation and verified Resident 3's eight (8) AM dose of tamsulosin hydrochloride, escitalopram, and omeprazole medication were not given on 01/04/2026 and the eight (8) AM dose of the levothyroxine medication was not given on 01/05/2026. Caregiver E and Surveyor then used the facility's eMAR, to verify the charting. Surveyor and Caregiver E found there was no documentation the dose of the tamsulosin hydrochloride, escitalopram, or omeprazole medication was given on 01/04/2026 at eight (8) AM. Caregiver E further verified the levothyroxine medication was documented as being administered on 01/05/2026 at eight (8) AM in Resident 3's eMAR, but the medication remained in the blister pack.

On 01/06/2026 at approximately 11:40 AM, Surveyors discussed the above observations of Resident 3's eight (8) AM medication remaining in the blister packs and not being documented as given on 01/04/2026 with Administrator A. Surveyor also shared Resident 3's levothyroxine medication remained in the blister pack on 01/05/2026 but was signed out as given. Administrator A acknowledged Surveyor's observation and Resident 3's January 2026 eMAR documentation.

Resident 5

On 01/06/2026, Surveyor reviewed Resident 5's record which indicated, the resident was admitted to the facility on 03/14/2022 with diagnosis to

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include anxiety, epilepsy and hypertension. Additionally, the facility managed and administered all of Resident 5's medication. Resident 5 had physician's orders for, "aripiprazole 5 mg tablet by mouth daily."

On 01/06/2026 at approximately 9:15 AM, Surveyor observed the medication cart with Caregiver E. Surveyor observed Resident 5's eight (8) AM aripiprazole 5 mg blister pack card was dispensed by the pharmacy on 12/30/2025, and noticed a tablet remained in the card for 01/02/2026 and 01/05/2026. Caregiver E acknowledged the observation and verified Resident 5's eight (8) AM aripiprazole medication was not punched out on 01/02/2026 and 01/05/2026. Caregiver E verified the medication was documented as being administered in Resident 5's eMAR, but the medication remained in the blister pack.

On 01/13/2026 at 1 PM, Surveyor interviewed Pharmacist I. Pharmacist I indicated Resident 5's aripiprazole medication blister pack card dispensed on 12/30/2025 started on 01/02/2026.

On 01/06/2026 at approximately 11:45 AM, Surveyors discussed the above observation of Resident 5's aripiprazole medication remaining in the blister pack and being documented as given with Administrator A. Administrator A acknowledged Surveyor's observation and Resident 5's January 2026 eMAR documentation.

Resident 2

On 01/06/2026, Surveyor reviewed Resident 2's record which indicated, the resident was admitted to the facility on 08/30/2023 with diagnosis to include anxiety, depression and dementia.

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N 352	Continued From page 12 Additionally, the facility managed and administered all of Resident 2's medication. Resident 2 had a physician's order for, "aripiprazole 10 mg tablet by mouth daily at 8 AM" On 01/06/2026 at approximately 9:25 AM, Surveyor observed the medication cart with Caregiver E. Surveyor observed an eight (8) AM aripiprazole 10 mg blister pack card for Resident 2, which was dispensed by the pharmacy on 12/02/2025. Surveyor noticed a tablet remained in the card for 12/09/2025, 12/18/2025, 12/27/2025, 12/29/2025 and 12/31/2025. Surveyor reviewed Resident 2's December 2025 eMAR which revealed Resident 2's aripirazole 10 mg medication was documented as being administered but the medication remained in the blister pack. Surveyor observed a second eight (8) AM aripiprazole 10 mg blister pack card for Resident 2, which was dispensed by the pharmacy on 12/30/2025. The blister pack had a tablet remaining in the card for 01/02/2026, 01/03/2026, 01/04/2026 and 01/05/2026. Caregiver E acknowledged the observation and verified Resident 2's eight (8) AM aripiprazole medication was not punched out on 01/02/2026, 01/03/2026, 01/04/2026 and 01/05/2026. Caregiver E also verified the medication was documented as being administered in Resident 2's eMAR, but the medication remained in the blister pack. A total of nine (9) doses of aripiprazole 10 mg remained in the blister packs and were not administered to Resident 2. On 01/13/2026 at 1 PM, Surveyor interviewed Pharmacist I. Pharmacist I indicated Resident 2's aripiprazole medication blister pack card dispensed on 12/02/2025 started on 12/05/2025 and ended on 01/01/2026. Resident 2's aripiprazole medication blister pack card	N 352		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 13 dispensed on 12/30/2025 started on 01/02/2026. On 01/06/2026 at approximately 11:45 AM, Surveyors discussed the above observation of Resident 2's aripiprazole medication remaining in the blister packs and being documented as given with Administrator A. Administrator A acknowledged Surveyor's observation and Resident 2's December 2025 and January 2026 eMAR documentation. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 352		
N 366	83.34(1) Limitations on control of resident funds. Authorization. Except for a resident in the custody of a government correctional agency, the CBRF may not obtain, hold, or spend a resident ' s funds without written authorization from the resident or the resident ' s legal representative. The resident or the resident ' s legal representative may limit or revoke authorization at any time by writing a statement that shall specify the effective date of the limitation or revocation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain written authorization from residents or their legal representatives before obtaining, holding or spending resident funds. Findings include:	N 366		

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N 366	Continued From page 14 The Department received a complaint alleging concerns with Administrator A's management of resident funds. On 01/06/2026 at 10:05 AM, Surveyor interviewed Resident 5. Resident 5 said Administrator A has his/her debit card and helps him/her to purchase items. Resident 5 said Administrator A is currently helping him/her purchase a necklace and s/he has purchased other items in the past. Surveyor reviewed Resident 5's record at 10:30 AM, and the record indicated s/he had a legal representative. On 01/06/2026 at 3:23 PM, Surveyors interviewed Administrator A who confirmed s/he manages funds for Resident 5 and typically makes purchases for Resident 5 using Amazon. Administrator A accessed the computer and showed surveyor his/her personal Amazon account. The payment methods associated with the account included Resident 5's credit card, along with at least 3 other residents from a sister facility. Administrator A also said s/he had possession of a physical copy of 5's credit card. Administrator A said Resident 5's legal representative was aware s/he had access to the credit card but s/he did not have evidence of written authorization from Resident 5's legal representative to obtain, hold or spend Resident 5's funds. Administrator A said s/he was unaware of the requirement. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Law N0214 DHS 83.15(3)(a) Administrator Shall	N 366		

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N 366	Continued From page 15 Supervise Daily Operations N0368 DHS 83.34(2)(b) Accounting Method for Tracking Resident Cash	N 366		
N 368	83.34(2)(b) Accounting method for tracking resident cash The CBRF shall have a legible, accurate accounting method for tracking residents ' cash and shall include a record of any deposits, disbursements and earnings made to or on behalf of the resident. The CBRF shall provide a receipt to the resident or the resident ' s legal representative for all expenditures in excess of $20. This Rule is not met as evidenced by: Based on interview and record review, the provider did not have an accounting method for tracking resident funds to include a record of deposits or disbursements and did not provide receipts to the resident or their legal representatives for all expenditures in excess of $20.00. Findings include: The Department received a complaint alleging concerns with Administrator A's management of resident funds. On 01/06/2026 at 10:05 AM, Surveyor interviewed Resident 5. Resident 5 indicated Administrator A makes purchased on his/her behalf using a debit card. On 01/06/2026 at 3:23 AM, Surveyors interviewed Administrator A. Administrator A confirmed s/he manages funds for Resident 5 in the form of a	N 368		

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N 368	Continued From page 16 prepaid credit card which s/he primary uses to shop on Amazon on Resident 5's behalf. Administrator A indicated s/he set up this method of managing funds for Resident 5 and other residents in sister facilities because s/he does not want any cash in the facility. Administrator A explained guardians inform him/her when they make deposits on the prepaid cards, but Administrator A said s/he has no idea what the current balances are or if they are in excess of $200.00. Administrator A confirmed s/he does not have an accounting method to track deposits to the card, purchases or balances. Administrator A said s/he relies on legal representatives to access the account information themselves on the credit card website. Administrator A explained if s/he was asked to provide an accounting of the spending, s/he would go through his/her personal Amazon account and print receipts for all the orders that were for Resident 5. Administrator A did not indicate s/he proactively provides receipts to legal representatives. Administrator A said this is the method s/he uses for all the facilities s/he manages and s/he was unaware of the requirement to have an accounting method for tracking resident funds or to provide receipts for purchases over $20.00. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0366 DHS 83.34(1) Limitations On Control of Resident Funds N0368 DHS 83.34(2)(b) Accounting Method for Tracking Resident Cash	N 368		

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N 389	Continued From page 17	N 389		
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 observation, interview and record review, the provider did not ensure an individual service plan (ISP) was updated when there was a change in Resident 2's needs. Resident 2 frequently refused toileting/incontinence cares and meals. The provider did not evaluate the resident's refusals, in an attempt to determine the reason for the refusals, offer/implement new interventions or update the ISP to ensure Resident 2's physical health does not deteriorate. Findings include: On 10/15/2025, the Department received a complaint regarding resident care. On 01/06/2026 from 8:30 AM until 10:30 AM, Surveyor observed Resident 2 lying in bed	N 389		

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N 389	Continued From page 18	N 389		

sleeping. At 10:30 AM, Caregiver E told Surveyor Resident 2 was incontinent of bowel and bladder, used a walker, and required some staff assistance with ADL's (activities of daily living). Caregiver E stated, "I check [Resident 2] every two hours for toileting and incontinence, but [Resident 2] often refuses toileting/incontinence cares and wants to be left alone." Surveyor then asked Caregiver E what s/he does when [Resident 2] refuses cares. Caregiver E stated, "I call [Administrator A] and will re-approach...Sometimes it works." Surveyor questioned Caregiver E if Resident 2's ISP listed any interventions for staff to offer/utilize to prevent and/or manage the refusals. Caregiver E was not aware of any written interventions and indicated s/he does not document the two hour toileting checks for Resident 2.

On 01/06/2026, Surveyor reviewed the medical record for Resident 2. The record indicated the resident was admitted to the facility on 08/30/2023 with diagnosis to include history of UTI (Urinary Tract Infection), diabetes, Lewy Body Dementia, aneurysm, right hip fracture and depression. The record also noted Resident 2 had an activated POA (Power of Attorney).

On 01/06/2026, Administrator A provided Resident 2's current unsigned ISP (Individual Service Plan) dated 01/06/2026. Review of Resident 2's ISP dated 01/06/2026 indicated Resident 2 ambulated with a walker, was incontinent of bowel and bladder and required assistance from staff for bathing, dressing and toileting. The ISP indicated, "[Resident 2] is totally incontinent of stool and urine and wears an incontinent brief. [Resident 2] is to be toileted every two hours and as needed...[Resident 2] needs assistance with eating as needed.

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N 389	Continued From page 19 [Resident 2] is diabetic make sure [s/he] is up and eats three meals and snacks every day." Resident 2's observation notes were reviewed from 09/01/2025 to 01/06/2026. The following was documented: *09/09/2025- "[Resident 2] is all wet and refuses to get up...and won't eat..." *09/14/2025- "[Resident 2] is refusing to get toileted and to eat breakfast..." *09/19/2025- "[Resident 2] has refused every attempt to get [her/him] up and ready..." *09/26/2025- "[Resident 2] had a BM (Bowel Movement) in depend, was soiled completely. Shower done and [s/he] was complaining of [her/his] bottom being sore..." *09/28/2025- "[Resident 2] continues to reject any offer to get [her/him] up...just wants to be left alone." *10/03/2025- "[Resident 2] refused to get up and eat breakfast says [s/he] wants to be left alone." *10/17/2025- "[Resident 2] refused to be toileted and get up for breakfast..." *11/07/2025- "[Resident 2] refused to go to the washroom." *11/10/2025- "[Resident 2] is refusing to eat or be toileted." *11/18/2025- "As I came onto my shift [Resident 2] was sitting in common area and was full of poop another staff was approached by [Resident	N 389		

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N 389	Continued From page 20	N 389		

2's] family and staff assisted in getting [Resident 2] showered and cleaned up."

*11/19/2025- "[Resident 2] refuses to eat just wants to be left alone and sleep."

*11/23/2025- "[Resident 2] refused changing incontinent brief and cloths..."

*12/05/2025- "[Resident 2] has refused every attempt to get up this AM. [S/he] refused breakfast and to be toileted."

*12/12/2025- "[Resident 2] refused...to be toileted, did not want to eat breakfast and wants to sleep and be left alone."

*12/16/2025- "[Resident 2] refused dinner..."

***Surveyor noted Resident 2's most current ISP dated 01/06/2026 did not include information about the resident's refusals for toileting/incontinence care and meals, nor did the ISP list interventions for staff to offer/utilize to prevent and/or manage the refusals. In addition, no documentation was found to show the provider attempted to determine the reason for Resident 2's refusals, offer or implement new interventions, or update the ISP to ensure the resident's physical health does not deteriorate.

On 01/07/2026 at 3:50 PM, Surveyor spoke with Family Member H regarding Resident 2. Family Member H indicated s/he visits Resident 2 at least weekly. Family Member H stated, "[Resident 2] gets frequent UTIs...There have been several times I would come to visit and [Resident 2] smelled of urine and feces and it was all over [her/him]. I talked to [Resident 2's] care team about this and they would tell me to talk to

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N 389	Continued From page 21 [Administrator A]. I would talk to [Administrator A] about this and nothing happens...When I find [Resident 2] soiled in urine or feces, which is quite often, a UTI happens." On 01/06/2026 at 11:30 AM, Surveyor interviewed Administrator A about Resident 2. Administrator A verified Resident 2 is incontinent of bowel and bladder and often refuses toileting/incontinence cares and meals. Surveyor then asked what interventions were attempted to ensure Resident 2's physical health does not deteriorate. Administrator A stated, "We keep checking on [Resident 2] and will re-approach to get [Resident 2] up...It really depends on the day, sometimes music or singing to [her/him] works." Surveyor then asked Administrator A about Resident 2's current ISP to address the resident's refusals. Administrator A verified Resident 2's ISP dated 01/06/2026 did not address the resident's refusals and confirmed the ISP did not contain any interventions for staff to offer/utilize when Resident 2 refuses toileting/incontinence cares and meals. Administrator A stated, "I will talk to the care team about getting a behavioral support plan in place...There's nothing developed yet, but it's in the works." Administrator A acknowledged Resident 2's ISP dated 01/06/2026 was the most current ISP and was not signed by the resident or resident's legal representative. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 389		
{N 481}	83.43(1) Environment safe, clean, and comfortable	{N 481}		

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{N 481}	Continued From page 22 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 home was clean, comfortable, well maintained and homelike. This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) 6DQN11, dated 04/24/2025 and SOD 6DQN12 dated 09/16/2025 . Findings include: The Department received a complaint alleging the facility was dirty. On 01/06/2026 at 9:25 AM, Surveyor toured the facility to verify correction of the previous environmental concerns. Surveyor observed some previously identified concerns were uncorrected and new concerns were identified: Kitchen --There were scrapes and food splatters on the kitchen cabinets and drawers. Three of the cabinet doors would not stay closed and one drawer was not aligned in the track. (PHOTOS 0516, 0515 and 0526) --The edge of the kitchen counter where it met the dishwasher had a section broken off approximately 12 inches long by 2-3 inches wide. (PHOTO 0517)	{N 481}		

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{N 481}	Continued From page 23 --The edges of the kitchen counter where it met the stove were broken off and further separating, exposing the raw countertop material. The fully exposed sections were approximately 4 inches long. (PHOTO 0512 and 0520) --The walls behind the counters were dirty with food splatters. (PHOTO 0513 and 0519) --The exterior of the dishwasher was dirty with a dark substance splattered on it. (PHOTO 0517) --The exterior of the stainless steel stove was discolored, water stained and dirty. (PHOTO 0512 and 0523) --The window had large cracks that were covered with tape. (PHOTO 0610 and 0611) --The floor register was covered in an orange substance that appeared to be rust. (PHOTO 0526) --A kitchen sized garbage can with a broken cover was positioned against a wall. The hood of the cover was missing, thus the can was open and the internal garbage exposed. There was dried food and bits of garbage on the exterior of the cover and along the front of the can. There were splatter marks on the wall behind the trash can. Surveyor observed the food splatters and debris were dried, indicating this was not recent. (PHOTO 0525) Other concerns: --The transition strip from Resident 1's room to the hallway was missing. This exposed jagged edges of the floor and an uneven transition that presented a tripping hazard. (PHOTO 0527 and 0528) --The west side bathroom was missing a piece of wood floor trim approximately 2 feet long. (PHOTO 0530 and 0531) --Resident 6's bedroom floor had debris from paper and candy wrappers. During at interview at 10:00 AM Resident 6 said s/he would like more	{N 481}		

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{N 481}	Continued From page 24 help from staff with keeping his/her floor clean. (PHOTO 0545, 0546 AND 0547) During an interview with Administrator A on 01/06/2026 at 1:36 PM , Surveyor reviewed the aforementioned concerns. Administrator A did not offer additional information. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0492 DHS 83.45(1)(a) Exterior Areas N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperatures	{N 481}		
{N 492}	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure exterior areas were in good repair and free from hazards This is a repeat deficiency. See Statement of Deficiency 6DQN12, dated 09/16/2025 . Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: developmentally disabled, irreversible dementia/Alzheimer's, physically disabled, terminally ill, traumatic brain injury and	{N 492}		

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{N 492}	Continued From page 25 emotionally disturbed/mental illness. Upon arrival at the facility on 01/06/2026 at 8:00 AM, Surveyors observed the parking lot and exterior of the home were not in good repair, well maintained or free from hazards. The parking lot was covered in a layer of snow and ice. Surveyors found the parking lot very slippery as they walked to the entrance of the facility. (PHOTO 0502) The snow and ice were not cleared anytime prior to Surveyor's departure at a 4:50 PM. Surveyor reviewed the provider's fire evacuation plan which documented the safe meeting place was in the road at the end of the large parking lot. During the onsite visit on 01/06/2026, Surveyor observed at least three residents relied on assuasive devices for ambulation. Surveyor noted there had been no snowfall in recent days. This was verified by checking historical weather date from Weather Underground; no precipitation was recorded from 01/04/2025 at 6:15 AM through 01/06/2025 at 6:15 AM. Source: https://www.wunderground.com/history/daily/us/wi , retrieval date 01/14/2026. Surveyor observed garden beds that lined the front of the home were littered with items that were partially covered or blocked by snow (PHOTO 0503, 0504, 0505, 0535, 0533, 0537 and 0536). This included: --Two full sized couches, 1 stacked on top of the other. There was snow on top of the couches indicating they had not been recently placed there. --Two commodes and a rusted metal gardening tool; all were behind snow banks.	{N 492}		

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{N 492}	Continued From page 26 --A broom and garden hose laying on the ground partially covered in snow. --Two children's bikes were in the same position as the last survey and covered in snow. Surveyor observed the east exit door. Based on review of the posted exit diagram, this was one of 3 identified emergency exits. There was a painted, wooden hand rail leading from the doorway, alongside a concrete ramp and to the driveway. The railing was worn and chipped, exposing raw and jagged pieces of wood. Three spokes of the handrail had separated from the structure. (PHOTO 0541, 0542 and 0544) Surveyor observed the approach to the main entrance door. A long black floor mat was placed horizontally at the base of the ramp leading to the door. The matt was affixed to the ground but an edge of the mat was raised up approximately 1 inch and presented a tripping hazard. (PHOTO 0549) At 12:00 PM, Surveyor observed Resident 3 sitting on the seat of his/her walker smoking on the back patio. Resident 3's walker left tracks where it traveled approximately 5 feet through a thin layer of snow, slush and ice. (PHOTO 0604 and 0605) Surveyor interviewed Resident 3 who confirmed the area had not been cleared for days and was slippery. At 12:30 PM Surveyor observed Resident 1 using the same snow covered smoking area. During an interview with Administrator A on 01/06/2026 at 3:23 PM, Surveyor identified the concerns regarding the exterior areas. On 01/12/2026 at 10:25 AM, Surveyors conducted a return visit to the facility and	{N 492}		

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	0017961	A. BUILDING: _____ B. WING _____	R-C 01/13/2026

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{N 492}	Continued From page 27 observed the following: --the exterior remained the same with the exception of; (1) snow and ice was no longer present in the parking lot (temperatures had been warm enough to melt) and (2) the commodes were removed. --new concerns were observed including overflowing and uncovered garbage cans and cardboard boxes strewn on the ground next to the front entrance ramp. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0492 DHS 83.45(1)(a) Exterior Areas N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperatures	{N 492}		
{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, the provider did not ensure the water heater was set to a	{N 617}		

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{N 617}	Continued From page 28 temperature of at least 140°F. This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) 6DQN11, dated 04/24/2025 and SOD 6DQN12, dated 09/16/2025. Findings include: The provider is licensed to serve up to 8 residents from the following client groups; irreversible dementia/Alzheimer's, Emotionally Disturbed/Mental Illness, Physically Disabled, Advanced Aged, Terminally Ill, Traumatic Brain Injury. On 01/06/2026 at 3:05 PM, Surveyors and Licensee C went to the basement to verify correction of the previous citation related to the temperature setting of the water heater. Surveyor observed there was a thermostat dial with 9 settings ranging from "LOW" to "VERY HOT": Setting : LOW Settings with three unnumbered hash marks Setting: HOT Settings A, B and C Setting: VERY HOT The dial on the water heater was set between HOT and A, a setting of approximately 125°F (PHOTO 0615) Surveyor observed 2 temperature gauges on top of the water heater. The temperature gauge to the left read 112°F and a second gauge placed higher and to the right, read 110°F. (PHOTO 0307, 0616, 0617 and 0618) Surveyor stated to Licensee C the thermostat was at the same setting as during the previous	{N 617}		

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{N 617}	Continued From page 29	{N 617}		

survey, indicating the water was being held at a temperature lower than 140°F. In addition, neither of the two temperature gauges had readings to indicate the water was held at least 140°F.

Licensee C responded that the plumbing company was onsite in November of 2025 and the thermometer dial was turned up. However, this resulted in water temperatures at the faucets being too hot for residents so the plumbing company advised Licensee C to the turn the thermostat back down.

Surveyor reviewed the dual regulatory requirements for the water heater to be set at a minimum temperature of 140°F to prevent bacteria growth, and for the use of a mixing valve to ensure water temperatures at the faucets used by residents were 115°F or below to prevent burns. Licensee C reiterated s/he had a plumber look at the system, s/he had the temperature gauge set where they recommended and it was his/her believe that was the only way to ensure the water at the faucets used by residents would be a safe temperature.

Surveyor observed the water heater had an affixed sticker identifying Plumbing Company F.

On 01/07/2026 at 8:06 AM, Surveyor conducted an interview with Service Manager E from Plumbing Company F. Surveyor also emailed Service Manager E photos of the water heater, thermostat setting and temperature gauges as observed the previous day.

--Service Manager E confirmed all water heaters should be set at atleast 140° F to prevent bacteria growth and that hot water from the heater should be mixed with cold water via use of a mixing

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{N 617}	Continued From page 30	{N 617}		

valve to ensure the temperatures at common use faucets would not cause burns. Service Manager F said the exception to cooling water at the faucets should be made in the kitchen to ensure the temperatures are high enough to sanitize dishes.
--Service Manager E said after reviewing the photos, the thermostat was set at approximately 125°F. She also explained the temperature guages; the gauge to the left should read the temperature of the water in the water heater, and the gauge up higher and to the right should read the temperature of the water after it was mixed with cold water. Surveyor informed Service Manager E that while s/he was onsite, the water at a bathroom faucet was 115.3°, which was warmer than the 110°F reading on the corresponding temperature gauge. Surveyor also noted the thermostat was set at 125°F but the corresponding temperature gauge read 110°F.

Service Manager E acknowledged the discrepancies and said it was possible the gauges were faulty. S/he said the only way to confirm that would be to conduct a service call at the facility. Service Manager E said according to their records, they had not been to the facility since 2019.

On 01/12/2026 at 9:04 AM, Surveyor interviewed Licensee C and reviewed the aforementioned concerns, including the information received from Service Manager E. Licensee A did not provide additional information.

SURVEYOR NOTES:
--"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

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{N 617}	Continued From page 31 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/#:~:text=Next%20on%20the%20dial%20is,is%20for%20160%20degrees%20Fahrenheit, retrieval date 01/13/2026. -- "Domestic hot water systems are 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 01/13/2026. --"Legionnaires' disease is a severe form of a lung infection called pneumonia. It's caused by a bacterium known as legionella. Most people who catch Legionnaires' disease breathe in the bacteria from water or soil. Older adults, people with weakened immune systems and people who smoke have a higher risk of getting Legionnaires' disease. The legionella bacterium also causes Pontiac fever, a milder illness that's like the flu. Pontiac fever usually clears on its own. But untreated Legionnaires' disease can kill." Source: https://www.mayoclinic.org/diseases-conditions/legionnaires-disease/symptoms-causes/syc-20351747, retrieval date 01/13/2026.	{N 617}		

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{N 617}	Continued From page 32 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0492 DHS 83.45(1)(a) Exterior Areas	{N 617}		